HIV/AIDS in Malawi

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Preface

This research was undertaken as part of the Country AIDS Policy Analysis Project, which is managed by the AIDS Policy Research Center at the University of California San Francisco. The project is funded by the U.S. Agency for International Development, Cooperative Agreement PHN-A-00-01-00001-00. Stephen F. Morin, PhD, is the project’s Principal Investigator. The views expressed in this paper do not necessarily reflect those of USAID.

The overarching objective of the Country AIDS Policy Analysis Project is to inform planning and prioritizing of effective and equitable HIV/AIDS prevention and treatment interventions through multidisciplinary research on HIV/AIDS. The project evolved from the acute need for analysis of the epidemiology of HIV/AIDS in tandem with analysis of countries’ political economy and sociobehavioral context — at household, sectoral, and macro levels. This multidisciplinary analysis aims to:

- help inform national HIV/AIDS policies
- strengthen ability to plan, prioritize, and implement effective interventions
- highlight the range of sectoral interventions that may affect or be affected by HIV/AIDS
- facilitate multisectoral/interministerial coordination
- facilitate intercountry information sharing
- increase national and subregional capacity for effective partnerships

The project develops and disseminates online, easy-to-download, continually updated analyses of HIV/AIDS in 12 USAID Rapid Scale-Up/Intensive Focus/Basic Program countries: Ethiopia, Kenya, Malawi, Senegal, South Africa, Uganda, Tanzania, Zambia, Zimbabwe, Brazil, Cambodia, and India.

The primary audience for the country analyses is in-country HIV/AIDS planners, including those from government ministries and agencies, multi- and bilateral donors, international and local NGOs, health care institutions, prevention programs, academia, faith-based organizations, affected communities, and the private sector. International investigators and policymakers also report using the analyses in their work.

All country analyses undergo peer review at the AIDS Research Institute of the University of California San Francisco. In addition, two in-country experts from each profiled country serve as peer reviewers. A scientific advisory board also reviews all analyses.

Each analysis is linked with national strategic plans for HIV/AIDS prevention, care, and support. Analyses also include extensive links to related resources. An interactive, global database of key HIV/AIDS and socioeconomic indicators is under development; it will allow users to conduct a variety of comparative analyses.

Project staff are in regular contact with national HIV/AIDS professionals who provide and verify data as needed. Staff continually assess and incorporate new data to maintain the timeliness of the analyses.
**Note on Data Sources**

All racial categorizations and nomenclature used in the data sources cited throughout this paper have been maintained; they do not constitute an endorsement of any particular terminology.

**Acknowledgments**

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**Contact Information**

Because this analysis is continually updated, comments and suggested sources of new data are welcome and may be sent to the coinvestigator/project director at UCSF’s AIDS Policy Research Center: Lgarbus@psg.ucsf.edu

**Executive Summary**

**Epidemiology**

During the early years of the HIV epidemic, prevalence among women attending ANC sites rose rapidly in urban areas, with the highest prevalences in Blantyre, the country's commercial center. In 1998, Malawi's adult HIV prevalence was estimated at 14 percent. Among regions, adult prevalence was highest in Southern Region, followed by Central and Northern regions. In 2001, HIV prevalence ranged from 10 percent in rural ANC sites to nearly 30 percent in urban ones. Adult HIV prevalence was estimated at 15 percent (13 percent in rural areas and 25 percent in urban areas). Although prevalence declines have recently been observed among some age groups in ANC sites in Lilongwe and Blantyre, whether they indicate a real trend requires validation and further study.

At the end of 2001, UNAIDS estimated that 850,000 Malawians were living with HIV/AIDS and that adult prevalence was 15.0 percent. Of adults infected with HIV, 56.4 percent were women.

The first case of AIDS in Malawi was reported in 1985. AIDS cases among women peak between ages 15 and 29, and among men at ages 30 and above.
Heterosexual transmission accounts for 90 percent of HIV infection in Malawi. Mother-to-child transmission of HIV represents 9 percent of infections, and transmission via unsafe blood products about 1 percent. Data on transmission via men who have sex with men are unavailable.

Determining current HIV/AIDS dynamics and trends in Malawi is impeded by lack of complete and timely surveillance and behavioral data. Although ANC data currently serve as Malawi's primary HIV sentinel surveillance, they may not accurately reflect the population, in particular rural and younger age groups. Moreover, poverty and the current food crisis may affect ANC attendance.

**Political Economy and Sociobehavioral Context**

Many of the factors discussed below exist in countries that, unlike Malawi, have low HIV prevalence; these include poverty, gender inequality, and history of colonialism and political and economic disenfranchisement. Analysis of these factors seeks to highlight the range of sectoral policies and interventions that may affect or be affected by HIV/AIDS.

Malawi is one of the world's poorest countries. HIV/AIDS has undermined the country’s efforts to reduce poverty and is now itself an important part of structural poverty in Malawi.

Structural adjustment programs failed to create sustainable, broad-based growth. Further, many of the high costs of these programs were borne by the poor. Malawi is deeply dependent on a single crop for export earnings. The economy has been adversely affected by a severe drought in the 2001-02 agricultural season, and the country continues to rely heavily on foreign aid. In December 2000, Malawi qualified for debt relief under the Enhanced Heavily Indebted Poor Countries Initiative (HIPC). However, the projections and assumptions underlying HIPC have been strongly criticized.

Throughout southern Africa, high levels of movement among urban, rural, and mining areas facilitate HIV transmission. Poverty may lead to increased migration, both within Malawi and to other countries, as people move from rural to urban areas in search of work — or return to families if they lose their jobs or fall ill and cannot afford care. Male migration separates men from their families, places them in close proximity to "high-risk" sexual networks, and often results in their having an increased number of sexual contacts. Concurrently, it may lead to women's reliance on sex to supplement their incomes while their male partners are away for long periods.

Key mobile groups in Malawi include truck drivers, sex workers, fishermen/women and fish traders, migrant and seasonal workers, military personnel, prisoners, and refugees. Floods, cholera, and famine also involve significant movement of people and regroupings of family units, which entail exposure to new sexual networks and thus may heighten vulnerability to HIV. Moreover, AIDS directly spurs population dislocation as, for example, orphans are sent to live with relatives residing in other regions of the country.

An estimated 29 percent of Malawians are in need of food aid. Although erratic weather has contributed to the current food crisis, one of the key underlying factors is the depletion of human resources as a result of HIV/AIDS. High levels of HIV/AIDS infection mean that the coping strategies of communities, already under major stress, are at breaking point.
Despite some improvements in health outcomes since independence, Malawians' health status remains poor. The human and financial constraints to improving Malawians' health care system are enormous. Concurrently, almost all the strategies that form the government's national response to HIV/AIDS depend heavily on the country's ability to improve delivery of basic health services.

Although general awareness of AIDS is nearly universal, behavior change messages may not be effectively highlighting key strategies for HIV prevention, nor adequately debunking false beliefs about HIV transmission. Strong stigma around HIV/AIDS persists. Overall condom use is low.

Malawian women become infected with HIV at younger ages than men for both biological and behavioral reasons. Many women are unable to insist on condom use and negotiate the timing of sex and the conditions under which it occurs. Gender inequality remains a major barrier to improving the standard of living and reproductive health of women in Malawi. Some communities observe certain practices that promote ritual sex and may entail risk of HIV infection, including initiation ceremonies, widow inheritance, and sexual cleansing. A related phenomenon is "grabbing," wherein relatives forcefully take possession of the deceased's assets. This scenario exacerbates the already precarious economic (and social) situation of widows and their children.

Male circumcision is uncommon in Malawi. One Malawian study found that lack of male circumcision was associated, though not significantly, with HIV acquisition.

**Impact**

In 2002, life expectancy in Malawi was 38.5 years, whereas it would have been 56.3 in a "no-AIDS" scenario. By 2010, life expectancy is projected to fall to 36.9.

In the medium term, Malawi will experience a 4.8 percent reduction in GDP per capita because of HIV/AIDS. Much of this decrease is the result of lost knowledge and skills due to AIDS mortality within the workforce.

HIV/AIDS-related conditions currently account for over 40 percent of all inpatient admissions. Increases in health worker morbidity and mortality have reduced the supply of personnel and increased stress and overwork. Lost time and labor have rendered health care more scarce and more expensive, leaving households to take on a significant burden.

Malawi's National TB Control Program is internationally recognized for its success. However, since the early 1990s, it has been struggling to cope with increasing numbers of HIV-infected TB patients and worsening economic conditions.

Malawi's poor have traditionally relied on informal safety nets, such as the extended family. However, HIV/AIDS, poverty, macroeconomic policies, and food shortages have rendered traditional coping mechanisms largely irrelevant. Because of AIDS mortality, many elderly Malawians — themselves facing economic hardship — are caring for numerous orphans.
Response

Shortly after the first AIDS case in Malawi was diagnosed in 1985, the government adopted a blood screening policy. Subsequently, a public education strategy on HIV/AIDS was developed. In 1989, the government established the National AIDS Control Program (NACP) within the Ministry of Health and Population. The Cabinet Committee on HIV/AIDS Prevention and Care was formed to provide policy and political direction to NACP. During the 1990s, Malawi developed medium-term plans for HIV/AIDS and, as part of the country's larger decentralization process, district AIDS coordinators and district AIDS coordination committees were established.

In 1996, the government and its partners evaluated the response to date. They found that despite high awareness of HIV/AIDS, behavior change had been limited and HIV incidence continued to increase. They also cited NACP's inability to provide the required technical leadership. In response, the government developed a national strategic framework for HIV/AIDS, which was launched by the president in October 1999, at which time he also declared HIV/AIDS a national emergency.

As of the end of 2000, the government's efforts to grant NACP the autonomy to implement the strategic framework were proceeding slowly. Additionally, NACP remained understaffed, thereby impeding its ability to function. Given the limitations of NACP, the National AIDS Commission (NAC) was established in July 2001 to coordinate multisectoral implementation of the strategic framework.

In May 2000, Malawi began the process of developing a national HIV/AIDS policy. As of January 2003, it still did not have such a policy, though it had aimed to have one completed by the end of 2002. However, some major steps have been taken, including early development of National Orphan Care Guidelines and release of an integrated behavior change intervention strategy in 2002.

Among ministries outside health, Agriculture has undertaken major efforts to mainstream HIV/AIDS prevention and mitigation. The Ministry of Education, however, has faced numerous constraints in implementing HIV/AIDS-related curricula.

To fund treatment, care, and support activities, Malawi applied to the Global Fund to Fight AIDS, Tuberculosis & Malaria. In August 2002, it received final approval from GFATM for US$196 million over five years. As of January 2003, no GFATM funds had yet been disbursed. The GFATM funds will be used to improve the country's health care delivery system to support HIV/AIDS activities, emphasizing local capacity and drawing on Malawi's success with DOTS to apply a similar monitoring system to HAART. However, whether the timeframe for developing the necessary infrastructure for delivery of HAART is sufficient is questionable, especially given the entrenched weaknesses of the health sector. Moreover, local AIDS entities lack formal coordination mechanisms, trained staff, sufficient equipment and operating funds, and monitoring and financial management systems. The stretched economic resources available at the community level also play a role in constraining the local response.
Knowledge of human rights is low in Malawi, particularly the role of law in HIV/AIDS. Policies that explicitly integrate a human rights-based approach to HIV/AIDS are in development.

Although the government has long recognized that increasing numbers of children are being affected by HIV/AIDS, it has no means of identifying these children and no adequate safety net to protect them. Extended families, as well as numerous NGOs and CBOs (including faith-based organizations), are providing the majority of care for orphans and OVC.

Because public tertiary health facilities are overburdened and the care they provide is costly, the majority of PWHA receive care at home. Numerous NGOs, CBOs, faith-based groups, associations of PWHA, and household members have shouldered most of this responsibility, with little government assistance. However, home-based care skills, capacity, and financing are extremely inadequate to meet increasing need.

Many Malawians visit traditional healers. Given the deteriorating health care system, visits to traditional healers may be increasing. Although the government recognizes traditional healers as stakeholders in the national response to HIV/AIDS, there has been a lack of coordination between herbalists and health officials.

Malawi's strategic framework for HIV/AIDS is premised on informed consent and confidentiality. Malawi has developed draft VCT guidelines and is developing curriculum and other training materials. Currently, the majority of VCT facilities are in urban areas.

PMTCT services are offered on a pilot basis by NGOs and within research projects in medical institutions in eight districts. Malawi has a PMTCT Task Force but no national PMTCT program. With funding from GFATM, Malawi plans to establish a PMTCT working group to finalize and disseminate policy guidelines.

Treatment of OIs has been limited by lack of HIV/AIDS diagnostic facilities, unclear treatment guidelines, frequent drug stock-outs, inadequate training of health care personnel, and poor referral processes. In January 2000, Malawi launched a pilot HAART program in Lilongwe and Blantyre. Several universities and NGOs are also conducting pilot HAART projects. Currently, Malawi has no national policy or guidelines on HAART, though there are plans to develop them.

Malawi developed its "Industrial Relations Code of Practice on HIV/AIDS" in 1996. In 2001, it issued a comprehensive policy on HIV/AIDS in the workplace. To what degree these instruments are being implemented, however, is unknown.

**Epidemiology**

**At a Glance**

*Surveys of Women Attending Antenatal Clinics*
During the early years of the HIV epidemic, prevalence among women attending ANCs rose rapidly in urban areas, with the highest prevalences in Blantyre. The 1985 sentinel survey in Blantyre found that HIV prevalence was 2 percent; in 1998, it had risen to 30 percent.

The 1998 ANC data found that across all age groups, HIV prevalence was higher among urban women than among those living in rural areas. HIV prevalence was highest among women ages 25 to 29 in Lilongwe (32 percent) and in Blantyre (44 percent). In rural areas, HIV prevalence ranged from 6 to 21 percent.

In 1998, Malawi’s adult HIV prevalence was estimated at 14 percent, with prevalence over twice as high in urban areas (26 percent) as in rural ones (12 percent). Among regions, adult prevalence was highest in Southern Region (18 percent) followed by Central (11 percent) and Northern (9 percent) regions.

In the 2001 ANC survey, HIV prevalence ranged from 10 percent in rural sites to nearly 30 percent in urban ones. Adult HIV prevalence was estimated at 15 percent (13 percent in rural areas and 25 percent in urban areas).

Although prevalence declines have recently been observed among some age groups in ANC sites in Lilongwe and Blantyre, whether they indicate a real trend requires validation and further study.

**UNAIDS Estimates**

At the end of 2001, UNAIDS estimated that 850,000 Malawians were living with HIV/AIDS (estimate range: 720,000 to 1.1 million) Of them, 780,000 were adults (ages 15 to 49), with adult prevalence at 15.0 percent.

UNAIDS estimates that of adults infected with HIV, 440,000 (56.4 percent) are women. HIV prevalence among women ages 15 to 24 ranges from 11.91 to 17.87 percent; the comparable range for men in the same age cohort is 5.08 to 7.62 percent.

According to UNAIDS, there were 65,000 Malawian children (ages 0 to 14) living with HIV/AIDS at the end of 2001.

**AIDS Cases**

The first case of AIDS in Malawi was reported in 1985.

AIDS cases among women peak between ages 15 and 29, and among men at ages 30 and above.

**AIDS Mortality**

HIV/AIDS is the leading cause of death among those ages 20 to 49.

In 2001, UNAIDS estimated that there were 80,000 adult and child AIDS deaths in Malawi.

The U.S. Bureau of the Census estimates that the crude death rate in Malawi in 2002 was 22.3 deaths per 1,000 population. In the absence of AIDS, this figure would have been 12.0. For 2010, the Census Bureau projects that these figures will be 23.1 and 9.9, respectively.

**Transmission Patterns**
HIV/AIDS in Malawi

- Heterosexual transmission accounts for 90 percent of HIV infection in Malawi. Mother-to-child transmission of HIV represents 9 percent of infections, and transmission via unsafe blood products about 1 percent. Data on transmission via men who have sex with men are unavailable.

Data Quality Issues

- Determining current HIV/AIDS dynamics and trends in Malawi is impeded by lack of complete, timely surveillance and behavioral data.
- ANC data currently serve as Malawi's primary sentinel surveillance of HIV. However, Malawi's National AIDS Commission and the U.S. CDC report that the HIV sentinel surveillance system in Malawi does not accurately reflect the population, in particular rural and younger age groups.
- Moreover, the population attending ANCs is likely to vary during the different stages of the epidemic. Poverty, the current food crisis, and other factors may also affect ANC attendance.

HIV Sentinel Surveillance

In 1985, Malawi's first HIV surveillance project was launched, among women attending the antenatal clinic at Queen Elizabeth Central Hospital in Blantyre. 1 (Blantyre, located in the country's Southern Region, is the country's main commercial center and largest city. Lilongwe is the capital, where all government ministries and Parliament are located, and is in the Central Region. [See accompanying map].) In 1994, Malawi's National AIDS Control Program (NACP) began HIV (and syphilis) sentinel surveillance among women attending antenatal clinics (ANCs) in 19 sites across the country. The average sample size is 500 to 600 for urban and semiurban sites and 150 to 200 for rural sites. 2

Findings

During the early years of the HIV epidemic, prevalence among women attending ANCs rose rapidly in urban areas, with the highest prevalences in Blantyre. The 1985 sentinel survey in Blantyre found that HIV prevalence was 2 percent; in 1998, it had risen to 30 percent.

The 1998 ANC data found that across all age groups, HIV prevalence was higher among urban women than among those living in rural areas. HIV prevalence was highest among women ages 25 to 29 in Lilongwe (32 percent) and in Blantyre (44 percent). In Mzuzu, a city in the Northern Region, prevalence was highest among those ages 20 to 24 (21 percent). Outside these three cities, the highest urban prevalences were in Mulanje and Nkhata Bay (25 percent). In rural areas, there was wider variation in HIV prevalences, ranging from 6 percent in Dowa to 21 percent in Thyolo. 3

In 1998, NACP used ANC data to estimate prevalence for the entire adult population: 14 percent, with prevalence over twice as high in urban areas (26 percent) as in rural ones (12 percent). 4 Among regions, NACP estimated that adult prevalence was highest in Southern Region (18 percent) followed by Central (11 percent) and Northern (9 percent) regions. It reported that
although HIV prevalence had increased in all parts of the country, the increase had been most dramatic in urban areas and in Southern Region.\textsuperscript{5}

In 1998, NACP estimated that 46 percent of new adult infections occurred in those ages 15 to 24; women accounted for 60 percent of these new infections. \textsuperscript{6}

In 2001, blood samples were drawn from 7,361 women attending ANCs from the 19 sentinel sites. HIV prevalence ranged from 10 percent in rural sites to nearly 30 percent in urban ones. \textsuperscript{7} Using these data, the National AIDS Commission (which had replaced NACP as the lead HIV/AIDS coordinating body) estimated that adult HIV prevalence in Malawi was 15 percent, with adult prevalence at 13 percent in rural areas and 25 percent in urban areas. NAC estimated that in 2001, there were 845,000 Malawian infected with HIV. \textsuperscript{8}

\textit{Prevalence Trends in Lilongwe and Blantyre}

In Lilongwe, the 2001 HSS found HIV prevalence of 20 percent, significantly below the average of 26.5 percent for 1996-98. Moreover, in Lilongwe, prevalence among women ages 15-24 has declined steadily, from 22 percent in 1998 to 13 percent in 2001. Examining trends in HIV prevalence in those ages 15-19 may provide some indication of trends in recently acquired HIV infection as this group is unlikely to have been infected for a long period of time. \textsuperscript{9} Given that an early indicator of behavior change is prevalence decline in the youngest age groups, \textsuperscript{10} this apparent decrease could be an indication of safer sexual behavior among youth in Lilongwe (although a study of behavior change among youth in Malawi is needed to validate this hypothesis). However, the perceived decline could be due to random fluctuations in the sample tested, increasing AIDS mortality, or migration (though migration is unlikely to play a major role.\textsuperscript{11}) The government and its partners agree that it is too early to state that HIV prevalence is declining in Lilongwe. \textsuperscript{12}

HIV prevalence in Blantyre was about 33 percent in 1996, and has averaged about 29 percent from 1998 to 2001. Prevalence among those 25 years and older has declined from 45 percent in 1996 to about 27 percent in 1998-2001, whereas prevalence among women ages 15 to 24 has not shown a declining trend. In 2001, 30 percent of 15- to 19-year-olds in Blantyre were HIV-positive. \textsuperscript{13} Again, apparent decline in Blantyre could be due to random fluctuations in the sample tested, AIDS mortality, or migration (though it is unlikely to be attributable to behavior change, for the reasons discussed above). \textsuperscript{14}

Examination of similar trends for Malawi's other sentinel sites reveals no clear trend in declining prevalence in the younger age groups. \textsuperscript{15} It is not clear why the situation in Blantyre and Lilongwe differs. Additional research will be needed to understand whether these trends are real and, if so, why the patterns differ. \textsuperscript{16}

\textbf{HIV Incidence}

Although monitoring trends in HIV prevalence provides information on the magnitude of the HIV epidemic, trends in prevalence cannot be relied upon to indicate trends in HIV incidence. \textsuperscript{17}
The major incidence data from Malawi are from a study of male workers from the Nchalo sugar plantation. Researchers from the University of Malawi, Johns Hopkins, and Rutgers examined the incidence of HIV infection among two cohorts recruited in 1994 and 1998. There was a slight decline in HIV prevalence among men screened in 1994 (n = 1692; prevalence 24.3 percent) and 1998 (n = 1349; prevalence 21.0 percent) ($\chi^2 = 4.65; p = .03$).

During 1994-95, incidence of HIV was extremely high (17.1 percent). Following this initial high peak, HIV incidence declined dramatically over a relatively short period of time. For example, incidence of HIV during the second year of follow-up for the 1994 cohort was only 3.1 percent, a decrease of 14 percent. During 1996-97, incidence was 4.2 percent; 1997-98: 2.5 percent; and 1998-99: 4.2 percent. For the 1998 cohort, incidence during 1998-99 was 3.8 percent.

In the 1994 cohort, there was a linear decreasing trend in HIV incidence with increasing age, with the youngest group (18-24 years) having an incidence nearly double that of their oldest (55 years) counterparts ($p = .12$). In the 1998 cohort, in which men were observed on average for one year, and in which fewer cases of seroconversions were observed, no clear trend of declining HIV incidence with age was apparent ($p = .91$).

Several factors may have played a role in the incidence decline and its subsequent stability. For example, in a closed cohort study conducted over a short period of time, there may have been few susceptible individuals to sustain transmission at the same rapid rate of seroconversion. Prevention interventions may have been a factor, as the researchers also found significant reductions in reported STIs and number and type of sexual partners, as well as a significant increase in reported condom use between 1994 and 1998. However, they believe that condom use was inconsistent (or that there were reporting errors) because there was no concomitant reduction in rates of reactive syphilis. Mortality, migration, and changes in the composition of the sugar plantation's labor force may also have been factors.

Thus, determining current HIV/AIDS dynamics and trends in Malawi is difficult. Part of this problem is lack of complete, timely surveillance and behavioral data. (Weaknesses in Malawi's health surveillance system are discussed in depth in the Political Economy & Sociobehavioral Context section below.)

**UNAIDS Estimates**

At the end of 2001, UNAIDS estimated that 850,000 Malawians were living with HIV/AIDS (estimate range: 720,000 to 1.1 million) Of them, 780,000 were adults (ages 15 to 49), with adult prevalence at 15.0 percent. (At the end of 1999, UNAIDS estimated adult prevalence at 15.96 percent.) Malawi's adult HIV prevalence is the eighth-highest in the world, following that of Botswana (38.8 percent), Zimbabwe (33.7), Swaziland (33.4 percent), Lesotho (31.0 percent), Namibia (22.5 percent), Zambia (21.5 percent), and South Africa (20.1 percent).

UNAIDS estimates that of adults infected with HIV, 440,000 (56.4 percent) are women. HIV prevalence among women ages 15 to 24 ranges from 11.91 to 17.87 percent; the comparable range for men in the same age cohort is 5.08 to 7.62 percent.
According to UNAIDS, there were 65,000 Malawian children (ages 0 to 14) living with HIV/AIDS at the end of 2001.25

**AIDS Cases**

The first case of AIDS in Malawi was reported in 1985. As of June 1999, over 53,000 AIDS cases had been officially reported. However, as most cases are not reported, the National AIDS Control Program estimated that the actual cumulative number of AIDS cases through 1998 was over 265,000.26

Examining cumulative AIDS cases, NACP found that AIDS cases among women peak between ages 15 and 29, and among men at ages 30 and above.27 This suggests significant transmission from older males to younger females. (See "Age Mixing" below.)

**AIDS Mortality**

According to Malawi's National AIDS Commission, HIV/AIDS is the leading cause of death among those ages 20 to 49.28 In 2001, UNAIDS estimated that there were 80,000 adult and child AIDS deaths in Malawi.29 (The comparable figure for 1999 was 70,000.30)

The U.S. Bureau of the Census estimates that the crude death rate in Malawi in 2002 was 22.3 deaths per 1,000 population. In the absence of AIDS, this figure would have been 12.0. For 2010, the Census Bureau projects that these figures will be 23.1 and 9.9, respectively.31

**Transmission Patterns**

Heterosexual transmission accounts for 90 percent of HIV infection in Malawi. Mother-to-child transmission of HIV represents 9 percent of infections.32 Data on transmission via men who have sex with men are unavailable.

**Blood Safety**

According to UNAIDS, in 1997, unsafe blood products accounted for 1.7 percent of HIV transmission in Malawi.33 During the early 1990s, HIV prevalence among blood donors in Blantyre remained fairly stable. In the late 1990s, there was a decline in HIV prevalence among blood donors to 18 percent.34 Several recently published studies reveal that HIV prevalence in blood donors remains high. (Moreover, because blood donors represent a younger and healthier group within the general population, screening of blood donors for HIV tends to provide a low estimate of viral marker prevalence.35)

- A retrospective randomized study that audited laboratory reports from 1990 to 1994 in Nsanje Rural Hospital in the Shire Valley in southern Malawi found that the hospital uses a substantial amount of blood in the treatment of anemia, as well as to address surgical and
obstetric emergencies such as caesarean sections. A total of 547 blood samples were audited; of them, 45.56 percent were positive for HIV.\textsuperscript{36}

- Researchers from Malawi's Ministry of Health and Population, the University of Cambridge, and Liverpool School of Tropical Medicine examined the prevalence of HIV, hepatitis B and C, and human T lymphotropic virus I (HTLV-I) among blood donors in Ntcheu in central Malawi (n=159). Prevalence of HIV was 10.7 percent, 8.1 percent for HBV carriage, 6.8 percent for anti-HCV, and 2.5 percent for anti-HTLV-I. HIV-1/HTLV-I and HIV-1/HCV dual infections were observed in 1.2 percent of donations.\textsuperscript{37}

- Analyzing data involving blood donors who underwent voluntary HIV counseling and testing between January 1998 and July 2000 in Thyolo, Médecins sans Frontières found that crude HIV prevalence was 22 percent, with the age-standardized prevalence (>15 years) at 17 percent. Prevalence was lowest among rural donors, students, and males ages 15 to 19. There was a highly significant positive association of HIV prevalence with increasing urbanization. Significant risk factors associated with prevalence for both male and female donors included having a business-related occupation, living in a semiurban or urban area, and being in the age cohort 25-29 for females and 30-34 for males.\textsuperscript{38}

These studies underscore that HIV transmission via blood and blood products remains a serious concern. Limiting blood transfusions is a crucial strategy, though difficult in Malawi, where the burden of malaria and maternal morbidity and mortality is high (discussed in depth below).

Malawi's 2000-04 strategic framework for HIV/AIDS stresses that inadequate quality control compromises efforts to ensure safe blood supply and that the government must strengthen policy and standards for safe blood supply and infection control in hospitals and health care centers, as well as home-based care and traditional health facilities.\textsuperscript{39}

**Data Quality Issues**

ANC data currently serve as Malawi's primary sentinel surveillance of HIV. Although widely used, ANC are imperfect (see box 1). Among other factors, the population attending ANCs is likely to vary during the different stages of the epidemic. Poverty and the current food crisis (see below) may also affect ANC attendance; for example, in November 2002, UNFPA reported that fewer Malawian women were likely to seek prenatal care (or give birth in hospitals), given that finding food has become their top priority.\textsuperscript{40}

Another factor is subfertility associated with HIV. Comparative studies have shown that HIV prevalence among pregnant women in sub-Saharan Africa underestimates prevalence in women of reproductive age because fertility among HIV-positive women is substantially lower than among uninfected women.\textsuperscript{41} For example, Gregson et al. have found 25 to 40 percent lower fertility in women with HIV in high-prevalence African countries; they attribute about half of this "subfertility" directly to HIV infection.\textsuperscript{42}

At a workshop in 2001, the National AIDS Control Program and its partners analyzed the methodology and assumptions underlying ANC data. They noted the effect of subfertility in underestimating HIV prevalence among the general population (except among the youngest age groups). For the total population, they posited that ANC data overestimate prevalence below age
25 and underestimate it over age 25. For the entire 15-49 age group, NACP asserted that these differences cancel out and that ANC prevalence is a reasonable estimate of total prevalence among men and women ages 15 to 49.\textsuperscript{43}

However, at the International AIDS Conference held in Barcelona in July 2002, researchers from Malawi’s National AIDS Commission and the U.S. Centers for Disease Control and Prevention reported that the HIV sentinel surveillance system in Malawi does \textit{not} accurately reflect the population, in particular the rural and younger age groups. They used data from the 2000 Malawi Demographic and Health Survey to generate a nationally representative sample of women who
Box 1. HIV Sentinel Surveillance: Evaluating Data from Antenatal Clinics

In many developing countries, estimates on the magnitude of and trends in the HIV epidemic are obtained through HIV seroprevalence surveys. These surveys are primarily conducted using sentinel populations. The most frequently used sentinel populations are women attending antenatal clinics and persons attending clinics for diagnosis and treatment of sexually transmitted infections. The objectives of sentinel seroprevalence surveys include:

1. obtaining information on the prevalence of HIV infection in the sentinel population
2. monitoring trends in HIV prevalence in the sentinel population
3. providing information for estimating future number of AIDS cases
4. providing information for program planning and evaluation of interventions

Seroprevalence surveys are usually conducted annually at preselected clinics or hospitals. Surveys of women attending antenatal clinics can provide a reasonable estimate of HIV prevalence within the general population. The surveys are conducted among women ages 15 to 49 years attending the antenatal clinic for the first time during a current pregnancy. Surveys are usually conducted in an unlinked manner, in which serum remaining from routine syphilis screening is tested for HIV infection after all personal identifying information is removed from the specimen. Sampling is usually conducted during an 8- to 12-week period, and all eligible women are sampled consecutively until the desired sample size is achieved. In general, samples of 250 and 400 women are usually sufficiently large as to provide reasonable estimates of HIV prevalence over time.

Although these surveys are extremely useful, there are several limitations to consider when interpreting the survey results. The surveys are not based upon a probability sample and therefore may not be representative of the population as a whole. True population-based surveys have found antenatal clinic data may overestimate or underestimate HIV prevalence.

Moreover, the ANC studies do not provide information on mortality or HIV-associated morbidity. In addition, although monitoring trends in HIV prevalence provide information on the magnitude of the HIV epidemic, trends in prevalence cannot be relied upon to indicate trends in HIV incidence. However, examining trends in HIV prevalence in younger populations, particularly 15- to 19-year-olds, may provide some indication of trends in recently acquired HIV infection, as this group is unlikely to have been infected for a long period of time.

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gave birth in the last year as a potential "universe" for the surveillance sample (however, see below for a caveat on the 2000 MDHS). Data from Malawi's 2001 sentinel surveillance were compared to the national sample to assess the validity of the data for national-level HIV prevalence estimations. NAC and CDC found that the sentinel surveillance sample differed significantly from the national data on pregnant women. Of the women who accessed antenatal care in the national sample, only 42 percent had blood drawn and thus had the potential to be sampled for surveillance. The percentage who had blood drawn ranged from 65 percent of clients in Northern urban areas, to 32 percent in the semiurban areas of the South. The surveillance sample was significantly more urban (25 percent) than the national sample (9 percent) (p< 0.05). The surveillance sample was also younger, more educated, and had fewer children.

Geographically, 27 percent of the surveillance sample came from the North, compared to 11 percent of the national sample. Among 15- to 24-year-olds, 86 percent of the national sample came from rural areas, compared to only 19 percent of the surveillance sample.44
Malawi's 2000 Demographic and Health Survey was undertaken by the National Statistical Office in collaboration with ORC Macro. It was funded by USAID, DFID, and UNICEF. A total of 14,213 households were interviewed during the survey. Within these households, 13,220 women ages 15 to 49 and 3,092 men ages 15 to 54 were interviewed. However, Malawi's Global Fund Coordinating Committee notes that:

[T]here is little programmatic data on HIV/AIDS. Current data on health systems performance are not well synchronized both in terms of data collection and analysis. These issues were not adequately addressed by the DHS which was completed in 2000.

Thus, the findings quoted from the 2000 MDHS throughout this report should be viewed with this caveat in mind.

### Political Economy and Sociobehavioral Context

#### At a Glance

- Many of the factors discussed in this section exist in countries that, unlike Malawi, have low HIV prevalence; these include poverty, gender inequality, and history of colonialism and political and economic disenfranchisement. This section does not seek to demonstrate causality; rather, it aims to analyze key political economy and sociobehavioral contextual elements to highlight the range of sectoral policies and interventions that may affect or be affected by HIV/AIDS.

#### Governance

- Fraud, corruption, and misappropriation of public funds remain major problems in Malawi.
- Despite extensive improvements in human rights under President Muluzi, abuses remain.

#### Poverty

- Malawi is one of the world's poorest countries. In 1998, 65.3 percent of the population was living below the poverty line. (This figure does not take account of the current famine.) In 2000, gross national income per capita was US$170, well below the average for all low-income economies (US$410) as well as for the sub-Saharan Africa region (US$470). Financial wealth is generally concentrated in the hands of a small elite.
- The Southern Region has the highest proportion of poor households, compared to the Central and Northern regions. The Southern Region’s poverty situation can partly be explained by high migration into it, including those seeking employment in its urban areas, including Blantyre.
HIV/AIDS has undermined the country’s efforts to reduce poverty and is now itself an important part of structural poverty in Malawi.

**Economy**

- Structural adjustment programs failed to create sustainable, broad-based growth. Further, many of the high costs of these programs were borne by the poor.
- Malawi is heavily dependent on a single crop — tobacco — for export earnings. The economy has been adversely affected by a severe drought in the 2001/02 agricultural season, and the country remains heavily dependent on foreign aid.
- In December 2000, Malawi qualified for debt relief under the Enhanced Heavily Indebted Poor Countries Initiative (HIPC). It is currently in its interim HIPC period, meaning that to qualify for the full amount of debt relief available via HIPC, it must successfully meet creditor conditions.
- HIPC is projected to release about US$90 million for additional social expenditure. However, the projections and assumptions underlying HIPC have been strongly criticized.

**Human Development**

- In 2000, Malawi's HDI value was 0.400, placing it among "low-human development" countries and ranking it 163 out of the 173. Malawi's HDI value is lower than that of the median for the world's least-developed countries (0.445) as well as for sub-Saharan Africa (0.471).
- A critical human development indicator is the maternal mortality ratio, which appears to have increased by about 45 percent from the late 1980s to the late 1990s. One can infer that a variety of factors that include HIV/AIDS played a role in this increase.

**Population Mobility**

- Throughout southern Africa, high levels of movement among urban, rural, and mining areas facilitate HIV transmission. Poverty may lead to increased migration, both within Malawi and to other countries, as people move from rural to urban areas in search of work — or return to families if they lose their jobs or fall ill and cannot afford care. This scenario can place an additional burden on receiving households, which concurrently lose any remittance income from the person who has fallen ill.
- Male migration, a common phenomenon in Malawi, separates men from their families, places them in close proximity to "high-risk" sexual networks, and often results in their having an increased number of sexual contacts. Concurrently, it may lead to women's reliance on sex to supplement their incomes while their male partners are away for long periods.
- Both Malawian men and women are increasingly mobile as they pursue trading activities. Some studies in southern African have found that female cross-border traders are particularly vulnerable to HIV infection. Other key mobile groups in Malawi include truck drivers, sex workers, fishermen/women and fish traders, migrant and seasonal workers, military personnel, prisoners, and refugees.
Floods, cholera, and famine in Malawi involve significant movement of people and regroupings of family units, which also entail exposure to new sexual networks and thus may heighten vulnerability to HIV.

Moreover, AIDS directly spurs population dislocation as, for example, orphans are sent to live with relatives residing in other regions of the country.

**Food Crisis**

- An estimated 3.3 million Malawians — 29 percent of the population — are in need of food aid. Although famine threatens all three regions of Malawi, Central and Southern regions have proportionately more people at risk than the North.
- Reports from an array of multilateral and civil society agencies who have recently conducted missions in Malawi concur that although erratic weather has contributed to the current food crisis, one of the key underlying factors is the depletion of human resources as a result of HIV/AIDS. Unsustainable debt, chronic poverty and malnutrition, deteriorating public health services and poor health outcomes, and reliance on a single crop have also played a role.
- After years of World Bank- and IMF-supported agricultural sector reforms, Malawi still faces chronic food insecurity. Many argue that these reforms were imposed too rigidly and too quickly, often leaving poor farmers without support from or access to either state or market institutions.
- Malawi's response to HIV/AIDS is predicated on an effective, efficient health care system as well as strengthened capacity at local level. However, given the impacts of the humanitarian crisis, the ability of the country to mount a national response to HIV/AIDS is gravely imperiled.
- High levels of HIV/AIDS infection mean that the coping strategies of communities, already under major stress, are at breaking point.
- Recent missions to Malawi have reported increased malnutrition, which is likely to further weaken the immune systems of people living with HIV/AIDS, thereby contributing to higher rates of morbidity and mortality.
- Famine has also raised the opportunity cost of sending children to school. Girls, in particular, are affected. Lack of food, coupled with a subsequent breakdown in family structure, has placed more children on the streets where they may be at higher risk of mistreatment, sexual exploitation, and physical and emotional abuse. Communities caring for increasing numbers of AIDS orphans are facing additional economic pressure.

**Health Sector**

- Despite some improvements in health outcomes since independence, Malawians' health status remains poor. HIV/AIDS is the leading cause of death among those ages 15 to 49, followed by malaria. Other major health problems include TB, cholera, schistosomiasis, acute respiratory infection, acute diarrheal disease, and meningitis.
- As with other health data, those on STIs are difficult to access. Findings from several studies demonstrate that STIs (particularly herpes) are fueling the HIV/AIDS epidemic in Malawi.
- The human and financial constraints to improving Malawians' health care system are enormous:
Access to care is limited. Although 80 percent of Malawians live in rural areas, most of the country’s health resources are located in the major urban centers. Only 3 percent of Malawians live in a village with a health center.

Quality of care is highly variable.

There is a critical shortage of medical personnel, particularly in rural areas.

Training capacity falls far short of needs.

Essential drug distribution is unreliable.

Technical support services, such as laboratories and pharmacies, are highly inadequate.

Basic health information is often of low quality and is consequently not adequately factored into policy formulation and program planning.

Although districts now prepare budgets tailored to their local priorities, resources reaching district health offices vary significantly by month.

Concurrently, almost all the strategies that form the government's national response to HIV/AIDS, as outlined in its proposal to the Global Fund to Fight AIDS, TB & Malaria, are heavily dependent on the country's ability to improve delivery of basic health services.

Knowledge

- General awareness of AIDS is nearly universal (though knowledge of MTCT of HIV is weak). Education is strongly related with belief that AIDS can be avoided.
- Men and women cite abstinence and use of condoms as ways of avoiding HIV far more frequently than limiting number of sexual partners and avoiding sex with partners who have multiple partners.
- Despite high knowledge of HIV/AIDS, behavior change messages may not be effectively highlighting key strategies for HIV prevention, nor adequately debunking false beliefs about HIV transmission.

Stigma

- Strong stigma around HIV/AIDS persists.
- Although an overwhelming majority of women and men report that they would be willing to care for a relative with AIDS in their home, health care workers consistently report reluctance by families and communities to care for members with chronic and terminal conditions. This has resulted in “dumping” of family members in hospitals, which are already overstretched.
- There is also a belief among some Malawians that HIV/AIDS is related to witchcraft, though the prevalence of and sociodemographic characteristics related to holders of this belief have not been quantified.

Gender

HIV Prevalence among Women

- Malawian women become infected with HIV at younger ages than men for both biological and behavioral reasons. HIV prevalence among Malawian women ages 15 to 24 ranges from
11.91 to 17.87 percent, whereas the comparable range for men in the same age cohort is 5.08 to 7.62 percent.

- AIDS cases among women peak between ages 15 to 29, and among men at ages 30 and above. This suggests significant transmission from older males to younger females.
- By 2020, there will be more men than women in each of the five-year-age cohorts between the ages of 15 and 44, which may push men to seek partners in increasingly younger age cohorts. This factor in turn may increase HIV infection rates among younger women.
- Many women are unable to insist on condom use and negotiate the timing of sex and the conditions under which it occurs. Even when women know that their husbands are at high risk of HIV, many do not raise the issue of condoms as to do so might be perceived as accusing their husbands of infidelity or depriving them of sexual pleasure. Women who do suggest condom use may be at increased risk of physical violence and/or economic abandonment.
- Other factors that may render women vulnerable to HIV infection include:
  - sex work
  - transactional sex, in which sex may be exchanged for gifts, money, or food
  - resulting sense of fatalism that may reduce women's motivation to protect their sexual health

**Women's Status**

- Gender inequality remains a major barrier to improving the standard of living and reproductive health of women in Malawi.
- There are major gender disparities in literacy and education. Women's lower educational levels are related to lower formal labor force participation and decreased earnings and thus lessened economic autonomy. This situation may increase women's economic dependence on men and inability to refuse sex or insist on condom use — factors that can increase vulnerability to HIV. Moreover, compared with boys, girls are more often kept out of school when household income and/or labor supply falls (an increasing phenomenon given high AIDS mortality and the famine).

**Women and Poverty**

- In 1998, about 52 percent of the poor were female. Females head 25 percent of all Malawian households, and these households have always been disproportionately poor, especially in rural areas.

**Widows**

- Some communities in Malawi observe certain practices that promote ritual sex and may entail risk of HIV infection. The most common are initiation ceremonies, widow inheritance, and sexual cleansing. Widows may be particularly vulnerable to HIV because of sexual cleansing and wife inheritance.
- A related phenomenon is "grabbing," wherein relatives forcefully take possession of the deceased's household goods, land, livestock, clothes, and other assets. This scenario exacerbates the already precarious economic (and social) situation of widows and their children.
Sexual Violence

- Reliable data on sexual violence in Malawi are scarce. The Malawian government reports that gender-based violence remains a persistent problem.

Condoms

- Overall condom use is low in Malawi. An enormous percentage of pre- and extramarital sex is unprotected.
- Urban men and women are more likely to use a condom with a spouse or with a noncohabiting partner than are those living in rural areas. Educational attainment is strongly associated with condom use for men and — especially — for women.
- Among those ages 15 to 24, being able to obtain a condom — even when a source is known — is a serious constraint.

Male Circumcision

- Male circumcision is uncommon in Malawi. In a study of male workers from the Nchalo sugar plantation, researchers found that lack of circumcision was associated, though not significantly, with HIV acquisition.
- Some observational studies from sub-Saharan Africa have indicated that male circumcision may reduce the risk of HIV acquisition, though circumcision does not appear to affect transmission from HIV-positive men to their partners. The limitations of these studies have been highlighted, and further study is needed on both biomedical and sociobehavioral issues before promoting male circumcision as a public health intervention.

Alcohol and Drug Use

- Researchers have noted an increase in alcohol and drug use among young people, attributed, in part, to the lack of resources and alternative activities for youth in Malawi.

Many of the factors discussed in this section exist in countries that, unlike Malawi, have low HIV prevalence; these include poverty, gender inequality, and history of colonialism and political and economic disenfranchisement. The relationship between HIV prevalence and socioeconomic factors is highly complex. Increasingly, risk of HIV infection is recognized as related to, inter alia, one’s socioeconomic status as well as the socioeconomic profile of the community in which one is situated.\(^47\),\(^48\)

This section does not seek to demonstrate causality; rather, it aims to analyze key political economy and sociobehavioral contextual elements to highlight the range of sectoral policies and interventions that may affect or be affected by HIV/AIDS.
Postcolonial Context

Malawi achieved full independence in July 1964. Dr. Hastings Kamuzu Banda, who returned to the country in 1958 to head the Malawi Congress Party (MCP), had been named prime minister in 1963. In 1966, he became Malawi's first president under a new constitution that made the country a one-party state. In 1970, Dr. Banda was declared President for Life of the MCP, and in 1971 he was named President for Life of Malawi.

The police as well as the paramilitary wing of the MCP, the Young Pioneers, helped President Banda keep Malawi under authoritarian rule until 1994. Human rights abuses were common, as the government imprisoned opponents, who had almost no recourse to the justice system. Prisons were overcrowded and conditions brutal.

Increasing domestic unrest and internal and external pressure led to a 1993 referendum, in which Malawians voted overwhelmingly in favor of multiparty democracy. In May 1994, free national elections were held. Bakili Muluzi, leader of the United Democratic Front (UDF), defeated President Banda. The UDF won 82 of the 177 seats in the National Assembly and formed a coalition government with the Alliance for Democracy (AFORD). Malawi's newly written constitution (1995) eliminated special powers previously reserved for the MCP. It also created the Malawi Human Rights Commission under chapter XI. Accelerated economic liberalization and structural reform also accompanied the political transition (discussed below).

President Muluzi and the UDF were reelected in June 1999 with little concomitant violence. Local elections were held in the country for the first time in November 2000, and the UDF won 70 percent of the wards.

Governance remains a major problem in Malawi, e.g., fraud, corruption, and misappropriation of public funds. Additionally, President Muluzi is proposing a constitutional amendment that would permit him to run for a third term as president. (Currently, the president is limited to two terms.) In July 2002, this constitutional amendment was rejected by Parliament, and President Muluzi indicated that he would accept the parliamentary ruling. However, the UDF has again scheduled the bill for parliamentary debate during 2002-03. (Some UDF members have publicly declared their opposition to the amendment, along with numerous human rights NGOs.) President Muluzi issued a decree banning demonstrations linked to the amendment, a decree that was reversed by Malawi's High Court in October 2002. Recent demonstrations by civil rights groups protesting the amendment have been accompanied by clashes with police and ruling party supporters.

Donors, including the EU, Germany, Norway, U.K., and U.S., have expressed concern about the amendment and about the concomitant intimidation of and violence toward those opposing it. The Malawi Human Rights Commission is investigating alleged police abuses related to recent demonstrations, as well as alleged government harassment of journalists and interference with the judiciary.

In its own poverty reduction strategy, the government noted that despite extensive improvements in human rights under President Muluzi, abuses remain. (See also Human Rights Watch: http://www.hrw.org/africa/malawi.php and Amnesty International: http://web.amnesty.org/ai.nsf/countries/malawi?OpenView&Start=1&Count=30&Expandall)
Economy

Landlocked Malawi's economy is heavily dependent on agriculture, which accounts for over 90 percent of its export earnings, contributes 45 percent of gross domestic product (GDP), and supports 90 percent of the population. 68

Almost 70 percent of agricultural produce comes from smallholder farmers operating on less than one hectare of land. 69 Maize is the principal food crop and the preferred staple for the majority of households. It is supplemented by sorghum, rice, cassava, sweet potatoes, and pulses. Production of these food crops, based mainly on rainfed agriculture, fluctuates often as a result of climatic disasters, especially frequent droughts, which cause extensive crop failures. Irrigation use is limited. 70

Cash crops in Malawi include tobacco, tea, sugar, cotton, groundnuts and coffee. 71 Tobacco accounts for about 60 percent of export earnings. 72 Malawi's dependence on a single crop, coupled with a decline in terms of trade, underscores the need for rapid diversification. 73

High transport costs, which can represent over 30 percent of its total import bill, constitute a serious impediment to economic development and trade. Malawi must import all its fuel products. Paucity of skilled labor; "red tape"; corruption; and inadequate and deteriorating road, electricity, water, and telecommunications infrastructure further hinder the country's economic development. However, recent government initiatives targeting improvements in roads, together with private sector participation in railroad and telecommunications, had begun to render the investment environment more attractive. 74 (Though the current humanitarian crisis could reverse this scenario; see below.)

Traditionally, Malawi has been self-sufficient in maize, and during the 1980s exported substantial quantities of it to its drought-stricken neighbors. 75 From independence through 1979, the Malawi economy experienced impressive growth. Real output growth, mainly spurred by the agricultural sector, averaged 6.7 percent during this period. However, the benefits of this growth were poorly distributed, as growth was narrowly based on estate (versus smallholder) agriculture. 76 From 1979, Malawi's economy experienced high import costs as a result of oil price shocks, disruptions in trade routes, the influx of refugees from Mozambique, and droughts. 77

Structural Adjustment

Since 1981, Malawi has implemented a series of policy interventions through World Bank- and IMF-backed Structural Adjustment Programs (SAPs). These seek to stimulate private sector activity and participation through the elimination of price controls and industrial licensing, liberalization of trade and foreign exchange, rationalization of taxes, privatization of state-owned enterprises, and civil service reform. 78 Since 1994, SAPs have been complemented by the Poverty Alleviation Program (PAP), which emphasizes the need to raise national productivity through sustainable broad-based economic growth and sociocultural development. 79

Malawi began to experience relatively strong economic growth between 1988 and 1991. Real GDP growth rose from 3.3 percent in 1988 to 7.8 percent in 1991. However, the gains arising from this growth were short-lived as growth fluctuated through the 1990s, largely as a result of external shocks such as droughts and the reduction of donor financial support between 1992 and
1994. Growth has averaged 2.6 percent between 1997 and 2000 and stood at 1.8 percent in 2001.\textsuperscript{80}

Malawi's economy has been adversely affected by a severe drought in the 2001-02 agricultural season, and the country remains heavily dependent on foreign aid. In March 2000, the country started the process for obtaining debt relief under the HIPC initiative (see below). \textsuperscript{81}

In 1999, the World Bank and IMF replaced SAPs with new conditions for loans and debt relief: the Poverty Reduction Strategy Paper (PRSP). PRSPs are created by governments but with substantial Bank involvement. Moreover, only when the Bank and IMF are satisfied with their creation and implementation are funds for HIPC released. (Malawi's first full PRSP was launched in April 2002 and discussed and endorsed by the Board of the World Bank in August 2002.\textsuperscript{82})

Criticism of PRSPs, from in-country parliamentarians, trade unionists, and NGOs, include complaints of being marginalized and that national ownership is undermined by externally imposed parameters and use of foreign consultants.\textsuperscript{83} Christian Aid highlights that in Malawi, "the relationship between civil society and the state is marked by mistrust, and there is little government experience with participatory policy-making."\textsuperscript{84} The Malawian government screened civil society organizations permitted to participate in the PRSP process. In response, the Malawi Economic Justice Network was formed to advocate for greater civil society involvement.\textsuperscript{85}

Another criticism of PRSPs is that they seem very similar and fail to reflect the different histories, characteristics, and economies of individual countries.\textsuperscript{86} This was the case with the Malawi and Zambia PRSPs, recently reviewed by the author of the present report.

Malawi's 2002 Poverty Reduction Strategy Paper states that:

Inconsistent implementation of the SAPs led to only short-lived economic recovery and failed to create sustainable broad based growth. Further, many of the high costs of adjustment were borne by the poor. Despite some successes, the PAP suffered from the absence of a well-articulated action plan to ensure a holistic approach to implementation. In particular, there have been inadequate linkages to the budget, little prioritization and a lack of target setting.

The impact of the wide ranging policy reforms implemented during the adjustment period has been mixed and mostly unsatisfactory insofar as poverty reduction is concerned. Although there have been periods of macroeconomic stability, sustainable growth has proved elusive. The instability has to a large extent arisen from external shocks, inconsistent implementation of reforms, fiscal policy slippages and the narrow base of production capacity. The inability to sustain high rates of growth over a long period has undermined any poverty reducing impact of growth. Furthermore, macroeconomic instability has aggravated the poverty situation.\textsuperscript{87}

As is usually the case when the Bank evaluates projects and policies it has championed, it lays most of the blame on poor government implementation. The Bank believes that the Malawian government has not adequately implemented structural adjustment policies because of, inter alia, "fiscal slippages."\textsuperscript{88} Certainly, this is the case to some degree, but serious concerns have been
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raised about underlying elements of SAPs. Oxfam, among other social justice groups, stresses that SAPs exacerbate the exclusion of the poorest from the market while further undermining human development and food security. 89

Researchers from the School of Oriental and African Studies at the University of London have found that in Malawi (and other sub-Saharan African countries), development benefits have been slow to emerge from economic liberalization. 90 After almost two decades of structural adjustment, Malawi's 2000 per capita income of US$170 is well below the average for all low-income economies (US$410) as well as for the sub-Saharan Africa region (US$470). 91 The government acknowledges that this poor economic growth performance implies that the majority of the population has experienced almost no improvement in its economic status. 92

Inflation

Inflation is another pressing macroeconomic problem in Malawi. Between 1980 and 1990, the inflation rate, as indicated by the Consumer Price Index, remained stable, averaging 16.6 percent. During 1990-2000, the annual inflation rate fluctuated. Average inflation declined from 83 percent in 1995 to 9 percent in 1997. However, a large depreciation of the kwacha in August 1998 resulted in annual inflation rates of 29.8 percent and 44.7 percent in 1998 and 1999, respectively. In recent years, inflation has averaged 30 percent. 93

Poverty

Malawi is one of the world's poorest countries. In 1991, 54 percent of the population was living below the poverty line. 94 According to Malawi's 1998 Integrated Household Survey, 65.3 percent of the population is now poor (this figure does not take account of the current famine). (Poor is defined as those whose consumption of basic needs [both food and nonfood] is below the minimum level, estimated at MK10.47 per day in 1998 [about US$0.34, given average exchange rate in 1998 of MK31.1 = US$1].) Among the poor population, 28.2 percent are living in "dire poverty" 95 (not defined in Malawi's PRSP).

Poverty is more prevalent in rural areas (where there are limited economic activities) than in urban areas. It is estimated that 66.5 percent of the rural population live in poverty, compared to 54.9 percent of the urban population. Although about 80 percent of the population lives in rural areas, 96 91.3 percent of the poor and 91.5 percent of the "ultra poor" also live in rural areas. 97 However, pockets of poverty are found throughout the country. The areas with the highest poverty headcount are Ntcheu (84.0 percent), Phalombe (83.9 percent), Zomba Municipality (78.0 percent), Thyolo (76.8 percent), and Ntchisi (76.3 percent).

The Southern Region has the highest proportion of poor households (68.1 percent), compared to the Central (62.8 percent) and Northern (62.5 percent) regions. The Southern Region’s poverty situation can partly be explained by high migration into it, 98 including those seeking employment in its urban areas, including Blantyre. (Although the relationship between poverty and HIV prevalence is highly complex, note these data cited in the Epidemiology section: in 1998, adult HIV prevalence was highest in Southern Region (18 percent), followed by Central (11 percent) and Northern (9 percent) regions. 99)
Financial wealth in Malawi is generally concentrated in the hands of a small elite. 100 The richest 20 percent of the population consume 46.3 percent of total goods and services, whereas the poorest 20 percent consume only 6.3 percent. Consumption is also more unequally distributed within urban areas, where the Gini coefficient is 0.52, as opposed to 0.37 for rural areas. 101 (The Gini coefficient measures the extent to which the distribution of income or consumption among individuals or households within a country deviates from a perfectly equal distribution. A value of 0 represents perfect equality, a value of 100 perfect inequality.)

Some subpopulations are poorer than others, including:

- land-constrained smallholder farmers
- labor-constrained female-headed households
- estate workers or tenants
- *ganyu* and other casual laborers
- destitute or disadvantaged children, such as orphans, street children, and child heads of households
- persons with disabilities
- low-income urban households
- the elderly
- the uneducated
- the unemployed. 103

All these populations are also likely to be highly vulnerable to acquiring HIV/AIDS. Moreover, HIV/AIDS may also play a role in the further impoverishment of these populations. (See Impact section below.)

Poverty in Malawi is caused by numerous factors, including limited access to land, low education, poor health status, limited off-farm employment, and a lack of access to credit. Environmental degradation, rapid population growth, and gender inequalities are also factors. (In 1998, about 52 percent of the poor were female.) All these factors are exacerbated by generally weak institutional capacity within the country. 104

According to the National AIDS Commission, HIV/AIDS has undermined the country’s efforts to reduce poverty. 105 The U.N. notes that "HIV/AIDS is now an important part of structural poverty in Malawi, and its prevention and control are a central development concern." 106 In its 2002 poverty reduction strategy paper, the government noted that "there are clear links between HIV/AIDS and poverty. Poverty is one of the major underlying factors driving the epidemic." However, it did not provide contextual analysis specific to Malawi, but rather standard text on HIV/AIDS and poverty also found in the Zambia PRSP. 107

**Population Mobility**

Throughout southern Africa, high levels of movement among urban, rural, and mining areas facilitate HIV transmission. 108 Poverty may lead to increased migration, both within Malawi and to other countries, as people move from rural to urban areas in search of work — or return to families if
they lose their jobs or fall ill and cannot afford care. This scenario can place an additional burden on receiving households, which concurrently lose any remittance income from the person who has fallen ill.\textsuperscript{109}

According to Malawi’s National AIDS Control Program, male migration is a common phenomenon.\textsuperscript{110} Migrant labor separates men from their families, places them in close proximity to "high-risk" sexual networks, and often results in their having an increased number of sexual contacts. Concurrently, it may lead to women's reliance on sex to supplement their incomes while their male partners are away for long periods.

NACP also noted that both men and women (adults and youth) are increasingly mobile as they pursue trading activities.\textsuperscript{111} Some studies in southern African have found that female cross-border traders are particularly vulnerable to HIV infection. Many female traders report exchanging sex for transport. They also report rape and sexual harassment.\textsuperscript{112, 113}

Other key mobile groups in Malawi include:

- truck drivers
- sex workers
- fishermen/women and fish traders
- migrant and seasonal workers
- military personnel
- prisoners (in the sense that they often return to their families/communities upon release)
- refugees

The study on male workers from the Nchalo sugar plantation, discussed above, recruited men primarily from 11 residential communities located inside and around the estate. (On sugar estates, men usually leave their families to work as cane cutters from March to November.) The study found that men's rate of HIV acquisition followed a gradient based on distance from the Nchalo trading center (where most recreational activities and commercial sex occurs): Both HIV and syphilis prevalences were highest in communities closest to the trading center and lowest in communities furthest from it.\textsuperscript{114}

Between 1985 and 1995, Malawi accommodated over 1 million refugees from Mozambique. The refugee crisis placed a substantial strain on Malawi's economy, but also drew significant inflows of international assistance. Malawi's accommodation and eventual repatriation of Mozambicans are considered a major success by international organizations.\textsuperscript{115} However, the movement of large numbers of refugees may have played a role in facilitating HIV transmission, in Malawi, Mozambique, and the subregion. (Conflict and instability in the region have led to Malawi's continuing to receive refugees, for example, from Rwanda and the Democratic Republic of the Congo.)

AIDS directly spurs population dislocation as, for example, orphans are sent to live with relatives residing in other regions of the country. Researchers from Brunel University in the U.K. note that a legacy of labor migration in southern Africa is a high degree of family dispersal. In examining the movement of orphans in Malawi (and Lesotho), they found that strategies for dealing with AIDS commonly involve young people's movement between households of the extended family. They also found that:
- Migration occurs locally and over longer distances, which may involve moving from urban to rural areas.
- Children’s migration is highly complex, with many children engaging in multiple migrations in response to changing situations.
- Migrant children typically reside with maternal grandparents. \(^{116}\)

Children who migrate face numerous difficulties, which are often exacerbated by AIDS. These include fitting into:

- new families where they may feel discriminated against and/or have a high workload
- new communities, which may involve having to make new social contracts, attend a new school, and (especially in rural areas) learn to undertake unfamiliar forms of work

Children generally find ways of coping with migration, but these may involve adopting behaviors (such as smoking or drinking to "fit in"). \(^{117}\) (Further findings from this study are discussed in the Impact section.)

As discussed in the Food Crisis section below, flooding and famine involve significant movement of people and regroupings of family units, which also entail exposure to new sexual networks and thus may heighten vulnerability to HIV. \(^{118}\)

**Food Crisis**

On February 27, 2002, the Malawian government declared a national disaster due to actual and anticipated food shortages. In November 2002, USAID estimated that 3.3 million Malawians — 29 percent of the population — will be in need of food aid from September 1, 2002, through March 31, 2003. \(^{119}\)

Although famine threatens all three regions of Malawi, Central and Southern regions have proportionately more people at risk than the North. (Part of this is because maize prices are highest in Central Region and lowest in Northern Region.) The U.N. has identified the following priority districts for food aid: Lilongwe, Dedza, Salima, and Mangochi. \(^{120}\) (Again, the vulnerability of Southern Region is highlighted.)

The U.N. notes that:

> The first three months of 2002 saw hunger in rural Malawi at a level which older villagers cannot remember since the drought of 1949-50. Yet the proportionate shortfall in the harvest of April-May 2001 was not as severe as in that year, nor comparable to the disaster of the major drought year of 1991-92, when farmers were greatly impoverished but no famine was reported.... During the first three months of 2002 in Malawi, a threshold was crossed which had divided poverty in general, and seasonal hunger in particular, from food crisis.... Why was there such extraordinary hunger by late 2001 and early 2002? \(^{121}\)

And according to Oxfam U.K. and the World Development Movement, British social justice NGOs:

> Hunger and food shortage has always been a problem in Malawi. In the past, food shortages have been addressed through food aid from donors and government subsidies
for basic food channeled through the grain board, the Agricultural Development and Marketing Corporation (ADMARC). In 1991-92, there was a severe food shortage in Malawi, with yields much lower than those preceding the current famine. However, the state marketing board, ADMARC, had depots in the most inaccessible rural communities and made food available at subsidized prices. This system has allowed the people of Malawi to survive the seasons of adverse weather, and the government corruption and mismanagement which has persisted through years of good harvest and bad. This year, however, no such safety net exists.122, 123

ActionAid Malawi cites "misplaced complacency by many external actors, a failure to react to signals of an impending food crisis, the selling of the Strategic Grain Reserve, and the government's denial of the existence of a famine until February 2002" as contributing factors to the current situation. It goes on to state that:

These immediate causes of the 2002 famine must also be conceptualized by noting the following underlying vulnerability factors: Declining soil fertility and restricted access to agricultural inputs during the 1990s; deepening poverty which eradicated asset buffers that the poor could exchange for food to bridge food gaps; the erosion of social capital and informal social support systems in poor communities; the demographic and economic consequences of HIV/AIDS; and the relative neglect at the policy level of the smallholder agriculture sector.124

Reports from an array of multilateral and civil society agencies who have recently conducted missions in Malawi concur that although erratic weather (droughts, flooding, waterlogging) has contributed to the current food crisis, one of the key underlying factors is the depletion of human resources as a result of HIV/AIDS.125 Unsustainable debt, chronic poverty and malnutrition, deteriorating public health services and poor health outcomes, and reliance on a single crop have also played a role. Moreover, after years of World Bank- and IMF-supported agricultural sector reforms, Malawi still faces chronic food insecurity. Many argue that these reforms were imposed too rigidly and too quickly, often leaving poor farmers without support from or access to either state or market institutions.126, 127 Moreover, many households overstretched their coping mechanisms last year, reducing their resilience and increasing their vulnerability in the face of the continued food shortages.128

Certainly, Malawi needs agricultural reforms to enhance productivity and food security. Parastatals such as ADMARC require improved management and oversight. However, the agricultural reform policies implemented in Malawi since 1981 have led to crisis, rather than improved efficiency and productivity.129, 130 As in other countries, agricultural reforms were imposed on Malawi without proper analysis of their potential impact and consequences, particularly on the poor.131

Early in 2002, the Malawi Government sold almost all its 167,000 metric ton grain reserve. Malawian civil society groups have raised questions less about the wisdom of the sale than about what happened to the money raised, who benefited, and whether the proceeds could have been reinvested in buying new supplies on the commercial market.132 In April 2002, Malawi was
suspended from HIPC over allegations of corruption around the sale. Donors have called for a full audit of the sale, which has yet to be undertaken. 133, 134

Between October 2001 and March 2002, the price of maize in Malawi increased 400 percent. 135 In October 2002, the Famine Early Warning Systems Network (FEWSNet) released a report on cereal price trends in southern Africa, which indicated that the price of maize in Malawi (as well as Zimbabwe and Zambia) is likely to remain high and expected to escalate until the next harvest. 136 For most rural households, the availability and price of maize on the market are key to food security. In many places, this is the second or third consecutive year of food shortages, and many people's ability to cope has been exhausted as they have increasingly fewer ways to earn enough cash to buy food. 137

Malawi has removed all subsidies to agriculture and, under its last agreement with the World Bank, had committed to privatizing ADMARC by the end of 2002. The initial impact of the reforms implemented in the agricultural sector led to a substantial increase in the production of tobacco as well as private sector participation in marketing of agricultural produce. 138, 139 However, over time, these benefits have been offset by input prices increasing faster than producer prices. The lifting of price controls and elimination of fertilizer subsidies (the "Starter Pack" program) have contributed to increased input costs. The U.N. notes that the elimination of Starter Packs contributed to the shortfall in maize produced last year. 140 (NB: The Starter Pack program is being reintroduced. 141) Oxfam argues that reform measures have led to a widening gap between rich and poor and that liberalization has contributed to a massive increase in food insecurity. 142

At the same time that international financial institutions have been instructing Malawi and other countries to reform their agriculture sectors, Western Europe and the U.S. continue to pay their own farmers massive subsidies and refuse to fully open their markets to Africa’s exports. 143, 144

Impact

Malawi's response to HIV/AIDS is predicated on an effective, efficient health care system as well as strengthened capacity at local level. 145 However, given the impacts of the humanitarian crisis described below, the ability of the country to mount a national response to HIV/AIDS is gravely imperiled.

Recent missions to Malawi have reported increased malnutrition, which is likely to further weaken the immune systems of people living with HIV/AIDS, thereby contributing to higher rates of morbidity and mortality. 146 The International Food Policy Research Institute reports that people living with HIV have higher nutritional requirements: up to 50 percent more protein and up to 15 percent more calories. Moreover, diets rich in protein, energy, and micronutrients can help prevent opportunistic infections. HIV infection compounded by inadequate diet leads more rapidly to malnutrition. The poor suffer the most, as they are more likely to be malnourished before they become infected. 147

According to the World Food Program, female-headed households are poorer and more vulnerable to the effects of food shortages, because of fewer income opportunities, less mobility,
and high demands on their time as caregivers (they are also twice as likely to take in orphans than male-headed households).\textsuperscript{148}

High levels of HIV/AIDS infection mean that the coping strategies of communities, already under major stress, are at breaking point. Those who have undertaken recent missions to Malawi report the following survival strategies:

- eating potentially poisonous wild grasses
- eating much-reduced maize harvest prematurely, before it has ripened
- eating seed stocks (and thus lacking seeds to plant for the next agricultural season)
- reducing the number of meals consumed per day to two or, often, one
- stealing crops
- undertaking sex work
- bartering
- taking children out of school
- traveling enormous distances and queuing for days to purchase limited supplies of maize\textsuperscript{149},

Population dislocation was also observed in early 2002, as unusually heavy rains led to flood damage in parts of all three regions, displacing over 150,000 people. Floods, displacement, and the movement of people in search of food led to the country’s worst-ever cholera epidemic, with nearly 1,000 deaths, during the early part of 2002.\textsuperscript{151} As mentioned, these large movements of people also entail exposure to new sexual networks and thus may heighten vulnerability to HIV.

Intercountry migration is also affected, as famine, HIV/AIDS, and socioeconomic deterioration (and, in some cases, conflict and political unrest) are affecting Malawi’s neighbors as well. People will seek work in other countries so that they can send remittances home, although this possibility may be reduced as neighboring countries are hard-hit.

The U.N. notes that the famine has raised the opportunity cost of sending children to school. Girls, in particular, are affected. Lack of food, coupled with a subsequent breakdown in family structure, has placed more children on the streets where they may be at higher risk of mistreatment, sexual exploitation, and physical and emotional abuse. Communities caring for increasing numbers of AIDS orphans are facing additional economic pressure, thereby exacerbating the vulnerability of orphans.\textsuperscript{152}

Traditionally, funerals are important events in Malawi. Those attending provide large amounts of food to show respect. Given the famine, as well as the increasing number of funerals because of AIDS mortality, many people are not able to provide sufficient food at funerals and are thus ostracized.\textsuperscript{153}

(Malawi has expressed concerns over the environmental effects of biotech food, but is accepting such food aid as long as it is milled before distribution. And the government has publicly stated its intention not to disrupt the distribution of donated maize if milling is not possible.\textsuperscript{154})
Box 2. HIV/AIDS and Distribution of Food Aid

In some districts in Malawi, Village AIDS Coordinating Committees are responsible for targeting food supplies. This includes food supplements to village crèches that are caring for HIV-affected children or through home-based care programs.

Much of the maize required in Malawi (as well as Zambia and Zimbabwe) is being purchased and transported from South Africa, mostly by truck. Some commercial trucking companies have begun HIV awareness raising activities on their long-distance trucking routes. The Southern African AIDS Information Dissemination Service recommends that these interventions be scaled up and that civil society and governmental agencies already working in border towns coordinate to ensure that safer sex messages and condoms and related services be made accessible.


Women and children may be particularly vulnerable to sexual exploitation during humanitarian crises. UNICEF, for example, has highlighted that some women and children may offer sex to workers involved in transporting and distributing food aid to try and obtain preferential treatment in the distribution of supplies and services.


Debt

During the 1970s and 1980s, Malawi's servicing of its public and publicly guaranteed debt ranged from 13.67 to 39.69 percent of central government revenues, rendering it one of the world's most highly indebted countries. Most of the country's debt is owed to the World Bank.

In December 2000, Malawi qualified for debt relief under the Enhanced Heavily Indebted Poor Countries Initiative (HIPC). HIPC is not debt cancellation; rather it is a restructuring of debt repayment through provision of grants. Malawi is required to continue servicing its debt (even during the current humanitarian crisis). Moreover, HIPC does not preclude that a country will have to continue to borrow indefinitely. Malawi, for example, is and will continue to be heavily dependent on donors and foreign creditors.

Under HIPC, an estimated US$1 billion was committed to Malawi as total debt relief from all its creditors. This is equal to US$643 in net present value (the present value of future cash), of which US$331 million is to be provided by the World Bank and $30 million by the IMF. The World Bank projects that under HIPC, Malawi will save an average US$50 million annually in debt service payments over the next 20 years.

In its quest to qualify for HIPC, Malawi has had to undertake some activities that — at least on paper — have resulted in increased attention to the poor, social services, and HIV/AIDS, as well as consultation with civil society. For example, it was required to produce a poverty reduction strategy (which, again, some contend is simply another term for structural adjustment). However, creation of Malawi's first PRSP was not deemed to have sufficiently included civil society, and thus the government was compelled to consult more widely with nongovernmental groups.
Malawi, as with other countries, also had to demonstrate how funds from HIPC would be used to finance social sector services. The HIPC initiative is projected to release US$91.4 million for additional social expenditure from 2000-01 to 2002-03. Over these three years, about one-third will be spent on health, one-third on education, and the remainder on safe water, community services, rural roads, and agriculture. Note, however, that these are projections and that the assumptions underlying them have been strongly criticized (see below).

Another criterion is that Malawi must demonstrate progress in implementation of the National AIDS Strategic Framework (see Government Response section), in particular ensuring that:

1. the National AIDS Commission be fully staffed, functional, and autonomous
2. 75 percent of all condom outlet points be stocked at any given time
3. HIV blood test kits be continuously available at all blood transfusion sites by increasing the number of kits from 1,500 to 2,500
4. an effective behavior change communication strategy be implemented
5. syndromic management of STIs be undertaken in all central and district hospitals, as well as major Christian Health Association of Malawi hospitals

Malawi is currently in its interim HIPC period, meaning that to qualify for the full amount of debt relief available via HIPC, it must successfully implement its PRSP for at least a year.

Several social justice NGOs, including Jubilee Plus, point to serious problems with HIPC. For example, HIPC assesses whether a country can afford to pay its debts by looking primarily at its export earnings and often making very optimistic assumptions about them. For countries such as Malawi, dependent on one export commodity (tobacco), this is unrealistic, as it is vulnerable to external shocks such as changes in the price of and demand for tobacco as well as climatic fluctuations. HIPC also assumes that real GDP growth in Malawi will rise to 4.5 percent in 2003 and to 6 percent by 2020. It assumes that export volumes will grow at a rate of 4.6 percent from 2001-20, incorporating 3 percent growth in tobacco exports and 7 percent growth in nontraditional exports.

In September 2002, the World Bank and IMF themselves noted that although most commodity prices are forecast to rise over the medium term,:

...recovery would be slow and key export commodity prices of the HIPC's would remain below the levels projected two years ago for quite some time. This will have adverse effects on future export earnings of the HIPC's and hence on the debt and debt service-to-exports ratios.

They also note that Malawi has had "extended program interruptions, due largely to problems in fiscal and public resource management," thereby impeding its ability to reach "completion point" (i.e., meeting all creditor requirements).

Jubilee Plus projects that by 2019, the level of Malawi's debt will only be 4 percent less than it would have been without assistance under HIPC. It estimates that debt service will fall by 40 percent in the short term, 60 percent in the medium term, but only 30 percent in the long term,
compared to pre-HIPC levels; this pattern is partly due to new debt that Malawi will have to incur.  

Debt is considered sustainable if its net present value is less than 150 percent of export earnings. According to Jubilee Plus, Malawi's debt will not be sustainable on the basis of the debt-to-exports criterion decided by the World Bank until after 2010 (based on highly optimistic projections of growth in export earnings as well as the country's ability to meet Bank and IMF macroeconomic targets). Moreover, as soon as 2002-03, debt service will be roughly equal to the HIPC amount released for social expenditure.

These assumptions and assessments do not factor in famine and HIV/AIDS.

**Human Development**

One method of tracking human development in Malawi is to analyze trends in its Human Development Index. The HDI was created by UNDP to measures average achievements in life expectancy at birth; adult literacy and combined primary, secondary, and tertiary gross enrollment ratios; and GDP per capita (most UN agencies are now calling this gross national income [GNI]; details on its calculation can be obtained from the World Bank). An HDI of 0.800 or above = high human development; 0.500 - 0.799 = medium human development; less than 0.500 = low human development.

In 2000, Malawi's HDI value was 0.400, placing it among "low-human development" countries and ranking it 163 out of the 173 countries for which UNDP calculated an HDI. Malawi's HDI value is lower than that of the median for the world's least-developed countries (0.445) as well as for sub-Saharan Africa (0.471).

What is particularly worrying is that although Malawi's HDI value is already very low, it declined during the latter half of the 1990s. Between 1975 and 1995, the HDI value rose from 0.316 to 0.403, a reflection of, inter alia, the government's efforts to increase educational attainment and health outcomes. However, the HDI value fell to 0.400 in 2000. The decline in the HDI value doubtlessly reflects the enormous impact of AIDS mortality (see Impact section), which has drastically reduced the life expectancy component of the HDI value.

A critical indicator of the well-being of children is the under-five mortality rate. Since independence, Malawi has made great strides in improving child health. In 1960, its under-five mortality rate was 361 per 1,000 live births; in 2000, it had fallen to 188. However, the figure of 188 was the world's 15th-highest under-five mortality rate in 2000, exceeding that of all the least-developed countries (161) and of sub-Saharan Africa (175).

Infant mortality, another key human development indicator, fell from 205 in 1960 to 117 in 2000; however, as with under-five mortality, the 2000 figure exceeds that of all the least-developed countries (102) and of sub-Saharan Africa (108). The Demographic Impact section below quantifies the impact of HIV/AIDS on infant and child mortality.
Another critical human development indicator is the maternal mortality ratio (MMR), the number of deaths to women per 100,000 live births that result from conditions related to pregnancy, delivery, and related complications. The 2000 MDHS estimated that the maternal mortality ratio was 1,120 during the seven-year period prior to the survey. The 1992 MDHS found that the MMR was 620 (again, applicable to the seven-year period before the survey). Thus, the MMR appears to have increased by about 45 percent from the late 1980s to the late 1990s. Although the increase in the MMR that can be attributed to HIV/AIDS is not known, one can infer that a variety of factors that include HIV/AIDS played a role in this increase. (As the accompanying indicator table shows, UNFPA estimates that Malawi's 2001 MMR was 580, a continually revised consensus estimate of WHO, UNICEF, and UNFPA.)

Education

In 1994, the government of President Muluzi showed tremendous leadership by introducing universal free primary education. This resulted in a sharp increase in primary enrolments, from 1.9 million in 1993-94 to 2.9 million children in 1999-2000. Free primary education led to greater access to education for poorer groups in rural areas. The gross primary enrollment rate for the poorest quintile increased from 58 percent to 110 percent between 1990-91 and 1997-98, whereas for the richest quintile, it increased from 110 percent to only 119 percent. The share of recurrent educational expenditures for primary has risen from approximately 50 percent in 1993-94 to around 60 percent in 1999-2000. The shares of secondary (around 10 percent) and tertiary education (around 18 percent) have changed little. However, expenditures per pupil are eight times higher in secondary education than in primary education, and 202 times higher in tertiary education. Moreover, poverty, famine, and HIV/AIDS mean that the indirect costs of primary education remain formidable for many households, including uniforms and books, and the opportunity cost of child's labor.

There are significant geographic differences in access to primary schooling: Net enrolment rates are higher in the Northern region than in both the Southern and the Central regions. Enrolment rates are consistently higher in urban than in rural areas, where households are poorer and where physical access to schools is more difficult.

Despite the abolition of fees for primary education, dropout and repetition rates remain high. The largest dropout occurs between standard one and two, where approximately 30 percent of students drop out. Dropout rates are higher among the poorer income groups. The dropout rate is even higher for girls; despite equal numbers of girls and boys starting primary, girls represent only 42 percent of students in standard 8. Part of this phenomenon may be related to pregnancy and early marriage, as well as the need for household labor, particularly given persistent poverty and HIV/AIDS care burdens. Only 11.2 percent of adults ages 25 and above — and only 6.2 percent of women — have completed standard 8 (a common measure of educational attainment).

Despite increasing steadily since 1993-94, secondary enrolment remains low at 7 percent. Secondary education remains the preserve of the rich: The gross enrolment rate of children from the richest income quintile was over four times that of those in the poorest quintile and twice that
of the next richest quintile, indicating the strong relationship between wealth and enrolment. As with primary, secondary enrolment ratios are highest in the Northern region and highly skewed toward urban areas.\textsuperscript{181}

University enrollment is low by regional standards: There are only about 3,500 students enrolled. Women represent less than one-third of university students.\textsuperscript{182}

Malawi's school system is still struggling to meet the demands of the rapid expansion of primary enrolments. Teaching capacity remains highly inadequate; about half the current teaching force is not fully trained. Malawi's six teacher training colleges are not currently producing enough teachers to replace even the 5,000 lost annually because of AIDS and regular attrition. There has been a significant decline in the share of recurrent educational expenditures for teacher training and administration.\textsuperscript{183}

The Malawian government and its donor partners are concerned that overcrowding and teacher shortages are threatening the quality of education. A DFID study, for example, notes that the abolition of fees for primary enrollment has led to lower quality of education, suggesting that more years of schooling will be needed to attain the minimum skills required to achieve poverty alleviation goals; thus, the overall cost of achieving these skills will rise for both households and the government.\textsuperscript{184}

**Health Sector**

Malawi's health system is structured around eight service delivery levels:

1. community
2. health post
3. dispensary
4. maternity unit
5. health center
6. rural/community hospital
7. district level hospital (including those of the Christian Health Association of Malawi)
8. central/regional hospital\textsuperscript{185}

At community and health post levels, health surveillance assistants and community members are the main service providers. Dispensaries, maternity units, health centers, and rural/community hospitals are often collectively referred to as health centers.\textsuperscript{186} Only 3 percent of Malawians live in a village with a health center.\textsuperscript{187}

The Ministry of Health and Population (MOHP) provides about 60 percent of health services; the remainder are mainly provided by Christian Health Association of Malawi (CHAM) mission facilities. Other NGOs and private facilities provide around 3 percent of services.\textsuperscript{188}

Almost all public health expenditure is financed by taxation; public health insurance does not play a significant role. Private insurance accounts for only 8.3 percent of private expenditures on health.\textsuperscript{189} Within southern Africa, only Mozambique spends less on health per capita (US$8) than Malawi (US$11) (this figure includes public and private expenditures).\textsuperscript{190}
Public health allocations have remained between 2 and 3 percent of GDP since the mid-1990s. However, actual health spending has consistently fallen far short of budgeted amount because of slow donor disbursements, shortages of counterpart funds, and weak MOHP administrative capacity.\textsuperscript{191} Donor spending is increasingly being directed at the district level.\textsuperscript{192} Despite some improvements in health outcomes since independence, Malawians' health status remains poor (see accompanying indicator table). HIV/AIDS is the leading cause of death among those ages 15 to 49, followed by malaria, which is the main cause of child mortality.\textsuperscript{193} (More detail on malaria is found in box 3.)

Other major health problems include TB (discussed below), cholera (see box 4), schistosomiasis (also known as bilharzia), acute respiratory infection, acute diarrheal disease, and meningitis. Leprosy was seemingly eradicated in 1994, but resurfaced in 2001.\textsuperscript{194} An outbreak of bubonic plague was reported in April 2002. By May 2002, 71 cases of bubonic plague were reported in the district of Nsanje. The outbreak has affected 26 villages: 23 in the Ndamera area, two in Chimombo, and one in neighboring Mozambique.\textsuperscript{195}

**Box 3. The Impact of Malaria in Malawi**

Each year, about 8 million Malawians (mainly in rural areas) suffer from malaria, and up to 5,000 people die because of it. In 2000, there were 27,682 malaria cases per 100,000 population. (Data refer to malaria cases reported to WHO and may represent only a fraction of the true number, given incomplete reporting systems or incomplete coverage by health services, or both.) By comparison, this figure was 143 for South Africa, 1,466 for Namibia, 2,913 for Swaziland, 4,760 for Botswana, 5,422 for Zimbabwe, 18,108 for Mozambique, and 34,274 for Zambia. (Figures for other southern African countries are given to provide a sense of the magnitude of Malawi's malaria burden, although because of the diversity of case detection and reporting systems, country comparisons should be viewed with caution.) Malaria accounts for 40 percent of all hospital admissions, 18 percent of all hospital deaths, and is the leading cause of outpatient visits. If anemia — most of which is attributed to malaria — is included, malaria and its complications account for 53 percent of hospital admissions.

The Malawi government spends about US$7 million per year to treat malaria. Households spend an average US$35 each year on malaria-related medical expenses; moreover, there is the uncaptured cost of lost productivity associated with malaria.

Those most at risk of malaria are children over three months old and pregnant women. Pregnant women are four times more likely to suffer from complications of malaria than nonpregnant women. Children and pregnant women suffering from malaria-related anemia may require blood transfusions, which pose the risk of HIV transmission (see the Blood Safety section above). HIV infection increases malaria parasitemia and the incidence of malarial fevers; some studies have also found that viral load of HIV is higher in adults with malaria than in those without malaria. A malaria-associated increase in viral load could speed progression to AIDS, as well as increase HIV infectiousness, thereby resulting in increased probability of HIV transmission. Malawi participates in the Roll Back Malaria Initiative (see Links section).

Against the backdrop of these enormous health challenges, the human and financial resources to meet them are extremely inadequate. In its proposal to the GFATM, Malawi’s Global Fund Coordinating Committee notes the following constraints: Access to care is limited; although 80 percent of Malawians live in rural areas, most of the country’s health resources are located in the major urban centers. Quality of care is highly variable. Basic health information is often of low quality and is consequently not adequately factored into policy formulation and program planning. Training capacity falls far short of needs. Essential drug distribution is unreliable. Referral mechanisms are poorly defined. Technical support services, such as laboratories and pharmacies, are highly inadequate. Recent missions undertaken in conjunction with the food crisis have found an acute shortage of staff and basic equipment in most health facilities. (Among other findings, health facilities lack capacity to handle emergency obstetric care.) Moreover, the existing epidemiological surveillance system is incapable of providing timely information to national and international stakeholders.

Concurrently, almost all the strategies that form the government's national response to HIV/AIDS, as outlined in its proposal to the GFATM, are heavily dependent on the country's ability to improve delivery of basic health services (see Response section).

**Inefficiencies and Inequities**

The effectiveness and equity of public health expenditures partly explain why health outcomes remain poor. Only 18 percent of the recurrent health care budget is allocated to primary health care, which most directly benefits the poor, whereas tertiary health services receive the highest share of the budget. People seeking medical services avoid clinics, because of the poor quality of infrastructure and the shortage of medical workers, drugs, and supplies. Up to 85 percent of central hospital admissions and an enormous number of outpatients could be treated at lower-level facilities. Poor patient management in hospitals and lack of supervision of remote facilities exacerbate the lack of human resources and medical supplies, leading to overall poor service delivery. Moreover, the concentration of cases at secondary and tertiary levels further draws resources away from primary facilities.

For about 75 percent of Malawians, reaching a health facility takes over 30 minutes. The 2000 MDHS asked all women whether they believed that specified issues were "a big problem" when they wanted to obtain treatment for an illness that they were experiencing. The cost of transport (60.0 percent), lack of money for treatment (56.2 percent), the time required to reach a health facility (56.2 percent), and availability of transport (52.3 percent) were the top four obstacles cited. These four reasons were more often cited by women in the Southern and Central regions, than by those in the North.
Box 4. Cholera in Malawi

Malawi has recently experienced its worst-ever outbreak of cholera. From October 2001 through April 2002, there were 32,968 cholera cases and 980 cholera-related deaths reported. Almost all of Malawi’s 27 districts reported at least one case. Lilongwe led all other districts in disease burden, with 5,537 cases and 160 deaths. The most affected areas were districts in the Central and Southern regions, particularly those in close proximity to natural lakes, where epidemics usually begin before spreading to other districts. Because of the huge influx of cholera cases, hospitals and other treatment centers have been ill-equipped to provide adequate care.

The U.N. notes that the cholera epidemic of late 2001 and 2002 is linked in numerous ways to the food crisis:

1. The increased movement of people in search of food results in poor hygiene practices.
2. Because of unprecedented, high maize prices, urban households no longer have cash to pay for water from protected sources; thus, many have been forced to collect water from free though unprotected — and in many cases contaminated — water sources.
3. High food prices mean that cholera patients have deteriorated nutritional status.


Shortages of Medical Personnel

There is a critical shortage of medical personnel, particularly in rural areas. Most districts lack a doctor, and nurses are in extremely short supply.206 Vacancy rates range from 33 to 80 percent for some positions, resulting in extremely high ratios of population to medical personnel.207 A complex set of factors account for the staffing shortage, including low salaries, attrition to more lucrative jobs, insufficient capacity of in-country training institutions, and increased morbidity and mortality of health personnel (mainly because of HIV/AIDS).208

At the front lines, there are currently about 4,000 health surveillance assistants; MOPH plans to train another 4,000 over the next three years to raise the ratio to 1 HSA per 1,000-1,300 population. MOPH is dependent on donors for the requisite funding.209

Limited Access to Essential Drugs

Another key problem is limited access to drugs and medical equipment. Results from a recent household survey found that lack of drugs was the number-one source of frustration reported by those seeking health care. Respondents stated that drug shortages were particularly acute in rural health centers and district hospitals, whereas they are generally available in central/regional hospitals.210

The government has steadily increased its contribution to drug expenditures, and, according to the World Bank, the budget allocation to drugs, particularly when donor contributions are included, is close to best practice standards. However, the effectiveness of drug expenditures is seriously constrained by weaknesses in drug procurement, storage, and distribution by the Central Medical Stores (CMS), as well as pilfering and inappropriate usage by public health providers. The World Bank and IMF have made reform of CMS a condition of release of HIPC
Regardless of whether CMS reform should be tied to HIPC, reform is clearly needed. The Bank states that such reform involves making CMS an autonomous body, revising and adhering to an Essential Drug List, introducing need-based drug procurement, and creating a strong management information system that ensures equitable and timely distribution. To accomplish these will require a "cash-limited" system to ensure payment and tighter cost controls imposed on hospital drug budgets.

**Shortage of Clinical and Technical Support Services**

Because of low investment, there is also an acute shortage of clinical and technical support services in most district hospitals and health centers, including those related to laboratory and pharmacy services, radiology, ambulances, district and regional blood banks, orthopedics, and physiotherapy. Currently, most district-level and CHAM laboratories perform only basic functions, such as gram stains and HIV testing. A few, mainly in central hospitals, can undertake liver functions tests, bacterial cultures, and sensitivity analyses. The national response to HIV/AIDS depends on donor funding to implement the Essential Medical Laboratory Services Program, which will entail upgrades to existing laboratory standards and improvements in hematology and basic biochemistry capacity.

**Poor Surveillance**

A situation analysis conducted by WHO in ten districts most affected by the recent food crisis in Malawi revealed that there are major weaknesses in health facilities' data collection, analysis, and utilization. For example, the assessment found that there was a much higher mortality rate within communities than recorded by health facilities. Six district hospitals out of ten could not provide adequate records on deaths that occurred during the period under study. Lack of communication facilities (e.g., reliable telephone lines, faxes, and e-mail) affected the timeliness of data and its transmission to national level or other project coordination centers.

**Resource Gaps**

In its proposal to the GFATM, the MOHP mentions several health planning documents that have been adopted since the late 1990s, e.g.:

- To the Year 2020: A Vision of the Health Sector in Malawi
- Ministry of Health and Population District Planning Guidelines
- The National Health Plan 1999 – 2004
- The National Human Resources Development
- The National Health Facilities Development Plan 1999 – 2004

However, a World Bank analysis of Malawi's National Health Plan 1999-2004 found that:

- The plan's service coverage and program targets (e.g., halving the maternal mortality ratio, 50 percent reduction in HIV prevalence, and 50 percent reduction in childhood malnutrition) are not feasible.
The gap between the resources needed to implement the plan and those secured is severely underestimated; the Bank believes that the funding gap is between US$256 million and US$316 million over five years.

Although the plan's stated objective is to improve primary health care, its facility targets are biased toward hospitals.\textsuperscript{217}

The GFATM proposal states that the MOHP's approach to health sector reform is predicated on:

- introducing the essential health package, which targets:
  - vaccine-preventable diseases
  - malaria
  - maternal and neonatal outcomes (including family planning)
  - TB
  - acute respiratory infection
  - acute diarrheal disease
  - STIs, including HIV
  - schistosomiasis
  - nutritional deficiencies
  - eye, ear, and skin infections
  - common injuries
- decentralizing health care management
- broadening access to health services in remote areas
- promoting cost sharing through extending health insurance schemes and implementing user fees where appropriate\textsuperscript{218}

The MOHP estimates that implementation of the essential health package will cost, at present estimates, US$17.53 per capita annually.\textsuperscript{219} (Note that annual total health expenditure in Malawi — public and private — is US$11.\textsuperscript{220})

Health sector reform is predicated on decentralization and the transfer of responsibility for staffing decisions, management of primary health facilities, and communicable disease programs from the MOHP to local authorities. The timing of the transition depends on building the required financial and technical capacity at district level. The government has taken various steps to facilitate this process. Regional Health Offices were abolished in 1999/2000, and cost centers at the district level were established. Districts now prepare budgets tailored to their local priorities. However, largely due to variations in central government cash flow, resources reaching district health offices vary significantly by month. This lack of resource predictability is a serious constraint to budget execution.\textsuperscript{221}

\textit{User Fees}

The World Bank has advised Malawi to implement cost-sharing measures in the health sector.\textsuperscript{222} Discussions about cost-sharing have been ongoing since the 1980s, but Malawi does not have a comprehensive, national cost-sharing policy with strong political support. Currently, tertiary hospitals and a few district hospitals are the only facilities charging fees; fee structures and health services that are charged are determined on an ad hoc basis. For example, at Queen
Elizabeth Central Hospital, cost-sharing revenues account for 5 percent of total hospital expenditure. Few patients are covered by health insurance, and thus many who use hospital services cannot pay the entire cost of specialized services. However, there are services that can operate on a full cost recovery basis such as the use of private rooms, whereas the poor are likely to self-select into general wards. 223

The Bank points to CHAM facilities, which charge user fees set at the local level by independent committees. According to the Bank, CHAM generates as much as one-third of its revenues from user fees. Although CHAM facilities also suffer from shortages of medical personnel and drugs, user surveys suggest quality of care in CHAM facilities is higher than that provided by equivalent government hospitals. The Bank seems to be positing that health care seekers are willing to pay for higher-quality care and thus introduction of user fees in (improved) public health facilities is rational. To achieve improved public health service delivery, the Bank recommends that the government (which subsidizes the salaries of CHAM health workers) increase its subsidy to CHAM (which has been increasing, from 0.7 percent of recurrent health spending in 1997 to 5.2 percent in 2000); introduce explicit service contracts with CHAM; formally designate CHAM facilities as district hospitals in areas with no government hospitals; and closely coordinate policy decisions, including health facility construction, with CHAM.

The Bank also highlights the success of community-based drug revolving funds as illustration of Malawians' willingness to pay for quality services. It states that:

> The poor can be protected through fee exemptions for specific services (such as maternal and child health), through demographic targeting, or through community waiver programs organized along community health or other social funds. 224

The Bank's recommendations on closer and more formal collaboration with CHAM may be quite reasonable, especially as the national response to HIV/AIDS relies heavily on CHAM. 225 However, experience with user fee exemptions, in, for example, Zambia, has shown that there have been serious inequities in implementing them. There have been very high errors of exclusion and inclusion; those who can afford to pay or are ineligible under the criteria have been granted exemption, whereas many who were eligible have been denied exemption. Moreover, exemption mechanisms, even if they worked as intended, would not necessarily address inequalities in the use of services related to income or distance to health facility. 226

In addition, as discussed in previous sections, households are already at breaking point due to the humanitarian crisis and many if not most would not have any cash (or assets left that could be sold) to pay for health services.

**Sexually Transmitted Infections**

Malawi's strategic framework for HIV/AIDS includes:

- expanding STI syndromic management to all health institutions and health facilities, including in rural areas
- strengthening STI counseling services and mobilizing people for early treatment, especially among youth
- providing adequate STI drugs and training adequate numbers of medical personnel for STI syndromic management
- promoting routine screening and treatment of STIs in antenatal attendees and among "people associated with high risk behaviors""}^{227}

As with other health data, those on STIs are difficult to access. Findings from several studies are presented below, which demonstrate that STIs (particularly herpes) are likely fueling the HIV/AIDS epidemic in Malawi:

- In the study involving male workers from the Nchalo sugar plantation, discussed above, the most important risk factor for HIV acquisition in both the 1994 and 1998 cohorts was a reactive syphilis test. Reactive syphilis increased the probability of HIV acquisition about twofold among men in both the 1994 and 1998 cohorts; however, it was only statistically significant in the 1994 analyses.}^{228}

- As part of the same study, the authors investigated associations between HIV prevalence and herpes simplex virus 2, hepatitis C, and hepatitis B, using a nested case-control study of 279 HIV-positive and 280 HIV-negative male sugar plantation workers. The prevalence of herpes was 88.1 percent among HIV-positive men and 64.3 percent among those who were HIV-negative (p < .01). This difference persisted after adjusting for sexual behavior and history of STI (OR = 4.12; 95% CI: 2.21-7.68), with herpes significantly associated with HIV. The prevalence of hepatitis C was 12.7 percent among HIV-positive persons and 10.0 percent among those who were not infected with HIV (p = .31); the comparable figures for hepatitis B were 16.9 and 14.4 percent, respectively.}^{229}

- Researchers from the University of Malawi, Johns Hopkins, and Rutgers used a cross-sectional study to examine the association between bacterial vaginosis (BV) and HIV infection among women attending ANCs (n=1,196). They found that BV was significantly associated with antenatal HIV seroconversion (adjusted OR = 3.7) and postnatal HIV seroconversion (adjusted OR = 2.3). There was a significant trend of increased risk of HIV seroconversion with increasing severity of vaginal disturbance among both ante- and postnatal women. The approximate attributable risk of BV alone was 23 percent for antenatal HIV seroconversions and 14 percent for postnatal seroconversions.}^{230}

- Researchers working in the Shire Valley in rural southern Malawi have found that hepatitis B and C are endemic. They did not, however, find a statistical association between HIV and hepatitis B or C.}^{231}

**Sexual and Reproductive Health**

The accompanying table provides selected indicators of sexual & reproductive health. As shown, there is a high burden of fertility on young women. The 2000 MDHS found that the desired total fertility rate among all women is 5.2, meaning that 30 percent of married women (including those in consensual unions) have an unmet need for family planning.}^{232}

Malawi's maternal mortality ratio is already higher than the global average (550 vs. 400). A recent U.N. situation analysis conducted in ten districts hard-hit by the food crisis found higher maternal mortality during 2001-02 compared to 2000-01. In eight district hospitals for which mortality data were available, maternal deaths had increased by 72 percent, although the number
of deliveries had declined by 7.6 percent during the same period. These data indicated a diminishing number of women gaining access to hospitals, combined with increased mortality of those who do. The mission found that the increase in maternal mortality was directly attributed to the food shortage, which is exacerbating already high anemia rates found in pregnant women, as well as cultural practices that require mothers to eat last in the family. 233

Given these findings, UNFPA recently urged that reproductive health care be integral to the response to the humanitarian crisis. It noted that hunger and cholera also contribute to increasing maternal mortality. Concurrently, as finding food is the top priority, fewer women are likely to seek prenatal care or give birth in hospitals. Malnourished mothers are more likely to be anemic and therefore at risk of bleeding, particularly after delivery, thus rendering them more susceptible to infections. In these situations as well, blood transfusions may be necessary, thereby possibly increasing risk of acquiring HIV. 234

**Knowledge of HIV/AIDS**

The 2000 MDHS found that general awareness of AIDS is nearly universal: 98.9 percent of women and 99.7 percent of men have heard of AIDS. Among women, 93.1 percent believe that "there is a way to avoid getting AIDS"; for men, this figure is 97.7 percent. Women and men in rural areas and in the Northern Region are more likely to report that AIDS cannot be avoided than those in urban areas and Central and Southern regions. 235

Education is strongly related with belief that AIDS can be avoided. Among women with secondary education, 99.5 percent believed that AIDS can be avoided; for women with no formal education, this figure was 88.8 percent. For women with primary education 1-4, 91.7 percent believe that AIDS can be avoided; for women with primary education 5-8, 96.0 percent. 236

Abstinence and use of condoms were by far the most frequently cited ways of avoiding HIV by men and women. Among women, 67.1 and 54.6, respectively, cited these methods. Among men, these figures were 77.3 and 71.4 percent, respectively. Limiting number of sexual partners was cited by 27.4 percent of women and 20.4 percent of men. Only 2.5 percent of women and 1.3 percent of men cited avoiding sex with partners who have multiple partners. 237

Among women, 85.3 percent knew of two or three "programmatically important ways to avoid HIV/AIDS" (i.e., abstaining from sex, using condoms, and limiting number of sexual partners); for men, this figure was 91.7 percent. The relationship between educational attainment and knowledge of the three methods just mentioned was strong: only 4.9 percent of women with secondary education knew fewer than two ways to avoid HIV/AIDS, whereas for women with no schooling, this figure was 21.3 percent. There was also a strong rural-urban differential: 93 percent of urban versus 83.8 percent of rural women knew two or three ways to avoid HIV/AIDS. Among these women, knowledge was highest among women in Southern Region (88.8 percent), followed by Northern (82.8 percent) and Central (81.6 percent) regions. 238

The percentage of men with secondary or higher education who knew two or three "programmatic" ways to avoid HIV/AIDS was very close to that of women with the same educational attainment: 95.4 percent (for women: 95.1 percent). As with women, this figure also rose in tandem with educational levels. The urban-rural differential was not as pronounced (95.0
vs. 90.9 percent) as it was with women. With regard to regions, more men in Southern Region (94.0 percent) than in Central (90.8 percent) or Northern (85.4 percent) regions knew two or three programmatic ways to avoid HIV/AIDS.\textsuperscript{239}

Despite high knowledge of HIV/AIDS, some findings from the 2000 MDHS suggest that behavior change messages may not be effectively highlighting key strategies for HIV prevention, nor adequately debunking false beliefs about HIV transmission. Although HIV may be transmitted via unsafe injections, this is a rare occurrence compared to sexual transmission. Yet 10.6 percent of women and 10.9 percent of men cited avoiding injections as a method to avoid HIV/AIDS. Similarly, HIV transmission through sharing of razor blades is rare; however, 33.7 percent of women and 26.9 percent of men cited avoidance of sharing razors/blades as a means to avoid HIV/AIDS. (Compare these figures with those above regarding limiting number of sexual partners and avoiding sex with partners who have multiple partners.) Avoidance of kissing and of mosquito bites was rarely cited.\textsuperscript{240}

When asked whether a "healthy looking person can have the AIDS virus," 84.3 percent of women and 91.7 percent of men correctly replied yes. A strong urban-rural differential was found: among women: 95.1 vs. 82.3 percent, and among men: 80.5 vs. 70.9 percent.\textsuperscript{241}

Knowledge of MTCT of HIV is weak. The percentages of women who responded that HIV can be transmitted from mother to child during pregnancy, delivery, or breastfeeding were 65.6, 62.3, and 64.8 percent, respectively. Among men, these figures were 70.4, 61.5, and 62.1 percent, respectively.\textsuperscript{242}

Twenty-four percent of women and 16.5 percent of men do not believe that condoms are safe. This belief was highest among those who have never had sex (women: 32.1 percent; men: 22.8 percent) and among those living in Northern Region (women: 52.8 percent; men: 29.2 percent).\textsuperscript{243}

**Stigma**

Among Malawian women, 72.2 percent report that they personally know someone who has AIDS or has died because of AIDS (urban women: 78.0; rural women: 71.1 percent). Among men, this figure is 81.5 percent (urban: 82.0 percent vs. rural: 81.3 percent).\textsuperscript{244}

Among currently married women who have heard of AIDS, 72.3 percent report that they have discussed HIV prevention with their spouse; for men, this figure is 85.8 percent. There was a high urban-rural differential among women (80.5 vs. 70.9 percent), though not among men (85.6 vs. 85.8 percent). For both men and women, educational level was strongly associated with having discussed HIV with one's spouse.\textsuperscript{245}

The 2000 MDHS found that 51.3 percent of women and 46.9 percent of men believe that a coworker with HIV should not be allowed to continue working. This attitude was much greater among those with lower educational levels and among those living in rural areas.\textsuperscript{246}
An overwhelming majority of women and men report that they would be willing to care for a relative with AIDS in their home (93.6 and 95.9 percent, respectively). However, according to Malawi's Global Fund Coordinating Committee, which drafted the proposal to the GFATM, health care workers consistently report reluctance by families and communities to care for members with chronic and terminal conditions. This has resulted in “dumping” of family members in hospitals, which are already overstretched.

There is also a belief that among some Malawians that HIV/AIDS is related to witchcraft, though the prevalence of and sociodemographic characteristics related to holders of this belief have not been quantified.

**Gender**

**HIV Prevalence among Women**

Malawian women become infected with HIV at younger ages than men for both biological and behavioral reasons. As discussed in the Epidemiology section, UNAIDS published data in July 2002 indicating that HIV prevalence among Malawian women ages 15 to 24 ranges from 11.91 to 17.87 percent, whereas the comparable range for men in the same age cohort is 5.08 to 7.62 percent. Examining cumulative AIDS cases, NACP found that AIDS cases among women peak between ages 15 to 29, and among men at ages 30 and above. This suggests significant transmission from older males to younger females. (See Age Mixing section.)

The U.S. Bureau of the Census projects that by 2020, there will be more men than women in each of the five-year-age cohorts between the ages of 15 and 44, which may push men to seek partners in increasingly younger age cohorts. This factor in turn may increase HIV infection rates among younger women.

High male-to-female transmissibility of HIV is considered likely to play a significant role. Also, many women are unable to insist on condom use and negotiate the timing of sex and the conditions under which it occurs. Even when women know that their husbands are at high risk of HIV, many do not raise the issue of condoms as to do so might be perceived as accusing their husbands of infidelity or depriving them of sexual pleasure. Women who do suggest condom use may be at increased risk of physical violence and/or economic abandonment.

**Women's Status**

In the National HIV/AIDS Strategic Framework 2000-2004, NACP noted that:

Most Malawian men and boys view pre- and extra-marital sex as a demonstration of manhood. This is basically because the Malawian cultural values regarding sex and sexuality tend to emphasize and strengthen the dominance of men and boys and insubordination of women and girls. Some of these views are entrenched by initiation ceremonies and the whole process of socialization.
UNFPA ranks Malawi a category "A" country, meaning that it is furthest from achieving the sexual and reproductive health and rights goals of the International Conference on Population and Development (ICPD), held in Cairo in 1994. Group A countries have the greatest need for external assistance and the lowest capabilities for mobilizing domestic resources to close this gap.

UNDP measures gender inequality by using the unweighted average of three component indices: life expectancy, education, and income. Its Gender-related Development Index (GDI) value ranges from 0 (lowest gender equality) to 1 (highest gender equality). In 2000, UNDP calculated Malawi's GDI value at 0.389, ranking it 137 out of 146 countries on this index. (For comparison, GDI values range from 0.263 [Niger] to 0.956 [Australia].)

UNFPA reports that gender inequality remains a major barrier to improving the standard of living and reproductive health of women in Malawi. The 2000 MDHS found that over 65 percent of women currently married or cohabiting reported that they have no say in their health care, large household purchases, and daily households purchases. The majority of unmarried women make these decisions with someone else.

There are major gender disparities in literacy and education, as shown in the accompanying indicator table. The 2000 MDHS found that women had completed 3.1 median years of schooling, whereas this figure was 5.1 for men. Among those residing in rural areas, median years of schooling for women was 2.5, for men: 4.5. For women and men, those residing in Northern Region had far more years of schooling than those in the Central and Southern regions.

Women's lower educational levels are related to lower formal labor force participation and decreased earnings and thus lessened economic autonomy. This situation may increase women's economic dependence on men and inability to refuse sex or insist on condom use — factors that can increase vulnerability to HIV. Moreover, compared with boys, girls are more often kept at home when household income and/or labor supply falls (an increasing phenomenon given high AIDS mortality and famine). Malawi's National AIDS Control Program reports that as HIV/AIDS continues to place new demands on family resources and reduce the time that adults spend on income-generating activities, the burden of care is largely borne by women and girls. (See the Household Impact section.)

Women and Poverty

In 1998, about 52 percent of the poor were female. Females head 25 percent of all Malawian households, and these households have always been disproportionately poor, especially in rural areas. Over 71 percent of Malawian men are in formal sector employment, compared to only 24 percent of women. And among the latter, most are concentrated in low-paying, traditionally female jobs such as nurse, teacher, home crafts worker, or secretary.

Although full-time female farmers comprise 70 percent of the agricultural labor force, they continue to have limited access to agricultural extension, training, and inputs. This scenario hinders their full participation in agriculture.

Widows
Some communities in Malawi observe certain practices that promote ritual sex and may entail risk of HIV infection. The most common are initiation ceremonies, widow inheritance, and sexual cleansing. Widows may be particularly vulnerable to HIV because of sexual cleansing and wife inheritance. To be purged of evil forces assumed to have caused the death of the spouse, the widow or widower is cleansed through sexual intercourse with a relative of the deceased. Wife inheritance refers to a brother or cousin marrying the deceased’s wife.

A related phenomenon is "grabbing," wherein relatives forcefully take possession of the deceased's household goods, land, livestock, clothes, and other assets. This scenario exacerbates the already precarious economic (and social) situation of widows and their children. Recent reports have found that the practice is escalating in the wake of AIDS. Women and Law in Southern Africa (WLSA) note that property grabbing is illegal in Malawi; however, the law states that in the absence of a written will, the property of the deceased should be divided between family and relatives. Most rural Malawians do not have wills. Moreover, widows have to deal with obtaining the required paperwork, such as death certificates, and then obtaining a hearing in magistrates' courts, where inheritance claims are processed. Corrupt officials sometimes demand bribes, or well-connected relatives of the deceased may use their influence to block a widow's claim. However, WLSA notes that many traditional leaders are supportive of widows' rights, and therefore WLSA is advocating that traditional leaders be granted greater administrative powers. NGOs such as the Mponela AIDS Information and Counseling Center are also working to help widows become aware of and pursue their legal rights.

**Sexual Negotiation**

The 2000 MDHS asked respondents whether a wife is justified in refusing sex with her husband under four scenarios: she is tired or not in the mood, she has recently given birth, she knows her husband has had sex with other women, and she knows her husband has an STI. Overall, 49.7 percent of women agreed with all four reasons. The urban-rural differential was not strong. Women in Northern Region and those with higher educational attainment were more likely to agree with all four reasons. Overall, 16.6 percent of all women did not agree with any reason specified. Rural women, those in Central and Southern regions, and those not employed were more likely to believe that the reasons specified did not justify refusing sex.

Overall, 31.8 percent of women did not believe that knowing their husband had sex with other women justified refusing sex; 26.7 percent did not believe that knowing one's husband had an STI was justification.

**Polygyny**

In the 2000 MDHS, 17.0 percent of married women reported being in polygynous unions. Polygyny is more common in rural areas and in the Northern Region. Among women with no formal education, 20.9 percent are in polygynous unions, compared with 15.5 percent with primary education and 8.4 percent with secondary or higher education. Based on previous surveys, the authors of the 2000 MDHS report that polygyny is declining in Malawi (21 percent of married women reported being in polygynous unions in 1992).
Sexual Violence

Reliable data on sexual violence in Malawi are scarce. The Malawian government reports that:

Gender-based violence remains a persistent problem, leading to physical, psychosocio consequences such as drug and alcohol abuse, sexual abuse, unwanted pregnancies, HIV infection and homicide, all of which deplete labor productivity, create health care expenses and reduce the capability of men and women to be empowered and to be productive. According to a study by GTZ, 90 percent of the cases of violence against women are to do with domestic violence. Reported cases of violence against women increased from a total of 800 cases in 1990 to 8,000 in 1999. On the other hand, there were 20 male cases reported in 1990 and 510 in 1999.269

The World Bank quotes a study in rural Malawi that found that 55 percent of adolescent girls reported coerced sex (no detail on the study was provided).270

Intravaginal Practices

There is limited evidence of an association between intravaginal practices and vaginal infections, which in turn may be associated with HIV acquisition.271 Some studies have suggested that intravaginal practices may increase heterosexual transmission of HIV and other STIs by:

1. drying out and irritating the vaginal and cervical mucosa
2. disturbing the normal vaginal flora, eliminating lactobacilli that form a natural barrier against colonization of STI pathogens and transmission of HIV
3. interfering with the acceptability and efficacy of barrier methods of HIV/STI prevention272

One study conducted by researchers from Johns Hopkins and the University of Malawi among women attending ANCs (n=6,603) found that 13 percent reported using intravaginal agents for tightening (to increase male sexual pleasure) and 34 percent reported using them for self-treatment of vaginal discharge and itching. A higher proportion of HIV-infected than uninfected women (17 vs. 14 percent) reported use of intravaginal agents for treatment (OR, 1.29; 95% CI: 1.05-1.57), but no difference in HIV status was found when these agents were used for tightening. The association of HIV infection with vaginal agents for self-treatment, but not for tightening, may point to infection with an STI as the link.273 Moreover, study of the effect of intravaginal practices on the acceptability and efficacy of male and female condoms as well as the interplay between intravaginal practices and topical vaginal microbicides would be useful.274,275

Other factors that may render women vulnerable to HIV infection include:

- situations such as food insecurity, in which women may trade sex for food or other necessities (see Food Crisis section above)
- sex work (see below)
- transactional sex, in which sex may be exchanged for gifts or money (see below)
- resulting sense of fatalism that may reduce women's motivation to protect their sexual health
**Sexual Behavior**

According to Malawi's HIV/AIDS strategic framework:

"Culture prevents critical discussions of sex and sexuality issues and development of curricula to address sex and sexuality through formal and informal education systems."  

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**Age at First Sex**

According to the 2000 MDHS, the median age at first sex for women is 16.8 for the age cohort 25-49. Among women ages 20-24, it has risen slightly, to 17.1. Among adolescent women, 57.3 percent have had sex. For all women, the median age at first sex is about one year earlier than the median age at first marriage.

Among men, however, age at first sex appears to be declining. Among those ages 20-24, the figure is 17.7; among those ages 25-54, it is 18.4. Among adolescent men, 61.1 have had sex. Men begin having sex about five years before first marriage, though this gap may lengthen if age at first sex continues to decline.

(NB: All these figures are self-reported. Zaba et al. note that in some southern African countries, men and women may report a later initiation of sex resulting from denial of any kind of sexual activity by adolescents.)

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**Number of Sexual Partners**

According to the 2000 MDHS, among those who are married, 99.3 percent of women and 82.5 percent of men reported no sexual partner other than spouse/cohabiting partner in the last year. There was almost no relationship with age, residence, region, and educational attainment.

Among unmarried women ages 15 to 19 who have ever had sex, 65.4 report one sexual partner in the last year (2.1 percent report two or more partners). Among men in the same age cohort, these figures are 56.1 and 14.5 percent, respectively.

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**Condoms**

The 2000 MDHS found that 77.0 percent of women and 87.2 percent of men knew a source for condoms. When asked whether they could "get a condom if they wanted to," 57.4 percent of women and 79.1 percent of men replied yes. Men and women in urban areas and with higher educational attainment were far more likely to know a condom source and report personal access to them.

Among those ages 15 to 19, only 69.1 percent of women reported knowing a source for condoms; 48.2 percent reported being able to obtain one if desired. For men, these figures were 83.8 and 71.5 percent, respectively. The same phenomenon wherein far fewer respondents reported ability to obtain a condom than reported knowledge of a condom source was seen in those ages 20 to 24. For women in this age cohort, 82.2 percent reported knowledge of a condom
sources, whereas 66.4 percent reported being able to obtain a condom. For men, these figures were 93.4 and 88.0 percent, respectively.\footnote{282}

(Malawi’s 2000-04 strategic framework for HIV/AIDS, discussed in depth below, stresses the importance of condoms, but does not state how it will improve access to them.\footnote{283})

Overall condom use is low in Malawi. Among women who had sexual intercourse in the last 12 months, only 4.7 percent used a condom with any partner; for men, this figure is 14.0 percent. Condoms are used far less frequently during sex with a spouse/cohabiting partner than with a casual partner. Of women who had sex in the last 12 months, 2.5 percent used a condom with a spouse or cohabiting partner, whereas 28.7 percent used a condom with a noncohabiting partner. For men, these figures were 5.9 and 38.9 percent, respectively. Using demographic data from 1996, the authors of the 2000 MDHS found that condom use within marriage had declined slightly among both women and men. With regard to noncohabiting partners, condom use had increased among women, though there was little increase among men.\footnote{284} (Data specific to Lilongwe or Blantyre were not available.)

Among those ages 15 to 19, only 31.9 percent of women and 28.9 percent of men used a condom with a noncohabiting partner during the last year. For the 20-24 age cohort, 32.6 percent of women and 46.9 percent of men used a condom with a noncohabiting partner during the last year. These data indicate that an enormous percentage of pre- or extramarital sex is unprotected.\footnote{285}

Urban men and women are uniformly more likely to use a condom with a spouse or with a noncohabiting partner than are those living in rural areas. Educational attainment is strongly associated with condom use for men and — especially — for women.\footnote{286}

Among men who reported having paid for sex in the last year, 35.4 percent reported using a condom at last paid intercourse. (This percentage is less than that for sex with a noncohabiting partner: 38.9 percent.) Urban residence and — especially — higher educational attainment were strongly associated with condom use. There was little association among marital status, drinking patterns, and condom use.\footnote{287}

\textit{Transactional Sex}

According to the 2000 MDHS, among men who have ever had sex, 20.5 percent report having paid for sex in the last 12 months. For unmarried men, this percentage was 21.0 percent; for married men, 20.3 percent. Among all men in urban areas, 24.9 percent report having paid for sex; this percentage was 19.6 percent in rural areas. Married men in urban areas were much more likely to have paid for sex than those in rural areas (29.6 vs. 18.5 percent), whereas unmarried urban men were somewhat less likely to have paid for sex than those in rural areas (17.1 vs. 22.1 percent). All men who had been drunk in the last three months were more likely to have paid for sex (23.9 percent) versus men who consumed alcohol but did not become drunk (19.4 percent).\footnote{288} Better data on the dynamics of transactional sex in Malawi are not available. However, as previously mentioned, the famine may be increasing episodes of transactional sex.
Sex Work

Data on HIV prevalence among sex workers are scarce. The U.S. Bureau of the Census cites several studies, including one published in 1994, which found that HIV prevalence among sex workers attending Lilongwe's AIDS Counseling Center was 70 percent. Other studies in the Central and Southern regions have found prevalences as high as 86 percent.\textsuperscript{289}

Male Circumcision

Male circumcision is uncommon in Malawi.\textsuperscript{290} Some observational studies from sub-Saharan Africa have indicated that male circumcision may reduce the risk of HIV acquisition,\textsuperscript{291, 292} though circumcision does not appear to affect transmission from HIV-positive men to their partners.\textsuperscript{293} The limitations of these studies have been highlighted, and further study is needed on both biomedical and sociobehavioral issues before promoting male circumcision as a public health intervention.

In the study of male workers from the Nchalo sugar plantation previously mentioned, researchers found that lack of circumcision was associated, though not significantly, with HIV acquisition.\textsuperscript{294}

Alcohol and Drug Use

Data from the 2000 MDHS suggest that those who engage in excessive drinking are more likely to have multiple partners. Among married men who have gotten drunk in the last three months, 20.3 percent reported extramarital sexual activity over the past year (vs. 13.7 percent who consumed alcohol but did not get drunk). For women, these figures were 1.3 and 0.6 percent, respectively. Among unmarried men who have gotten drunk in the last three months, 23.0 percent reported two or more sexual partners over the last year (vs. 12.7 percent who consumed alcohol but did not get drunk). For women, these figures were 9.6 and 1.5 percent, respectively.\textsuperscript{295}

Among men who had gotten drunk over the last three months, only 13.8 percent used a condom with any partner. For those who consumed alcohol but did not get drunk, 14.0 percent used a condom. For women, these figures were 7.3 and 4.7 percent, respectively. However, for men, these figures are similar to men's overall condom use with any partner (14.0 percent). For women, overall condom use with any partner is 4.7 percent, identical to condom use with any partner with alcohol consumption but not drunkenness.\textsuperscript{296}

Researchers from the University of Malawi, Johns Hopkins, and the University of Illinois at Chicago note that with the 1994 transition to multiparty democracy, there has been an increase in alcohol and drug use among young people. Smoking chamba (marijuana) has become increasingly prevalent among youth, particularly in bars and at social gatherings. To examine chamba's effects on disinhibiting behavior, the researchers conducted in-depth interviews with key informants, including medical and mental health providers and other in-country experts. They found that chamba is one of the world's most potent forms of marijuana and that the behavioral manifestations of its use include aggression, hallucinations, depression, and sexual
arousal. Additionally, *chamba* is sometimes consumed with alcohol, which may heighten its effects. *Chamba* use accounts for 25 percent of admissions to the country's largest mental hospital. Key informants attributed alcohol and drug use, in part, to the lack of resources and alternative activities for youth in Malawi.

**Impact**

**At a Glance**

**Demographic**

- In 2002, the U.S. Bureau of the Census estimated that life expectancy in Malawi was 38.5 years, whereas it would have been 56.3 in a "no-AIDS" scenario. By 2010, life expectancy is projected to fall to 36.9.
- The Census Bureau estimates that Malawi's population growth rate in 2002 was 2.3 percent, whereas it would have been 3.3 percent without AIDS. Infant mortality was 106.1 deaths and under-five mortality 184.7 deaths per 1,000 live births (without AIDS, these figures would have been 87.2 and 155.0, respectively).
- By 2010, the Census Bureau's projects that Malawi's growth rate will be 1.9 percent (3.2 percent in a "no-AIDS" scenario). Life expectancy will be 36.9 years (59.4 without AIDS), the crude death rate 23.1 (9.9), infant mortality 97.9 (73.2), and under-five mortality 165.1 (125.2).

**Mortality**

- HIV/AIDS is the leading cause of death among Malawians ages 20 to 49. UNAIDS estimated that there were 80,000 adult and child AIDS deaths in Malawi during 2001. (The comparable figure for 1999 was 70,000.)
- Malawi's 2000 Demographic and Health Survey found that mortality among both adult women and men has risen sharply from the late 1980s to the late 1990s. The increases in male mortality are largest from age 30 and above, whereas for women, an earlier impact is seen (age 20 and above). These figures correspond to the gender-disaggregated peak in AIDS cases and imply significant age mixing in sexual activity (older men and younger women).
- The 2000 MDHS estimated that the maternal mortality ratio increased by about 45 percent from the late 1980s to the late 1990s. Although the increase in the MMR that can be attributed to HIV/AIDS is not known, one can use other mortality data to infer that it was a significant factor.
- Note, however, that despite AIDS mortality, Malawi's population growth (2.4 percent) and total fertility (6.34) rates remain high.
Macroeconomic Impact

- In the medium term, Malawi will experience a 4.8 percent reduction in GDP per capita because of HIV/AIDS. Much of this decrease is the result of lost knowledge and skills due to AIDS mortality within the workforce.

Labor Force

- The International Labor Organization projects that Malawi will lose 18.9 percent of its labor force by 2020 (compared with the labor force size without HIV/AIDS).

Agriculture

- In June 2001, the Food and Agriculture Organization of the United Nations (FAO) estimated that Malawi lost 5.8 percent of its agricultural labor force in 2000 because of HIV/AIDS. FAO projected that this figure would rise to 13.8 percent by 2020. NB: These figures do not take account of the current food crisis.

Health

- HIV/AIDS-related conditions currently account for over 40 percent of all inpatient admissions (70 percent in medical wards); these figures are likely to increase.
- Increases in health worker morbidity and mortality have reduced the supply of personnel and increased stress and overwork. Lost time and labor have rendered health care more scarce and more expensive, leaving households to take on a significant burden.
- An IMF analysis found that providing a minimal level of HIV-related health services would account for 4.3 percent of Malawi's GDP in 2000 and 6.5 percent of GDP in 2010. By comparison, total public spending on health in Malawi was 2.8 percent of GDP in 1998.

TB

- Malawi's National TB Control Program (NTP) is internationally recognized for its success. Malawi's TB treatment success rate of 71 percent is higher than the rate for the Africa region (69.6 percent) and close to the global rate of 80.8 percent. However, since the early 1990s, the NTP has been struggling to cope with increasing numbers of HIV-infected TB patients and worsening economic conditions.
- A national survey conducted in 1999 indicated HIV prevalence of 77 percent among TB patients. A 2000 national survey found that over 60 percent of hospitalized TB patients had one or more other OIs.

Malaria

- A study in Malawi found that HIV viral loads increased significantly over baseline among participants with malaria. A malaria-associated increase in viral load, especially if sustained, could lead to increased infectiousness and thus greater probability of transmission of HIV as well as to more rapid disease progression.
Households

- Malawi's poor have traditionally relied on informal safety nets, such as the extended family. However, HIV/AIDS, poverty, macroeconomic policies, and food shortages have rendered traditional coping mechanisms largely irrelevant.

- With an increasing number of dependents, household food stores are now drastically inadequate. Household assets are being sold as families try to buy commercially available foods, which have escalated in price. To survive, some engage in activities such as sex work or border trading, increasing their risk of exposure to HIV.

- AIDS morbidity and mortality are reducing the time that adults can spend on income-generating activities. The burden of care is largely borne by women and girls.

- Medicines, treatment, and other care often consume a large share of family income. As families experience economic pressure to generate cash, they often sell assets; by the time death occurs, the family may be reduced to poverty.

- Poverty means that the economic basis for redistribution is contracting, with fewer informal transfers between households. Women head 25 percent of Malawi's households and these households have always been disproportionately poor, especially in the rural areas.

- Famine has raised the opportunity cost of sending children to school. Lack of food coupled with the breakdown of household coping strategies have placed more children on the streets, where they find themselves at risk of mistreatment, sexual exploitation, and physical and emotional abuse.

- The number of child-headed households is rising.

Orphans and Other Vulnerable Children

- At the end of 2001, UNAIDS estimated that 470,000 AIDS orphans (ages 0 to 14) were living in Malawi. USAID, UNAIDS, and UNICEF estimated that the percent of Malawi's orphans due to AIDS rose from 5.7 percent in 1990 to 49.9 percent in 2001; they projected that this percentage would rise to 59.5 percent in 2005 and 64.4 percent in 2010.

- Orphans are one of the groups most affected by poverty in Malawi. Most orphans live with a grandparent, who are in most cases single and themselves resource-constrained.

- Many Malawian orphans are socially excluded and feel disillusioned and desperate. Their hunger and social exclusion undermine school attendance and lead to further social exclusion.

Prisons

- Despite extensive efforts since 1994 to improve security and human rights, Malawi is experiencing a rising trend in crime. Food shortages, poverty, and HIV/AIDS-related destitution may be factors.

- There is inadequate police presence, especially in rural areas, and the justice system does not have sufficient lawyers, judges, or courts to process cases effectively and in a timely manner. Among other factors, AIDS mortality has reduced the number of police officers and lawyers. As a result, the number of prisoners has expanded, with many individuals on remand. Little additional prison infrastructure has been built, and prisons remain severely overcrowded.
Malawi's Health in Prisons (HIP) disseminates HIV/AIDS and family planning educational materials and provides free treatment for STIs, malaria, and scabies. HIP has been advocating for condom distribution in prisons, but to no avail. Homosexuality is illegal in Malawi, and prison authorities do not accept that unsafe sexual activities occur.

In its proposal to the GFATM, Malawi noted that:

The burden of disease on the country’s economy, the social distress of thousands of child-led households, the loss of large numbers of the country’s workforce, and the spiral of poverty that accompanies continued ill-health threaten to disrupt the political stability of the country.\textsuperscript{298}

The goal of the National Response is to reduce the burden of HIV/AIDS related illnesses and deaths so that they no longer pose a threat to economic growth and political stability, thereby preserving the young democracy in Malawi.\textsuperscript{299}

**Demographic**

In 2002, the U.S. Bureau of the Census estimated that life expectancy in Malawi was 38.5 years, whereas it would have been 56.3 in a "no-AIDS" scenario. By 2010, life expectancy is projected to fall to 36.9.\textsuperscript{300}

The Census Bureau estimates that Malawi's population growth rate in 2002 was 2.3 percent (the highest in southern Africa), whereas it would have been 3.3 percent without AIDS.\textsuperscript{301} Further Census Bureau estimates for 2002 are found in Table 2.

<table>
<thead>
<tr>
<th>Table 2. Demographic Characteristics with and without AIDS, 2002</th>
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<tbody>
<tr>
<td><strong>Indicator</strong></td>
</tr>
<tr>
<td>Crude Death Rate (deaths per 1,000 population)</td>
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<tr>
<td>Infant Mortality Rate (deaths per 1,000 live births)</td>
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<tr>
<td>Under-Five Mortality Rate (deaths per 1,000 live births)</td>
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</tbody>
</table>


The Census Bureau's 2010 projections for Malawi are found in Table 3.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>With AIDS</th>
<th>Without AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth Rate (%)</td>
<td>1.9</td>
<td>3.2</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>36.9</td>
<td>59.4</td>
</tr>
<tr>
<td>Crude Death Rate (deaths per 1,000 population)</td>
<td>23.1</td>
<td>9.9</td>
</tr>
<tr>
<td>Infant Mortality Rate (deaths per 1,000 live births)</td>
<td>97.9</td>
<td>73.2</td>
</tr>
<tr>
<td>Under-Five Mortality Rate (deaths per 1,000 live births)</td>
<td>165.1</td>
<td>125.2</td>
</tr>
</tbody>
</table>


Mortality

The 2000 MDHS found that mortality among both adult women and men has risen sharply from the late 1980s to the late 1990s. It found a 74 percent increase in all-cause adult female mortality and a 76 percent increase in adult male mortality. The increases in male mortality are largest from age 30 and above, whereas for women, an earlier impact is seen (age 20 and above). These figures correspond to the gender-disaggregated peak in AIDS cases discussed earlier, and, again, imply significant age mixing in sexual activity (older men and younger women).

The 2000 MDHS estimated that the maternal mortality ratio was 1,120 deaths per 100,000 live births during the seven-year period prior to the survey. The 1992 MDHS found that the MMR was 620 (again, applicable to the seven-year period before the survey). Thus, MMR appears to have increased by about 45 percent from the late 1980s to the late 1990s. Although the increase in the MMR that can be attributed to HIV/AIDS is not known, one can use the other mortality data presented here to infer that it was a significant factor.

Moreover, a study conducted by researchers from the University Malawi and Johns Hopkins examined the impact of HIV infection on maternal morbidity and mortality at Queen Elizabeth Central Hospital in Blantyre. Of the 1,020 women enrolled in the study, 26 percent were HIV-positive. Women with HIV had more health problems during pregnancy than HIV-negative women; these problems included herpes zoster (5.0 vs. 0.3 percent), abnormal vaginal discharge (7.3 vs. 3.6 percent), TB (1.9 vs. 0.3 percent), and fevers (31.4 vs. 18.9 percent). Babies born to seropositive mothers were, on average, 550 grams lighter, and there were more prenatal deaths among seropositive mothers (6.4 vs. 3.8 percent).

Another study at Queen Elizabeth Central Hospital examined the impact of HIV infection on clinical presentation and case fatality rate among 250 severely malnourished children over one year of age. HIV prevalence was 34.4 percent and the overall mortality rate was 28 percent. The
in-hospital case fatality rate was significantly higher for HIV-infected children (38.4 percent) than for children without HIV infection (22.7 percent) (p<0.05).

In January 2002, Malawi's National AIDS Commission reported that HIV/AIDS is the leading cause of death in the most productive age group (20-49 years). In July 2002, UNAIDS estimated that there were 80,000 adult and child AIDS deaths in Malawi during 2001. (The comparable figure for 1999 was 70,000.)

Research undertaken by UNAIDS and WHO found that for Malawi, the HIV-attributable under-5 mortality rate (per 1,000 and corrected for competing causes of mortality) was 20.9 during the 1990s. (Rates among the 39 countries studies ranged from Madagascar [0.2] to Botswana [57.7].) The HIV-related population proportional attributable risk of dying before age 5 (i.e., the proportion of all-cause under-5 mortality attributable to HIV) was 8.9 percent; the average for the 39 sub-Saharan African countries studies was 7.7 percent, ranging from 0.1 percent in Madagascar to 42.4 percent in Botswana.

**Macroeconomic**

Haacker from the IMF has modeled the impact of HIV/AIDS on the Malawian economy under several scenarios. He estimates that in the medium term, Malawi will experience a 4.8 percent reduction in GDP per capita because of HIV/AIDS; of this percentage, 0.8 percent is due to total factor productivity, 1.4 percent to the capital/labor ratio, and 2.5 percent to "experience" (aggregate knowledge and skills of the workforce, lost due to AIDS mortality and to the lack of such experience among new labor force entrants). In the long term, he projects a 1.4 percent decrease in GDP per capita because of HIV/AIDS. The lower figure for the long-term reflects, partly, that the decline in experience will be somewhat reversed because of the lower growth rate of new entrants to the labor force.

**Labor Force**

The International Labor Organization projects that Malawi will lose 18.9 percent of its labor force by 2020 (compared with the labor force size without HIV/AIDS).

**Dependency Ratio**

The dependency ratio may be defined as:

\[
\text{dependency ratio} = \frac{\text{population ages 0 to 14 + population ages 50 and above}}{\text{working age population (15-49)}}
\]

During the initial stages of the epidemic, dependency ratios increase as most deaths occur among the working age population, thus decreasing the denominator. This scenario means that there are fewer working adults to support the nonworking youngest and oldest members of the population. The U.S. Bureau of the Census estimated Malawi's dependency ratio in 2000 at 116.5, whereas it would have been 115.0 in the absence of AIDS.
During later stages of the epidemic, as birth rates decline — given the high mortality among women of reproductive age and lower fertility of HIV-positive women, thus decreasing the numerator — dependency ratios may fall. The Census Bureau projects that Malawi's dependency ratio will be 95.0 in 2010, whereas it would have been 95.8 without AIDS. Note, however, that despite AIDS mortality, Malawi's population growth (2.4 percent) and total fertility (6.34) rates remain high.

**Agriculture**

See also the Food Crisis section above. In June 2001, the Food and Agriculture Organization of the United Nations (FAO) estimated that Malawi lost 5.8 percent of its agricultural labor force in 2000 because of HIV/AIDS. FAO projected that this figure would rise to 13.8 percent by 2020. NB: These figures do not take account of the current food crisis. Further studies of the impact of HIV/AIDS on agriculture are being undertaken by FAO and UNDP.

**Health**

See also the Health section above.

There are few reliable data on the number of HIV/AIDS patients occupying hospital beds or on costs (public and private) of treating OIs. Malawi's National AIDS Commission reports that HIV/AIDS-related conditions currently account for over 40 percent of all inpatient admissions (70 percent in medical wards) and that these figures are likely to increase.

With regard to supply, those working in the health sector are also affected by HIV/AIDS. Increases in health worker morbidity and mortality have reduced the supply of personnel and increased stress and overwork. Lost time and labor have rendered health care more scarce and more expensive, leaving households to take on a significant burden. Haacker notes that if Malawi were to maintain its current numbers of doctors and nurses, and assuming HIV prevalences for health sector staff are similar to those of the general population, training of doctors and nurses would have to increase by about 25-40 percent between 2000-10. Concurrently, increasing workloads and concerns over HIV infection may prompt some health personnel to avoid assignments in areas worst affected by HIV/AIDS and provide additional incentive to emigration, thereby exacerbating brain drain.

Haacker has also examined the costs of HIV/AIDS-related health services in nine southern African countries. To provide a common indicator to compare data across countries, his analysis was based on the assumption that the coverage rate for palliative care and prevention of OIs is 30 percent, coverage rate for clinical treatment of OIs is 20 percent, and the coverage rate for HAART is 10 percent. In Malawi, he found that total HIV-related health services, assuming these rates of coverage, would account for 4.3 percent of GDP in 2000 and 6.5 percent of GDP in 2010. (The HIV/AIDS-related costs were broken down as follows: Costs for palliative care and prevention of OIs were estimated at 0.4 percent of GDP for 2000 and 0.5 percent for 2010; for clinical treatment of OIs: 1.5 and 2.0 percent of GDP, respectively; and for HAART: 2.4 and 4.0 percent of GDP, respectively. NB: These estimates were published in February 2002.)
Compare the costs associated with these (low) coverage rates to total public spending on health in Malawi: 2.8 percent of GDP in 1998.\textsuperscript{322}

**TB**

Malawi's National TB Control Program (NTP) is internationally recognized for its success in treating TB.\textsuperscript{323} Since 1984, NTP has used the Directly Observed Short-Course Treatment Strategy (DOTS) for TB control. The accompanying indicator table demonstrates that Malawi's TB treatment success rate of 71 percent is higher than the rate for the Africa region (69.6 percent) and close to the global rate of 80.8 percent (data are for 1999 and represent percent of new smear-positive cases cured).\textsuperscript{324} Since the early 1990s, however, the NTP has been struggling to cope with increasing numbers of HIV-infected TB patients and worsening economic conditions.\textsuperscript{325}

According to WHO, TB notification rates (all cases) increased from 77 per 100,000 population in 1980 to 131 in 1990, 191 in 1995, and 209 in 2000. (In 2000, with the Africa region, only Botswana, Congo, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe had higher TB case notification rates.)\textsuperscript{326} A national survey conducted in 1999 indicated HIV seroprevalence of 77 percent among TB patients. A 2000 national survey found that over 60 percent of hospitalized TB patients had one or more other OIs.\textsuperscript{327}

Given that the NTP played a crucial role in developing the national HAART program and that NTP's success with DOTS may be a model for community-based provision of HAART,\textsuperscript{328} results from studies of TB in Malawi also have import for HIV/AIDS programs. In mid-1998, NTP produced guidelines for hospitals on TB control. A 1999 assessment of the impact of the guidelines found that introduction of the guidelines had not reduced the interval between admission and TB diagnosis, usually around four days, with treatment starting a day later. In over 90 percent of hospitals, ward staff reported that they had introduced a system of rapid sample collections; laboratory workers reported prompt processing of these samples. However, limited laboratory staff and facilities meant that only 35 percent of laboratories were testing samples on any day of the week.\textsuperscript{329}

The TB Equity Project (developed by Malawi's NTP and the Liverpool School of Tropical Medicine) assessed the capacity of the 43 hospitals that register and treat TB patients in Malawi. This assessment of three central, 22 district and 18 mission hospitals found that there is a shortage of facilities for managing TB and other HIV-related diseases, with central hospitals particularly underresourced. Among the findings:

- There are 86 trained laboratory personnel, 44 radiographers, and 83 program staff working on TB control. Of these, about 40 percent had periods of illness during 1998.
- Approximately one in five microscopes and x-ray machines are broken.
- Eighty-six percent of hospitals have designated TB wards. Occupancy of beds in TB wards exceeds 100 percent. In central hospitals, this figures is 164 percent, despite decentralization efforts.
- Although stocks of anti-TB drugs are good, half of district hospitals conduct no TB ward rounds, and only 50 percent of TB wards in district and mission hospitals have full-time nursing staff.
- There is a general absence of HIV counseling and testing services on TB wards as well as poor links with community groups that could provide care for TB patients after discharge.\textsuperscript{330}
The TB Equity Project has also found that:

- The poor have the highest burden of illness and the least access to TB services.
- People with TB seek care from various sources, including shops and private and traditional practitioners.
- Diagnostic procedures have developed around specific tests for infectious cases rather than patients' needs. Patients must visit the hospital numerous times for diagnosis (consultation, laboratory tests, X-rays) and supervision of treatment.  

The project recommended that TB control projects:

- ensure that sufficient numbers of staff are trained annually and that replacements are guaranteed before qualified staff leave the workplace to undertake further training
- cross-train hospital staff for tasks outside their work designation
- establish systems to ensure that all hospitals have functioning equipment and supplies to operate laboratory and x-ray services
- recognize the role of the TB program in the care of HIV/AIDS patients and foster stronger links with the National AIDS Control Program (now NAC)
- ensure that HIV counseling services are in place and that ward rounds are carried out
- continue decentralization of TB services to the community, using peripheral centers for ambulatory patients to relieve the demand on central TB bed capacity
- use community structures and home-based care to improve the general medical care of patients
- concentrate resources where the burden of TB is greatest and address the relative shortage of personnel, diagnostic facilities, and TB beds at central hospitals. 

(See also the previous Health section with regard to staffing, resource, and other constraints.)

Malaria

See also box 3. Researchers from the universities of Malawi, Maryland, North Carolina, Michigan State, and Liverpool assessed the impact of malaria on HIV infection, using a prospective cohort study in rural Malawi involving 362 HIV-positive adults. They found that HIV viral loads increased significantly over baseline among participants with malaria. A malaria-associated increase in viral load, especially if sustained, could lead to increased infectiousness and thus greater probability of transmission of HIV as well as to more rapid disease progression.

Anemia

Researchers from the University of Malawi examined the relationship between asymptomatic HIV infection and anemia among pregnant women (n=155) with high prevalence of both anemia (60 percent) and HIV seropositivity (30.1 percent). They found that HIV prevalence among women with anemia was 47.1 percent (95 percent CI: 39.2-55.0 percent), significantly higher than HIV prevalence within the entire sample (30.1 percent; p< 0.001), indicating that asymptomatic HIV infection was associated with increased prevalence and severity of anemia in pregnancy.
Households

See also the Poverty and Food Crisis sections.

Malawi's poor have traditionally relied on informal safety nets, such as the extended family. However, HIV/AIDS, poverty, macroeconomic policies, and food shortages have rendered traditional coping mechanisms largely irrelevant. With an increasing number of dependents, household food stores are now drastically inadequate. Household assets are being sold as families try to buy commercially available foods, which have escalated in price. To survive, some engage in activities such as sex work or border trading, increasing their risk of exposure to HIV. Erosion of these economic safety nets is limiting the extended family's ability to absorb the demands being placed on it.

AIDS morbidity and mortality are reducing the time that adults can spend on income-generating activities, with the burden of care is largely borne by women and girls. Medicines, treatment, and other care often consume a large share of family income. As families experience economic pressure to generate cash, they often sell assets; by the time death occurs, the family may be reduced to poverty.

One effect of poverty is that people are acutely vulnerable to physical or economic events that would have far less impact on better-off populations. Data on household expenditures for HIV/AIDS are not available; however, expenditures for malaria prevention and treatment are estimated at about four times greater a share of total expenditures for the poorest Malawian households than for those with average income.

In comparison with urban residents, those in rural areas have fewer income-generating opportunities. Researchers for the University of Sussex have found that informal transfers, either between rich and poor or among the poor themselves, appear to be declining over time, partly as a general consequence of commercialization and partly because deepening poverty means that the economic basis for redistribution is contracting.

Women head 25 percent of Malawi's households, and these households have always been disproportionately poor, especially in rural areas. The U.N. reports that the number of child-headed households is rising. Orphans fall to the care of grandparents or other relatives who are themselves facing economic hardship. In Malawi, it is common for grandparents to be caring for ten or more children, due to AIDS-related deaths.

Malawi's 1998 census found that 3.6 percent of households were headed by women over 65, while 0.6 percent of households were headed by individuals under age 20, a reflection of the emergence of child-headed households. As well as a significant loss of labor power, the loss of parents means that agricultural skills are often not passed down from one generation to the next; orphan-headed households try to farm with inadequate knowledge of agriculture.
Orphans and Other Vulnerable Children

See also the Population Mobility and Food Crisis sections above.

At the end of 2001, UNAIDS estimated that 470,000 AIDS orphans (ages 0 to 14) were living in Malawi. Children on the Brink 2002, a report on AIDS orphans commissioned by USAID and conducted with UNAIDS and UNICEF, estimated that the percent of Malawi's orphans due to AIDS rose from 5.7 percent in 1990 to 49.9 percent in 2001; it projected that this percentage would rise to 59.5 percent in 2005 and 64.4 percent in 2010.

According to Malawi's 1998 census, 1.5 percent of those ages 20 years or younger had lost both their parents. Orphans are one of the groups most affected by poverty. Children who lose a parent suffer great disadvantage, whether in terms of loss of a breadwinner or of parental care. A study undertaken in the Karonga District sought to determine the impact of HIV and orphanhood on child mortality. It found that, after adjusting for sociodemographic factors, the hazard ratio for death associated with having an HIV-positive mother was 3.0 (1.7-5.1) for infants and 5.5 (2.6-11.6) between 1 and 5 years. Death of HIV-positive mothers — but not of HIV-negative mothers or of fathers — was associated with increased child mortality.

Most orphans live with a grandparent, who are usually single and themselves resource-constrained. Famine has raised the opportunity cost of sending children to school and, according to Malawi's Ministry of Labor, has exposed children to harmful and exploitative forms of labor. Lack of food coupled with the breakdown of family structures have placed more children on the streets where they find themselves at risk of mistreatment, sexual exploitation, and physical and emotional abuse. Households and communities that have been caring for increasing numbers of orphans resulting from the HIV/AIDS epidemic are facing additional economic pressure under the famine; this scenario increases the vulnerability of orphans, particularly girls.

Research undertaken by Brunel University has found that:

- Malawian orphans are rarely asked about their preferences with regard to their care and residence. For many children, the only way out of a difficult household situation is to move onto the streets. (Malawi's Ministry of Gender, Youth and Community Services estimates that there are 22,000 children living on the streets of Malawi.)
- Children’s difficulties in fitting into new homes are exacerbated by poverty. If the costs of caring for children, particularly school-related costs, were reduced, children would be more readily accepted into households. This would enable them to stay with those relatives (often grandparents) best able to meet their nonmaterial needs. Furthermore, as most migrations are triggered by economic factors, reduced costs would diminish the need for multiple migrations.

Research undertaken by the University of Sussex found that:

- The poverty and exclusion associated with Malawian orphans is particularly acute with regard to girls.
- Orphans have little food, few clothes, no bedding, and no soap. The resulting hunger and social exclusion undermine school attendance and lead to further social exclusion.
- Community care of orphans is overwhelmed and disintegrating.
Military

Official figures on HIV prevalence in the Malawian armed forces are not available. In November 2002, the Malawi Defense Force reported during a workshop that between January and April 2002, the force lost 48 members, with majority of deaths due to AIDS. It also reported that these 48 AIDS deaths created 169 orphans.\(^{354}\)

Prisons

Between independence in 1964 and 1994, the government exercised power arbitrarily, imprisoning opponents and providing those accused of crimes little or no recourse to the justice system. Prisons were overcrowded and inhumane. Since 1994, extensive efforts have been made to reverse this situation through police reform, the closure of the most notorious prisons, and the creation of human rights bodies. However, there is a rising trend in crime (which may be related to food shortages, poverty, and HIV/AIDS-related destitution), a continuation of political violence, and a general decline in security.\(^{355}\)

The prison population has risen from 4,000 in 1995 to 8,000 in 2001, whereas the warder-prisoner ratio has fallen to 1:14, against an international standard of 1:5. This situation is partly a result of inadequate financial and human resources. There is inadequate police presence, especially in rural areas, and the justice system does not have sufficient lawyers, judges, or courts to process cases effectively and in a timely manner. (Among other factors, AIDS mortality has reduced the number of police officers and lawyers.) As a result, the number of prisoners has expanded, with many individuals on remand. Little additional prison infrastructure has been built, and prisons remain severely overcrowded.\(^{356}\)

Malawi's Health in Prisons (HIP) Project is implemented by the NGO Banja La Mtsogolo (BLM). BLM disseminates HIV/AIDS and family planning educational materials and encourages inmates to access family planning services when out of prison. BLM also provides free treatment for STIs, malaria, and scabies. The project — the only one of its kind in Malawi — is being implemented in 21 prisons across the country and has so far reached over 5,000 prisoners.

BLM has been advocating for condom distribution in prisons, but to no avail. Homosexuality is illegal in Malawi, and prison authorities do not accept that unsafe sexual activities occur.\(^{357}\)
Response

At a Glance

Government

Initial Response

- The first AIDS case in Malawi was diagnosed in 1985. Shortly thereafter, the Malawian government adopted a blood screening policy. Subsequently, a public education strategy on HIV/AIDS was developed.
- In 1989, the government established the National AIDS Control Program (NACP) within the Ministry of Health and Population. The Cabinet Committee on HIV/AIDS Prevention and Care was formed to provide policy and political direction to NACP.
- During the 1990s, Malawi developed medium-term plans for HIV/AIDS and, as part of the country's larger decentralization process, district AIDS coordinators and district AIDS coordination committees were formed.
- In 1996, the government and its partners evaluated the response to date. They found that despite high awareness of HIV/AIDS, behavior change had been limited and HIV incidence continued to increase. They also cited weaknesses of NACP at central level and its inadequate representation at district and local levels as reasons for its inability to provide the required technical leadership in a deteriorating HIV/AIDS situation. Other findings included:
  - insufficient coordination of planning, implementation, and monitoring & evaluation of activities of all implementing agencies, including donors
  - persistent stigmatization and isolation of PWHA
  - insufficient institutional support to NACP regarding transport, supply of drugs and other supplies, as well as laboratory backup for effective implementation of the adopted STI syndromic management approach
  - overreliance on the health sector for the national response, such that focal points appointed in various other ministries were ineffective or completely inactive
- The major recommendation was that Malawi develop a comprehensive five-year plan to guide HIV/AIDS prevention and mitigation.


- The national strategic framework was developed through a highly participatory, detailed process. It was launched by the president in October 1999, at which time he also declared HIV/AIDS a national emergency.
- NACP was given responsibility for implementing the framework, which emphasizes building on strengths and, where possible, using existing infrastructure to address HIV/AIDS.
- The framework was heavily focused on a biomedical approach. Where it sought to include other sectors, there was little indication of how the government would work with them nor ensure that they implemented HIV/AIDS-related interventions.
There was also heavy emphasis on NGOs and CBOs as the core implementing agencies. In giving implementing responsibly to civil society, government recognized the enormous and critical role it has played in HIV/AIDS prevention, care, and support. However, whether already burdened communities can take on increased HIV/AIDS responsibilities, which also exact a huge psychosocial toll, is unclear, especially against the backdrop of persistent poverty and famine.

Apart from PMTCT, HIV/AIDS treatment (including HAART and treatment of OIs) is not mentioned in the strategic framework (which was drafted in the late 1990s). (However, these issues are prominent in Malawi’s proposal to the GFATM — or "national response" — which was written in early 2002.)

As of the end of 2000, the government’s efforts to grant NACP the autonomy to implement the strategic framework were proceeding slowly. Additionally, NACP remained understaffed, thereby impeding its ability to function.

**National AIDS Commission**

- Given the limitations of NACP, the National AIDS Commission (NAC) was established in July 2001 to coordinate multisectoral implementation of the strategic framework.
- NAC reports to the president, through the minister for Presidential Affairs, and to the Cabinet Committee on HIV/AIDS.

**National HIV/AIDS Policy**

- In May 2000, Malawi began the process of developing a national HIV/AIDS policy. As of January 2003, it still did not have such a policy, though it had aimed to have one completed by the end of 2002.
- Malawi also does not have formal policies on HIV/AIDS and travel, prisons, confidentiality, breastfeeding, caregivers, research & surveillance, and migrants. Nor does it have policies or procedures for safe medical waste disposal.
- Intervention-specific policies and guidelines are at different stages of preparation. All these gaps in the strategic framework policy framework have limited the ability of some NGO and donor partners to finance or carry out certain activities, pending clarification of government policy.
- However, some major steps have been taken. For example:
  - As early as 1991, the Malawian government established the National Orphan Care Task Force to plan, monitor, and revise orphan care programs. (Malawi was the first country in the region to create such a task force.) In 1992, Malawi developed the National Orphan Care Guidelines.
  - An integrated behavior change intervention strategy was finalized in early 2002.
  - A high-level Government and Faith Communities Task Force held its inaugural meeting in early October 2001.
  - The first National HIV/AIDS Best Practices Conference was held in April 2002 to promote sharing of information and establishment of networks among national, district, and village level practitioners.
Ministries outside Health

- The Ministry of Agriculture has sought to mainstream HIV/AIDS prevention and mitigation. The ministries of Information; Sports and Culture; and Tourism, National Parks, and Wildlife are developing HIV/AIDS programs. The Ministry of Trade and Industry has a workplace-specific HIV/AIDS program.
- The Ministry of Education has faced constraints in implementing HIV/AIDS-related curricula. Discomfort discussing sex with young people and the stigma associated with HIV/AIDS are major barriers. In addition, there is a lack of training and materials in rural areas; perceived constraints on explicit education such as condom demonstration; uncertainty about community, parental, and church support; and lack of emphasis on HIV/AIDS in the tested curriculum.

Budgets

- The Government of Malawi projects that it will contribute US$14.8 million over the next five years to HIV/AIDS. It anticipates that donors will provide about US$77.2 million to HIV/AIDS prevention activities over the next five years. To fund (primarily) treatment, care, and support activities, Malawi applied to the Global Fund to Fight AIDS, Tuberculosis & Malaria.

Global Fund to Fight AIDS, Tuberculosis & Malaria (GFATM)

- Malawi’s proposal to the GFATM ("national response") was developed over one year and included extensive consultations. It is based on the country's larger decentralization process and promotes care, support, and treatment at the district and community levels. In emphasizing treatment, care, and support, the national response seeks to complement the prevention strategies outlined in the 2000-04 strategic framework.
- In April 2002, the GFATM recommended that the Malawi's US$284 million HIV/AIDS proposal be "fast-tracked," i.e., it was approved for deferred funded pending further adjustments and clarifications. In August 2002, NAC received final approval from the GFATM for US$196 million over five years. As of January 2003, no GFATM funds had yet been disbursed.
- The national response emphasizes the need to develop an effective health care system to support HIV/AIDS activities. The national response seeks to draw on Malawi's success with DOTS to apply a similar monitoring system to HAART.
- The national response envisions a six-month preparatory phase to develop necessary infrastructure for HAART delivery. Whether this timeframe is adequate is questionable, especially given the entrenched weaknesses of the current health care delivery system.
- Malawi's response to HIV/AIDS is premised on strong capacity at local level, within the context of the government's decentralized process. District authorities will have direct responsibility for prevention and treatment of HIV/AIDS. However, district AIDS coordination committees and district assemblies have not yet determined a formal mechanism for coordination; moreover, both lack trained staff and sufficient equipment, operating funds, and monitoring and financial management systems. The stretched economic resources available at the community level also play a role in constraining the local response.
The national response is also highly dependent on Malawi's creating an effective health information system and reforming its drug procurement and management agency, the Central Medical Stores.

**Current Constraints to the National Response**

- Strong social stigma persists.
- Although awareness of HIV/AIDS is nearly universal, open discussion of it and of sex and sexuality remains discomfiting for many.
- Use of schools and the media as HIV/AIDS communication vehicles has been limited.
- Development of culturally appropriate messages targeted to key social groups in their local language is just beginning.
- Capacity to carry out AIDS-related programs and to expand services — at local, district, and national level — is constrained by limited numbers of trained staff and volunteers, weak financial and management skills, and poor access to information about best practices.
- NAC is a new institution and still in the process of determining its role. In the interim, its management systems remain weak or undeveloped, including M&E.
- Mainstreaming of HIV/AIDS in the public sector has been uneven. There are few workplace awareness programs for staff and their dependents, and there have been few attempts to integrate HIV/AIDS issues into the design, delivery, or message of nonhealth public sector programs.

**Human Rights**

- Knowledge of human rights is low, particularly the role of law in HIV/AIDS.
- Guiding principles 4 and 5 of the National Strategic Framework for HIV/AIDS 2000-2004 state that "People living with HIV/AIDS have the right to protection against discrimination and stigmatization and should have equal access to education, health, employment and other services while at the same time playing their rightful role in HIV/AIDS prevention and care work" and "Laws should protect PLWAs and mitigate the suffering and economic deprivation of PLWAs, widows, widowers and orphans." However, attempts to modify laws to provide sufficient protection to, for example, orphans, have stalled. Policies that explicitly integrate a human rights-based approach to HIV/AIDS are in development.

**NGOs and CBOs**

- Among the major NGOs and CBOs addressing HIV/AIDS:
  - **The Lighthouse**: Based at Lilongwe Central Hospital, provides home-based care and VCT. It is also providing HAART to about 400 patients. Will play a major role in the national response to HIV/AIDS, with particular focus on the strategy of monitoring HAART using the DOTS model.
  - **Malawi Network of People Living with HIV/AIDS (MANET+)**
  - **Malawi Network of AIDS Service Organizations (MANASO)**
  - **National Association of People with HIV/AIDS in Malawi (NAPHAM)**
  - **Salima AIDS Support Organization (SASO)**
  - **Umoyo Network**: Builds the capacity of Malawian NGOs to respond to HIV/AIDS through training and information dissemination. Partners include NGO Networks for
Health, Save the Children, PATH, CARE, Plan International, and Adventist Development and Relief Agency.

Government and UNICEF have worked with local NGOs to establish about 3,200 anti-AIDS clubs among in- and out-of-school youth.

Orphans and Other Vulnerable Children

- Malawi's National Orphan Care Guidelines state that the preferred approach in orphan care is community-based programs, followed by formal foster care, with institutional care as the last resort.
- However, although the government has long recognized that increasing numbers of children are being affected by HIV/AIDS, it has no means of identifying these children and no adequate safety net to protect them. Lack of consensus on definitions and estimates of orphans and OVC impedes the ability of government, donors, NGOs, and CBOs to plan and implement needed actions.
- Extended families, as well as numerous NGOs and CBOs (including faith-based organizations), are providing the majority of care for orphans and OVC, providing material and psychosocial support.
- The National Orphan Care Task Force has submitted recommendations for modifying laws to protect orphans to the Ministry of Justice; however, a shortage of lawyers in the ministry has seriously delayed the modification process.

Care and Support

- Because public tertiary health facilities are overburdened and the care they provide is costly, the majority of PWHA receive care at home. Numerous NGOs, CBOs, faith-based groups, associations of PWHA, and household members have shouldered most of this responsibility, with little government assistance.
- Nevertheless, home-based care skills, capacity, and financing are extremely inadequate to meet the increasing need. About 10 percent of AIDS patients receive HBC services, with great variance among districts (and better access in urban areas).
- Several surveys on care of PWHA in Malawi have identified food as the number-one unmet need of PHWA, a situation that is being exacerbated by the current famine. Household need for financial assistance is also cited by patients and HBC providers.

Traditional Healers

- Many Malawians visit traditional healers. Given the deteriorating health care system, visits to traditional healers may be increasing.
- Despite claims by some members, the official stance of Malawi's National Association of Traditional Healers is that it has no cure for AIDS. The association's members do offer herbal treatments to mitigate the effects of OIs.
- Although the government recognizes traditional healers as stakeholders in the national response to HIV/AIDS, there has been a lack of coordination between herbalists and health officials.
**VCT**

- According to WHO, during 2001, 40,806 clients were seen at Malawi's 14 publicly funded/NGO VCT centers. (There were no VCT services offered in the commercial sector.) WHO estimates that 21 percent of the population in need of VCT services in Malawi was receiving them.
- Malawi's strategic framework for HIV/AIDS is premised on informed consent and confidentiality. Malawi has developed draft VCT guidelines and is working with CDC on development of curriculum and other training materials. Under the GFATM proposal, the Christian Health Association of Malawi will be a major partner in scaling up VCT. Currently, the majority of VCT facilities are in urban areas.

**PMTCT**

- Currently, PMTCT services are offered on a pilot basis by NGOs and within research projects in medical institutions in eight districts. According to WHO, only 3 percent of the population estimated to need PMTCT services (i.e., basic counseling, testing, and AZT or NVP treatment) received them during 2001. There were eight public/NGO sites providing basic PMTCT services in 2001; no such services were provided by the commercial sector.
- Malawi has a PMTCT Task Force but no national PMTCT program. With funding from GFATM, Malawi plans to establish a PMTCT working group to finalize and disseminate policy guidelines.

**Treatment of Opportunistic Infections and Provision of HAART**

- Treatment of OIs has been limited by lack of HIV/AIDS diagnostic facilities, unclear treatment guidelines, frequent drug stock-outs, inadequate training of health care personnel, and poor referral processes.
- In January 2000, Malawi launched a pilot HAART program in Lilongwe and Blantyre. Several universities and NGOs are also conducting pilot HAART projects.
- During 2001, WHO estimates that there were three public/NGO sites in Malawi providing HAART. These three clinics were serving 1,000 clients — 0.18 percent of Malawians living with HIV/AIDS.
- Currently, Malawi has no national policy or guidance on HAART, though these will be developed as part of the national response.

**Female-controlled Prevention Technologies**

- A phase II/III clinical trial of two microbicide candidates, BufferGel and PRO 2000/5 Gel, is planned in Blantyre and Lilongwe.
Workplace

- Several Malawian companies have or are developing HIV/AIDS programs and policies.
- Malawi developed its "Industrial Relations Code of Practice on HIV/AIDS" in 1996. In 2001, it issued a comprehensive policy on HIV/AIDS in the workplace. To what degree these instruments are being implemented, however, is unknown.

Government

Initial Response

The first AIDS case in Malawi was diagnosed in 1985. Shortly thereafter, the Malawian government adopted a blood screening policy, initially implemented in the two major referral hospitals in Lilongwe and Blantyre. Subsequently, a public education strategy on HIV/AIDS was developed. In 1989, the government established the National AIDS Control Program (NACP) and the National AIDS Secretariat (NAS) within the Ministry of Health and Population to provide technical leadership. A National AIDS Committee was established to provide NACP with policy guidance and technical support. Later, the Cabinet Committee on HIV/AIDS Prevention and Care was formed to provide policy and political direction to NACP. The cabinet committee is chaired by the vice president, with the minister of Health and Population as vice chair. Members include ministers of Information, Education, and Community Services, as well as the director of the National Economic Council.

During the 1990s, Malawi developed two medium-term plans for HIV/AIDS (1989-93 and 1993-98). The second plan stressed multisectoral approaches to dealing with the epidemic. During this period, NACP developed structures at central, regional, and district levels, including district AIDS coordinators and district AIDS coordination committees. These committees are part of a larger decentralization process that Malawi has been undertaking. They comprise government staff and community and NGO representatives and are tasked with developing district HIV/AIDS plans for implementation by CBOs and "public-private partnerships."

As the institutional framework for HIV/AIDS prevention became more complex — with the public and private sectors, NGOs, CBOs, PWHA, donors, and faith-based organizations becoming increasingly involved in HIV/AIDS prevention, support, and care — NACP became more diverse to include services in surveillance; counseling; home-based care; information, education, and communication; STI treatment and prevention; and research.

In 1996, the government and its partners (including the World Bank and UNDP) evaluated the response to date. They found that despite high awareness of HIV/AIDS, behavior change had been limited and HIV incidence continued to increase. They also cited weaknesses of NACP at central level and its inadequate representation at district and local levels as reasons for its inability to provide the required technical leadership in a deteriorating HIV/AIDS situation. Other findings included:

- insufficient coordination of planning, implementation, and monitoring & evaluation of activities of all implementing agencies, including donors
- persistent stigmatization and isolation of PWHA
- "pervasive culture of silence and persistent denial" around HIV/AIDS
insufficient institutional support to NACP regarding transport, supply of drugs and other supplies, as well as laboratory backup for effective implementation of the adopted STI syndromic management approach

overreliance on the health sector for the national response, such that focal points appointed in various other ministries were ineffective or completely inactive

The major recommendation was that Malawi develop a comprehensive national five-year strategic plan to guide HIV/AIDS prevention and mitigation. In February 1998, the government established a Strategy Planning Unit within NACP to manage the process.


The strategic framework was developed through a highly participatory, detailed process, involving 60 communities and covering 20 districts. In addition, 57 public, private, nongovernmental, community, and religious institutions participated in focus group discussions. (More detail on the process may be found in section 1.4 of the framework.)

In seeking to serve as the basis for the formulation of HIV/AIDS prevention and care activities during the planned period, the framework defines guiding principles, goals, objectives, and strategies for improved planning, management, and evaluation of interventions addressing the HIV/AIDS epidemic. Its overarching goal is to "reduce incidence of HIV and other sexually transmitted infections and improve the quality of life of those infected and affected by HIV/AIDS." In the M&E section, it states that "the overall target for the national response is to reduce the incidence of HIV in the age group 15-49 by about 50%. The annual incidence in this age group is currently estimated at 1.96% for 1999, and would be reduced to about 1.86% in the year 2004 even without any interventions. The national response as expounded in this Strategic Framework will aim to reduce this annual incidence to about 1.0% by the year 2004."

Additionally, the framework supports the overall policy goal of the health sector:

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

Although the framework repeatedly states that is highly multisectoral, it also underscores that the policy and strategy for national health will continue to provide the general operational framework for issues surrounding the HIV/AIDS epidemic. That the response to HIV/AIDS be situated within the health sector is common worldwide; however, this was an impediment, given the already overburdened health sector (as previously discussed) as well as reluctance of the nonhealth sectors to become involved. (Malawi has sought to address these issues through creation of the National AIDS Commission, discussed below.)

Nevertheless, Malawi has made a strong case for using HIV/AIDS to highlight the weaknesses of the health sector and for positioning its national HIV/AIDS response as a crucial component to strengthen the health care delivery system. (See GFATM section below.)
The HIV/AIDS strategic framework is guided by 10 principles:

1. "Government should support the creation of a conducive environment for effective mobilization and utilization of resources, for partnerships to form and for change to occur in those behaviors, values, beliefs and norms which put Malawians at risk of HIV infection.

2. All Malawians, women and men, girls and boys, have an obligation to prevent the continued spread of HIV through self protection, protecting others, and cultivating a culture of acceptance of PLWAs and affected families.

3. People living with HIV/AIDS have the right to protection against discrimination and stigmatization and should have equal access to education, health, employment and other services while at the same time playing their rightful role in HIV/AIDS prevention and care work.

4. Laws should protect PLWAs and mitigate the suffering and economic deprivation of PLWAs, widows, widowers and orphans.

5. Statutes protecting children and the youth should be enforced at all levels of society as a basis for creating a healthy, educated and responsible generation.

6. Appropriate child-rearing practices, counseling services and civic education should be provided to the youth to develop positive values, attitudes and norms, so that they grow into healthy and responsible citizens.

7. Informed consent should be obtained before any test is performed to diagnose a person's HIV infection status; the result should remain confidential and appropriate pre- and post-test counseling should be provided; disclosure should only come with the full consent of the individual concerned on need-to-know basis.

8. Stakeholders, including government, NGOs, religious organizations, private institutions, traditional institutions and communities should collaborate in the design, implementation and monitoring of multisectoral and multi-disciplinary programs.

9. All institutions, in particular the private and public sectors, will as a matter of urgency and practice mainstream HIV/AIDS control and management activities as a component part in the planning and management of human resources.

10. HIV prevention and HIV/AIDS management should pay attention to issues of gender, human rights, laws and socio-economic variations among communities which pose unique and ever-changing challenges to programs and exacerbate the course and impact of the epidemic."

Based on these principles, nine areas with related goals and strategies were also elaborated. Throughout, the emphasis is — laudably — on building on strengths and, where possible, using existing infrastructure to address HIV/AIDS. Gender also figures throughout, including mention of women's inadequate access to loans and other economic resources.
The first area addressed is "Culture," with NACP noting that:

Malawian culture is itself rich in norms, values, beliefs and practices which promote ideals of fidelity, mutual faithfulness and communal obligations to each other which should form the basis for planning interventions.  

The next section, Social Change, Youth and HIV/AIDS, begins with:

From the mid 1990s Malawi has witnessed a marked decline in discipline and moral responsibility among the youth attributed to a misinterpretation of democracy and a relaxation of censorship. The decline also owes to a weakening of the social control and guidance functions of the family, the school and religious institutions. In addition, youth do not seem to have appropriate role models to emulate. This situation calls for deliberate regulation, particularly as it influences behavior that predisposes many young people to HIV infection. The challenge, therefore, is to revive the authority of the family, school and religious institutions in the socialization and guidance of young people and to facilitate coordination in how these institutions should train young people.  

Many youth today misinterpret democracy. They view democracy, human rights and freedoms as doing as one pleases without regulation. The great increase in alcohol and drug abuse, indiscipline and casual sexual relationships can in part be attributed to this misunderstanding.  

These sections epitomize Malawi's struggles and frustration as it transitioned from authoritarian rule to multiparty democracy. The language used does not seem to reflect the views of youth, but rather of an older generation perplexed by change and/or nostalgic for a past (that perhaps never really existed as they would like to imagine). Of course, this language could easily be transposed to the U.S. or numerous other countries. One can, however, see the concern for young people behind the emphasis on behavior regulation and submission to authority. (Although there is a worrying tendency to lay blame at the feet of those whose behavior NACP deemed irresponsible, inappropriate, or dangerous; see below.)  

As the previous sections of this report have discussed, use of drugs is related, inter alia, to many young Malawians' belief (largely, correct) that they have few or no employment nor recreational opportunities. Moreover, pursuit of sexual relationships may provide a source of recreation, one in which having the "right" sexual partner confers status otherwise not attainable. The framework is generally lacking in analysis aimed at particular subpopulations.  

The framework does contain a subsequent section entitled "Despair and Hopelessness," which addresses reaction to HIV/AIDS, rather than how fatalism and hopelessness might be related to HIV acquisition. Regardless, this section is important as it positions the national response:

- to promote hope, faith, compassion and a spirit of acceptance of the reality of HIV/AIDS among Malawians
- to encourage and support religious institutions to present messages of hope, faith and compassion in the context of HIV/AIDS
- to strengthen the capacities of communities in the care and support of people living with HIV/AIDS and those affected
Chapter 10, "Prevention," states that:

HIV prevention strategies, however, have not addressed all issues equally given the diversity in HIV transmission modes. These include mothers-to-child transmission; infection through blood and blood products; homosexuality; use of unsterilized sharp, skin piercing instruments; and STIs which enhance HIV transmission. The challenge is therefore to promote safe sexual behavior and practices among individuals, families and communities and institutionalization of effective infection control procedures for hospital and home based care.  

Homosexuality, which is illegal in Malawi, is not mentioned anywhere else in the framework (nor in subsequent government documents).

Despite that its own evaluation found that HIV/AIDS focal points in line ministries were ineffective, the strategic framework spends several paragraphs stating that they will be established in all "line ministries, departments and parastatal organizations...at all levels and in all sections of the institutions." Their roles are better defined and they are now tasked with preparing HIV/AIDS plans of action and budget lines. However, it appears that this system remained dysfunctional and ineffective and did little to decrease fragmentation of the government's response. This is confirmed by the 2000-2004 Strategic Plan for the Agriculture Sector in Malawi, which identified "inadequate functional linkages laterally and vertically," "no clear budget lines and strategies," and "inadequate and unclear strategies for scaling up HIV/AIDS prevention and mitigation in rural communities."

Chapter 13 of the strategic framework lays out multiple tasks for the private sector, including:

- mainstream HIV/AIDS activities as a component of human resources development and management
- review and adopt policies and practices affecting personnel management (i.e., recruitment, training, workloads, medical cover, benefits) in line with legal and human rights tenets observed in Malawi
- conduct on-going HIV/AIDS impact assessment at all levels of establishment
- expand medical schemes and provide institutional medical services to their staff where capacity and infrastructure exist
- continue to make financial and other contributions to the national response through NACP or directly through implementing agencies requiring financial and other support

However, no indication was given of how the government would ensure that firms undertake these tasks, nor why the private sector would feel compelled to implement them.

Chapter 13 also appears to place a heavy burden on NGOs and CBOs, as they will form the "core of implementing agencies." In chapter 14, government's role is defined as "to provide overall leadership and direction to the national response. The government will implement a highly multi-sectoral approach which relies on the independent provision of a broad variety of interventions and service programs by many different actors. Government will be expected to:
"advocate for issues of HIV/AIDS and place HIV/AIDS on the national agenda as a critical emerging development issue.

- initiate and support processes that will lead to the strengthening of NACP and give it more independence to be able to effectively take up its role of coordinating and directing the national response.
- increase financial allocation to the national response and create direct disbursement mechanisms from Treasury to NACP.
- provide a supportive environment for multi-sectoral involvement of public sector institutions in HIV/AIDS, including creation of budget lines for HIV/AIDS related interventions.
- broaden the process of external resource mobilization, allocation and monitoring particularly in public sector responses.
- regularize policy/legal/ethical issues related to HIV/AIDS."

In giving implementing responsibly to civil society, government is recognizing the enormous and critical role it has played in HIV/AIDS prevention, care, and support. However, whether already burdened communities can take on increased HIV/AIDS support and care responsibilities, which also exact a huge psychosocial toll, is unclear, especially against the backdrop of persistent poverty and famine.

The framework includes an M&E section and suggests broad performance indicators. Specific targets for these indicators are to be developed by implementing agencies. Many actors are assigned M&E responsibilities: NACP Secretariat, MOHP, Cabinet Committee on HIV/AIDS, sectoral focal points, and implementing agencies. It is unclear who is in overall charge of M&E and who ensures the complex coordination outlined.

Apart from PMTCT, HIV/AIDS treatment (including HAART and treatment of OIs) is not mentioned in the strategic framework (which was drafted in the late 1990s). However, these issues are prominent in Malawi's proposal to the GFATM, which was written in early 2002. Moreover, they are part of the Essential Health Package.

The HIV/AIDS strategic framework was launched by the president in October 1999, at which time he also declared HIV/AIDS a national emergency. NACP was given responsibility for implementing the framework. As of the end of 2000, the government's efforts to grant NACP the autonomy to do so were proceeding slowly. Additionally, NACP remained understaffed, thereby impeding its ability to function.

**National AIDS Commission**

Given the limitations of NACP and its biomedical focus, the National AIDS Commission (NAC) was established in July 2001 to coordinate a multisectoral national response; provide technical and financial support to implementing agencies; mobilize resources to support the various initiatives under way against HIV/AIDS; and monitor and evaluate progress and impact of HIV/AIDS prevention, care, and impact mitigation. NAC provides leadership in strategic planning, policy guidance, epidemiological surveillance, research, and monitoring &
evaluation. NAC comprises a board of commissioners and secretariat. The board's 19 commissioners are drawn from the public and private sectors (including faith-based communities).

NAC reports to the president, through the minister for Presidential Affairs, and to the Cabinet Committee on HIV/AIDS, chaired by the vice president. The NAC Board of Commissioners has final approval authority for NAC Secretariat policies and procedures, the annual work program, hiring of secretariat executive staff, and clearance of major procurement packages.

**National HIV/AIDS Policy**

In May 2000, Malawi began the process of developing a national HIV/AIDS policy. As of January 2003, it still did not have such a policy, though it had aimed to have one completed by the end of 2002. Malawi also does not have formal policies on HIV/AIDS and travel, prisons, confidentiality, breastfeeding, caregivers, research & surveillance, and migrants. Nor does it have policies or procedures for safe medical waste disposal.

Intervention-specific policies and guidelines are at different stages of preparation, including manuals to facilitate training and dissemination of information at district and local levels. The gaps in the strategic framework policy framework have limited the ability of some NGO and donor partners to finance or carry out certain activities, pending clarification of government policy.

However, some major steps have been taken. For example:

- As early as 1991, the Malawian government established the National Orphan Care Task Force to plan, monitor, and revise orphan care programs. (Malawi was the first country in the region to create such a task force.) In 1992, Malawi developed the National Orphan Care Guidelines, which delineated the central role of the Ministry of Women and Children Affairs and regional and district social welfare systems in coordinating orphan program development, reinforcing this system, and building on the existing foster care (and extended family) systems in Malawi. (However, the government seems largely to have become overwhelmed by the orphan crisis and left NGOs and CBOs to address it; see below.)
- With technical guidance from Family Health International and funding from USAID, NAC's Behavior Change Intervention Unit worked with the MOHP's Reproductive Health Unit to develop a behavior change intervention strategy, which was finalized in early 2002.
- A high-level Government and Faith Communities Task Force held its inaugural meeting in early October 2001.
- The first National HIV/AIDS Best Practices Conference was held in April 2002 to promote sharing of information and establishment of networks among national, district, and village level practitioners. The conference, organized by NAC, identified attributes of successful HIV/AIDS programs, which have important policy implications; moreover, the conference underscores how some attitudes and approaches appear to have changed since the strategic framework was developed in the late 1990s. In particular, the strategic framework lacked careful analysis of subpopulations and thus its ability to respond to their needs is questionable, as is its ability to respond to HIV/AIDS against the backdrop of crises.
The April 2002 conference, in contrast, noted that programs will be more successful if they "build in the flexibility required to respond to the community's expressed needs and priorities...are based on formative research that identifies existing risk practices for each target group, as well as factors that influence behavior and potential opportunities for achieving positive behavior change...include participation by members of the program's target or beneficiary group in the planning and implementation of activities that address issues affecting them...[and] foster youth-friendly and male-friendly service delivery in health care facilities” 398

Other attributes of successful HIV/AIDS programs identified at the conference:
- recognize and meet the psychosocial needs, in addition to the biomedical and material needs, of orphans and vulnerable children
- consider gender issues (e.g., HBC volunteers tend to be predominantly female)
- promote the consumption (by PWHAs and other Malawians) of a diverse and balanced diet
- build on existing community structures and include traditional leaders and local opinionmakers in the design of programs399

*Macroeconomic Policy*

As mentioned in the Poverty section, HIV/AIDS is integrated into Malawi's poverty reduction strategy paper. As discussed, however, its integration as a "cross-cutting" issue appears to be part of a "one-size fits all" approach to PRSPs, with generally generic HIV/AIDS sections.

**Current Constraints to the National Response**

In addition to the issues mentioned above, the following constrain the national response:

- Strong social stigma persists.
- Although awareness of HIV/AIDS is nearly universal, open discussion of it and of sex and sexuality remains discomfiting for many.
- Use of schools and the media as HIV/AIDS communicate vehicles has been limited. (See box 5)
- There are six major language groups used in Malawi, and within each, there are culturally appropriate ways to communicate information about HIV/AIDS. Development of culturally appropriate messages targeted to key social groups in local languages is just beginning.
- Malawi's response to HIV/AIDS is premised on strong capacity at local level, within the context of the government's decentralized process. In 2001, district assemblies were established with the power to approve district plans and mobilize and allocate resources to district social service and development activities. Each district has a planning body, the district executive committee, with sector-specific subcommittees as deemed necessary by the district assembly. However, district AIDS coordination committees and district assemblies have not yet determined a formal mechanism for coordination; moreover, both lack trained
staff and sufficient equipment, operating funds, and monitoring and financial management systems.

- The stretched economic resources available at the community level also play a role in constraining the local level response.

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**Box 5. HIV/AIDS Education**

According to a University of Sussex study of the impact of HIV/AIDS on elementary and secondary education in Malawi (as well as Botswana and Uganda), there is little hard evidence to demonstrate that school-based HIV/AIDS education has had a major impact on sexual behavior. A lack of time, resources, and training mean that curriculum-based education as well as counseling and peer education are inadequate. Little training is provided for teachers, who lack the commitment to teach these topics in an already over-crowded and examination-driven curriculum.

The impact of the epidemic on pupils affected by HIV/AIDS was also assessed. Absenteeism in Malawi (and Uganda) was very high among all primary school children. This was mainly poverty-related. Schools offered little support for children affected by HIV/AIDS. There was insufficient guidance from education ministries and a lack of resources to carry out any support programs. The response of most education ministries in Africa has been limited, the study noted. Most ministries have appointed an official to act as the HIV/AIDS focal point; however, officials appointed to these posts have usually been relatively junior and have therefore lacked the power and authority to ensure that all departments and units properly mainstream HIV/AIDS.

The study recommends a number of measures to improve the level of school-based support, including the referral and monitoring of affected children; school feeding programs; care and counseling; financial assistance; and the involvement of guardians, caregivers, and children living with HIV/AIDS. Another recommendation involved hiring of full-time life skills teachers and regular time-tabled lessons for all children.


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- The myriad weaknesses of the health system (previously discussed) constrain ability to address HIV/AIDS. Drug availability for STIs/OIs is not continuously assured due to a weak procurement and management system for pharmaceuticals.
- Although the strong association between TB and AIDS is recognized, there are no program interventions in place (except at a pilot scale) to integrate prevention and care regimens.
- NAC is a new institution and is still determining its role. In the interim, its management systems remain weak or undeveloped, including M&E.
- NAC has not yet made the transition from a government department to a performance-based, autonomous entity; it is still perceived as an MOHP institution, rather than a national, cross-sectoral institution.
- Mainstreaming of HIV/AIDS in the public sector has been uneven. There are few workplace awareness programs for staff and their dependents, and there have been few attempts to integrate HIV/AIDS issues into the design, delivery, or messages of nonhealth public sector programs.
- Apart from a few ministries, the public sector — as an employer and as a provider of services — is not providing the required leadership.
- When NAC was created, the MOHP HIV/AIDS team was disbanded, leaving a leadership vacuum on biomedical aspects of HIV/AIDS.
**Budgets**

The strategic framework stated that the Ministry of Finance would allocate adequate funds to line ministries, departments, and parastatal organizations for HIV/AIDS control and management activities.\(^{401}\) To what degree this has occurred is unclear, although the example from the Ministry of Agriculture above indicates that this approach was not successful.

The government hosted a roundtable meeting in March 2000 to raise funds for implementation of the strategic framework.\(^{402}\) Approximately US$110 million was pledged by donors, leaving a funding gap of US$51 million.\(^{403}\) (NB: The pledged financial support for the strategic framework is largely for prevention activities. Care and treatment are now part of Malawi’s proposal to the GFATM, discussed below.)

In 2002, the Government of Malawi projected that it would contribute US$14.5 million over the next five years for HIV/AIDS activities. Funds released through HIPC are supposed to benefit HIV/AIDS (though see the previous Debt section for a discussion of constraints).

**Donors**

The World Bank, the European Union, and the United Nations are the major multilateral agencies active in Malawi. Britain, Canada, Germany, Japan, the Netherlands, and the United States are the major bilateral donors. Other important donors include Denmark, Iceland, Norway, Sweden, and Taiwan, the IMF, and the African Development Bank.

In 2002, Malawi projected that donors would provide about US$77.2 million to HIV/AIDS activities over the next five years. Key donors (and the assistance pledged) include:

- DFID: US$50 million for sexual & reproductive health
- USAID: US$22 million for community support
- EC: US$8 million for safe blood
- UN agencies: US$4.5 million
- CIDA: US$8.9 million for institutional and community support
- NORAD: US$800,000

Other donors have pledged less than US$1 million to HIV/AIDS activities.\(^{404}\) (The Links section includes more information on donors.) Malawi applied to the GFATM to address the gap between government and donor resources committed to implementing a new national HIV/AIDS plan.

**Global Fund to Fight AIDS, Tuberculosis & Malaria (GFATM)**

In October 2000, the vice president established the National Technical Working Group on HIV/AIDS. Among its subcommittees was one devoted to antiretroviral therapies. This subcommittee coordinated the development of Malawi’s GFATM proposal through an extensive process of national and international consultations. The subcommittee was formalized as the Malawi Global Fund Country Coordinating Committee (MGFCC) in February 2002. MGFCC comprises representation from the Office of the Vice President; ministries of Health and Population, Finance, and Agriculture; National AIDS Commission; National Tuberculosis Program; Agricultural Marketing and Development Corporation; State/Faith Taskforce; Christian
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Health Association of Malawi; College of Medicine, University of Malawi; MANET+ and MANASO, representing people living with HIV/AIDS; Salima AIDS Service Organization; the private sector; multilateral agencies; and other cooperating partners. It operates as an Advisory Committee to the National AIDS Commission. It is chaired by Dr. R.B. Pendame, Principal Secretary of the Ministry of Health and Population. NAC acts as its secretariat.405

In April 2002, the GFATM recommended that Malawi's US$284 million HIV/AIDS proposal be "fast-tracked," i.e., it was approved for deferred funded pending further adjustments and clarifications (discussed below). In August 2002, NAC received final approval from the GFATM for US$196 million over five years.406 As of January 2003, no GFATM funds had yet been disbursed.

Malawi's GFATM proposal may be found online at: http://www.cid.harvard.edu/gf/docs/10-3-2002.PDF. (Note that funding for malaria was not approved, as Malawi expects to receive US$24 million over the next five years through the Roll Back Malaria Initiative.) The proposal addresses TB as a component of OI treatment. As the TB program is fully funded over the next three years (by the government, DFID, and NORAD), the GFATM proposal did not seek incremental funding for TB.

Malawi’s proposal to the GFATM ("national response") is based on the country's decentralization process and promotes care, support, and treatment at the district and community levels. Within this framework, it states that HAART "can be effectively administered only through a well-developed community-based mechanism." To that end, it seeks to draw on Malawi's success with DOTS to apply a similar monitoring system to HAART. District authorities will have direct responsibility for prevention and treatment of HIV/AIDS (and malaria). In emphasizing care and support, the national response seeks to complement the prevention strategies outlined in the 2000-04 strategic framework.407

The national response envisions provision of HAART to at least 20 districts and 25,000 people over the course of five years. It plans a six-month preparatory phase to develop necessary infrastructure for HAART delivery. The preparatory phase will be followed by introduction of HAART in the context of operations research protocols in four hospitals in Lilongwe, Blantyre, Thyolo, and Mzuzu districts to determine safety, efficacy, and best practice delivery and monitoring systems. In the second year, HAART provision will continue in these four hospitals, but the program will expand to provide HAART in all the hospitals in one district using community HAART/DOTS. In the third year, HAART will expand to all hospitals in these four districts. In the fourth and fifth years, the HAART program will expand to a total of 20 districts that have the highest burdens of HIV and fewest resources, but still meet strict criteria with regard to OI management and other necessary operations. Guidelines on the use of HAART will be developed.408

Whether the six-month preparatory phase is adequate is questionable. Overall, the timeline for introduction of HAART seems rushed, especially given the entrenched weaknesses of the current health care delivery system. In addition, the food crisis (not factored into the GFATM proposal) will render meeting these timelines even more difficult. Indeed, the GFATM noted that although the proposal is "comprehensive and technically sound...the volume of resources being requested
appears to be very large and it is not clear whether appropriate absorptive capacity exists." The GFATM also highlighted that "a large proportion of the budget is devoted to human resource development and payment of salaries or salary supplementation" and requested more information on how these expenditures would improve outcomes. The fund also required that "amounts allocated for management, monitoring and evaluation must be significantly reduced."409

The national response also emphasizes the need to develop an effective health system to support HIV/AIDS (and other EHP) activities. Much stress is laid on health information systems and on reform of the Central Medical Stores (a condition of HIPC, as previously mentioned).410

The national response has the following objectives:

1. to establish effective delivery of HIV/AIDS prevention, care, and support services in every district
2. to increase access to VCT services to 50 percent (cumulative) of the adult population
3. to decrease mother-to-child HIV transmission by 25 percent by 2005 and by 50 percent by 2010
4. to ensure that a minimum of 50 percent of HIV infected individuals with OIs ill be treated according to standard guidelines
5. to provide long-term effective antiretroviral treatment to 25,000 eligible patients by 2005
6. to attain drug adherence rates of 95 percent for HIV-positive individuals receiving HAART
7. to increase the life span and quality of life for people with HIV so that 50 percent of people who start HAART are alive and ambulatory after three years
8. to ensure that 50 percent of HIV-positive patients on HAART are engaged in their previous employment or any other productive activity within six months of starting therapy
9. to reduce the number of new HIV-related orphans registered each year.417

Expected outcomes from implementation of the national response are:

- strengthened and expanded partnership among government, NGOs, and the private sector in responding to HIV/AIDS
- strengthened health delivery systems, including:
  - essential drugs, supplies, and equipment
  - human capacity development
  - management information systems
  - laboratory systems
  - referral systems
  - financing of services
- increased resource allocation for HIV/AIDS by government and international donors
- improved coordination with existing regional and international programs
- improved HIV/AIDS research capacity
- greater and expanded community awareness, involvement, and capacity to respond
- new public-private partnerships that will have an impact on the entire health sector
- improved capacity to assess, target, respond to, and meet needs
- improvements in child health, maternal health, primary health care, and chronic disease management
Ministries outside Health

□ Malawi’s Rural AIDS Initiative is a major effort to mainstream HIV/AIDS prevention and mitigation within rural communities and workplaces. It entails policy and field support, as well as field operations carried out by rural development management teams. Its aims are to:

→ reduce HIV infection rates among farmers, agricultural workers, and other rural development actors
→ reduce the adverse effects of HIV/AIDS on the agriculture sector
→ effectively integrate HIV/AIDS within poverty reduction and development strategies

□ The Ministry of Trade and Industry has a workplace-specific HIV/AIDS program. The ministries of Information; Sports and Culture; and Tourism, National Parks, and Wildlife are developing HIV/AIDS programs.

□ The Ministry of Labor and Vocational Training works with Project Hope on workplace HIV/AIDS education.

□ The Ministry of Education has faced constraints in implementing HIV/AIDS-related curricula. (See also box 5 above.) Despite that teachers have the potential to be important leaders in HIV prevention in schools and in their communities, implementation of HIV/AIDS education curricula in primary schools is highly constrained. Discomfort discussing sex with young people and the stigma associated with HIV/AIDS are major barriers. In addition, there is a lack of training and materials in rural areas, perceived constraints on explicit education such as condom demonstration, uncertainty about community, parental and church support, and lack of emphasis on HIV/AIDS in the tested curriculum.

Human Rights

Prior to 1994, human rights abuses in Malawi were common, as the government imprisoned opponents, who had almost no recourse to the justice system. Despite extensive improvements in human rights under President Muluzi, abuses remain. Moreover, the current political climate (discussed above) does little to foster respect for the rule of law.

Knowledge of human rights is low, particularly the role of law in HIV/AIDS. Chapter XI of Malawi's 1995 constitution created the Malawi Human Rights Commission. The commission is working on a national plan of action regarding civil, political, and economic rights.

Guiding principles 4 and 5 of the National Strategic Framework for HIV/AIDS 2000-2004 state that:

People living with HIV/AIDS have the right to protection against discrimination and stigmatization and should have equal access to education, health, employment and other services while at the same time playing their rightful role in HIV/AIDS prevention and care work.

Laws should protect PLWAs and mitigate the suffering and economic deprivation of PLWAs, widows, widowers and orphans.
However, attempts to modify laws to protect, for example, orphans have been delayed, as discussed below. Policies that explicitly integrate a human rights-based approach to HIV/AIDS are in development.\footnote{423}

**NGOs and CBOs**

The strategic framework recognizes that NGOs and CBOs (including associations of PWHA and faith-based organizations) have played and continue to play a major role in HIV/AIDS prevention, support, and care. Among the major NGOs are:

- The Lighthouse: Based at Lilongwe Central Hospital, provides home-based care and VCT. It is also providing HAART to about 400 patients.\footnote{424} Will play a major role in the national response to HIV/AIDS, with particular focus on the strategy of monitoring HAART using the DOTS model.
- Malawi Network of People Living with HIV/AIDS (MANET+) (see box 6)
- Malawi Network of AIDS Service Organizations (MANASO)
- National Association of People with HIV/AIDS in Malawi (NAPHAM)
- Salima AIDS Support Organization (SASO)
- Umoyo Network: Builds the capacity of Malawian NGOs to respond to HIV/AIDS through training and information dissemination. Partners include NGO Networks for Health, Save the Children, PATH, CARE, Plan International, and Adventist Development and Relief Agency.
- Government and UNICEF have worked with local NGOs to establish about 3,200 anti-AIDS clubs among in- and out-of-school youth.\footnote{425}

The Links section provides a continually updated list of NGOs and CBOs.\footnote{426}

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**Box 6. Catherine Phiri**

In October 2000, UNDP presented Ms. Catherine Phiri with the Race Against Poverty Award. Ms. Phiri was one of the first Malawians to go public about being HIV-positive after she learned of her diagnosis in 1990. In 1997, in partnership with others, she founded the Malawi Network of People Living with HIV/AIDS (MANET+). She later founded the Salima AIDS Service Organization, a major provider of care and support to PWHA in Malawi.


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**Orphans**

See also the discussion above within "National HIV/AIDS Policy." Malawi's approach to care of orphans and other vulnerable children (OVC). Malawi's National Orphan Care Guidelines state that the preferred approach in orphan care is community-based programs, followed by formal foster care, with institutional care as the last resort.\footnote{427}

In 1998, these guidelines were developed into a draft National Orphan Care Policy and Guidelines, which have been approved by the Cabinet Committee on Gender and Social Affairs.
The draft policy defines an orphan as a "child who has lost one or both parents because of death and is aged 18 years or below." A vulnerable child is defined as "one who has no parents or able guardian, is staying with elderly grandparents or in a sibling-headed household, lacks access to medical, material and psychological care, lacks access to education, and/or has no shelter." Family Health International reports that these definitions are being challenged; for example, some believe that orphans over 15 years should be excluded from the definition (as is the case with UNAIDS, UNICEF, USAID, and other orphan estimates). Lack of consensus on definitions and estimates of orphans and OVC impedes the ability to plan and implement needed actions. Indeed, Malawi's GFATM proposal notes that although the government has long recognized that increasing numbers of children are being affected by the HIV/AIDS epidemic, it has no means of identifying these children and no adequate safety net to protect them. A recent report from Britain's Overseas Development Group found little evidence "of support, provision or planning for the outcomes of HIV/AIDS or for the future of orphans."

The National Orphan Care Task Force has submitted recommendations for modifying laws to protect orphans to the Ministry of Justice; these laws include the Wills and Inheritance, Adoption, Child and Young Persons, and Foster Care acts. However, a shortage of lawyers in the Ministry of Justice has seriously delayed the modification process.

Extended families, as well as numerous NGOs and CBOs (including faith-based organizations) are caring for orphans and OVC, providing material and psychosocial support. Some villages, for example, have established orphan committees to monitor the local situation and assist vulnerable children and families.

The GFATM proposal includes components to improve and strengthen the mechanisms for identifying orphans and OVC and prioritizes provision of support (e.g., skills training, funding) to community groups that care for them.

**VCT**

As noted above, Malawi's strategic framework for HIV/AIDS is premised on informed consent and confidentiality. Malawi has developed draft VCT guidelines and is working with CDC on development of curriculum and other training materials. Under the GFATM proposal, the Christian Health Association of Malawi will be a major partner in scaling up VCT.

According to WHO, during 2001, 40,806 clients were seen at Malawi's 14 publicly funded/NGO VCT centers. (There were no VCT services offered in the commercial sector.) Of the African countries for which WHO provided data, the number of clients seen in Malawi was the third highest, following those seen in Zambia (213,000) and Zimbabwe (97,375). (See WHO June 2002 for discussion of methodology and limitations of cross-country comparisons.)

During 2001, WHO estimates that 21 percent of the population in need of VCT services in Malawi was receiving them. Of the African countries for which WHO provided data, only Mauritius (100 percent), Zambia (43 percent), and Senegal (37 percent) had higher percentages. To determine the demand for HIV testing, the 2000 MDHS added the percentage of women who had been tested for HIV (8.5) and those who wanted to be tested (72.6). Given a total demand of 81.1 percent, with 8.5 percent met, the 2000 MDHS posited that only 10.5
percent of demand for HIV testing was being satisfied. The demand among men was estimated at 87.4 percent; with 15.2 percent having been tested for HIV (and 72.2 wanting to be tested), 17.4 percent of demand was met. (NB: For those who had been tested, the services were not necessarily voluntary nor did they necessarily involve counseling.) Among those not tested (whether they did or did not want to be tested), 32.7 percent of women and 23.9 of men percent did not know a source for HIV testing. Knowledge of a testing site is lower among those with less formal education, who have not begun sexual activity, and living in rural areas. 438

( WHO notes that its quick and inexpensive method of utilizing service statistics and expert consensus opinions is less accurate than national surveys.)

Quality assurance for VCT services is in place, although it is not well defined. The majority of VCT facilities are in urban areas. Some NGOs have demonstrated efforts to initiate VCT service provision within their organizations, although inadequate resources have been a limitation. Another constraint is lack of coordination and networking in the provision of VCT services, resulting in duplication of effort. 439

ProTEST is a pilot project seeking to strengthen coordination of HIV/AIDS and TB treatment and referral by enhancing collaboration of service providers. The project promotes VCT as an HIV prevention strategy as well as an entry point to HIV/AIDS/TB interventions. Located in Lilongwe District, it includes training of HBC volunteers and traditional healers. 440

Malawi has recently piloted rapid HIV tests that provide same-day results. Use of rapid tests has yet to be approved by the government for use in the entire country. 441

**Female-controlled Prevention Technologies**

A multicountry phase I safety and acceptability trial of BufferGel, a vaginal microbicide candidate, was conducted between July 1998 and April 1999. A total of 288 women were screened and 98 women (30 sexually abstinent and 68 monogamous with a low-risk partner) enrolled, including participants from Queen Elizabeth Central Hospital in Blantyre as well as sites in India, Thailand, and Zimbabwe. The study concluded that BufferGel is safe and well tolerated, and effective in supporting vaginal acidity and reducing the prevalence of bacterial vaginosis. 442 A phase II/III clinical trial of BufferGel (as well as another microbicide candidate, PRO 2000/5 Gel) is planned in Blantyre and Lilongwe (as well as sites in South Africa, Tanzania, Zimbabwe, and the U.S.). 443

**PMTCT**

Currently, PMTCT services are offered on a pilot basis by NGOs and within research projects in medical institutions in eight districts. MSF (France and Luxembourg) is introducing PMTCT services in their impact areas in Malawi. UNICEF-supported sites are providing short-course NVP for PMTCT. The Elizabeth Glaser Pediatric AIDS Foundation and Project Hope are also planning pilot PMTCT projects. 444 Research institutions, such as Johns Hopkins and the
University of North Carolina, are offering short-course AZT or NVP for PMTCT under research settings. USAID-supported districts are promoting safer infant feeding options.\textsuperscript{445}

According to WHO, only 3 percent of the population estimated to need PMTCT services (i.e., basic counseling, testing, and AZT or NVP treatment) received them during 2001. There were eight public/NGO sites providing basic PMTCT services in 2001; no such services were provided by the commercial sector.\textsuperscript{446}

Malawi has a PMTCT Task Force but no national PMTCT program. With funding from GFATM, Malawi plans to establish a PMTCT working group to finalize and disseminate policy guidelines. Guidelines will include use of NVP, and the PMTCT program in Malawi will take advantage of a five-year free NVP offer by Boehringer Ingelheim. The GFATM proposal seeks to introduce a PMTCT program that builds on existing sites.\textsuperscript{447}

\textbf{Treatment of Opportunistic Infections and Provision of HAART}

As discussed above, Malawi’s response to HIV/AIDS to date has focused on prevention. Moreover, treatment of OIs has been limited by lack of HIV/AIDS diagnostic facilities, unclear treatment guidelines, frequent drug stock-outs, inadequate training of health care personnel, and poor referral processes.\textsuperscript{448} However, this situation is changing, with the national response to HIV/AIDS (GFATM proposal) focusing on care and treatment.

According to WHO, 120 Malawian adults with HIV received isoniazid prophylaxis during 2001, representing less than 1 percent of the population in need of such a service. (Data on children receiving cotrimoxazole prophylaxis and on adults receiving isoniazid prophylaxis were not available.) Access to HIV/AIDS care and support services in rural areas was deemed minimal.\textsuperscript{449}

In summer 2002, Family Health International reported that Malawi's Standard Treatment Guidelines address OI management, but that they require review, updating, and wider circulation.\textsuperscript{450}

WHO reported that during 2001, there were three public/NGO sites in Malawi providing HAART. These three clinics were serving 1,000 clients — 0.18 percent of Malawians living with HIV/AIDS.\textsuperscript{451} Malawi's Global Fund Coordinating Committee also cites the figure of 1,000 patients with access to HAART.\textsuperscript{452} There is no national policy nor guidance on HAART.\textsuperscript{453}

Médecins sans Frontières has been implementing a HAART program at Chiradzulu District Hospital for several years. After at least three drug counseling sessions, HAART is proposed (free of charge) to patients severely immunocompromised. Supply is based on local market competition, including quality-assured, registered generics. During the first few months, patients return for drug resupply/counseling and clinical check-up at frequent intervals. A CD4-cell count is performed every six months. HIV viral load testing is not available in most settings.\textsuperscript{454}

In November 1999, the University of North Carolina Project in Lilongwe and the University of North Carolina Hospitals Infectious Disease Clinic began a program whereby patients' unused antiretrovirals from U.S.-based clinics were donated to Malawi. The program was directed to treat UNC Project and Lilongwe Central Hospital employees or affiliates of these institutions.
Patients were eligible if their CD4 count was below 200 and a six-month supply of a three-drug combination was available. 455

In January 2000, NAC launched a pilot HAART program in the referral centers in Lilongwe and Blantyre. Its partners included the University of North Carolina at Chapel Hill. Initial medication availability was limited to AZT and 3TC combination therapy (and was not free to patients). In October 2001, Cipla's Triomune (D4T/3TC/NVP) was substituted as the preferred agent (and at 50 percent less cost). Demand for medications increased dramatically after this price reduction, although though loss to followup was common. 456

**Care and Support**

In its HIV/AIDS strategic framework, Malawi recognized that HIV/AIDS care and support are inadequately coordinated and that services to PWHA, their families, and communities are poor. 457

Because public tertiary health facilities are overburdened and the care they provide is costly, the majority of PWHA receive care at home. Numerous NGOs, CBOS, faith-based groups, associations of PWHA, and household members have shouldered most of this responsibility, with little government assistance. Among prominent NGOs and CBOs in this area are the Lighthouse, Catholic Diocese, Malawi Network of People Living with HIV/AIDS, National Association of People with HIV/AIDS in Malawi, Salima AIDS Service Organization, and Kanengo AIDS Support Organization. (More are listed in the Links section.)

Nevertheless, home-based care skills, capacity, and financing are extremely inadequate to meet the increasing need. About 10 percent of AIDS patients receive HBC services, with great variance among districts (and better access in urban areas). 458 Several surveys on care of PWHA in Malawi have identified food as the number-one unmet need of PHWA, 459 a situation that is being exacerbated by the current famine. Household need for financial assistance is also cited by patients and HBC providers. Other constraints include transport, poor referral mechanisms, weak monitoring & evaluation, inadequate support for caregivers, and funding shortfalls. 460

As mentioned above, women provide most care to family members with HIV/AIDS, with little help from outsiders. This burden interferes with performing basic survival activities such as planting crops, marketing goods, and child rearing. Given persistent and deep poverty, as well as their own caregiving responsibilities, extended family members are often unable to assist with caring for PHWA. A study among women caring for PHWA in Lilongwe District found that caregivers had little information about HIV/AIDS and no basic medical supplies (e.g., soap, lotion, and bandages). They were frustrated that they did not know how to provide appropriate care. Their access to hospitals was limited, given poor transportation and availability. 461

On a recent mission, Family Health International found that HBC programs with permanent professional staff (nurse, clinical officer, medical assistant, community health nurse, or health assistant) are more integrated and have better monitoring and supervisory mechanisms. 462
In its GFATM proposal, Malawi outlines a Community/Home-Based Care and Treatment (CHBCT) component to support existing service provider organizations.\(^{463}\)

**Traditional Healers**

Many Malawians visit traditional healers. Given the deteriorating health care system, visits to traditional healers may be increasing.\(^{464}\) With regard to HIV/AIDS, health-seeking behavior often begins by visiting traditional healers. When symptoms continue or worsen, PWHA then seek care at local hospitals.\(^{465}\)

Despite claims by some members, the official stance of Malawi's National Association of Traditional Healers is that it has no cure for AIDS. The association's members do offer herbal treatments to mitigate the effects of OIs.\(^{466}\)

The "Home-Based Care Herbal Treatment Guideline" has been developed for HBC providers and volunteers, but it has not been sanctioned by the government, nor has it been widely distributed or promoted.\(^{467}\) Although the government recognizes traditional healers as stakeholders in the national response to HIV/AIDS, there has been a lack of coordination between herbalists and health officials.\(^{468}\)

**Workplace**

The HIV/AIDS policy of Shire Bus Lines is viewed as best practice. The policy delineates responsibilities for all levels of managers and staff, including a system of checks and balances. The company entered into a collective bargaining agreement with its employees to enforce the policy's key aspects. Shire also created a data collection system, including a "sickness and death database," to enable it to prepare realistic HIV/AIDS program budgets. To expand medical services to include employees and their family members and to provide HAART at subsidized prices, the company approached donors for financial, technical, material, and other aid.\(^{469}\)

Malawi developed its "Industrial Relations Code of Practice on HIV/AIDS" in 1996. It includes guidelines on eliminating HIV/AIDS-related discrimination and suggests that companies undertake HIV/AIDS audits to inform human resource planning and restructuring of benefits schemes. In 2001, Malawi issued a comprehensive policy on HIV/AIDS in the workplace. The policy aims to protect the rights of workers based on real or perceived HIV status; safeguard health and promote HIV prevention; and foster "enterprise-level," community-based, regional, sectoral, national, and international action. It lays out rights and responsibilities of government, employers, employer associations, employees, and unions. It provides detailed guidelines on prevention programs, training, workplace testing and confidentiality, risk of HIV exposure, benefits and compensation, dismissal, grievance procedures, management and cost-benefit issues, and provisions for care and support. It also specifies how the public, private, and informal sectors should implement the policy.\(^{470}\)
To what degree these instruments are being implemented, however, is unknown. As previously mentioned, Malawi is developing a labor policy that explicitly integrates a human rights-based approach to HIV/AIDS in the workplace.  

Portland Cement and ESCOM/Malawi are among the companies that have developed HIV/AIDS programs or policies. Others include:

- Bowler Beverages Company Ltd. (BBCL), which is working with Umoyo Network and Family Health International to develop an HIV prevention program for BBCL brewery workers, truck drivers, tavern owners and managers, and sex workers and their clients.
- Blantyre Christian Church has launched a program to provide HIV/AIDS services to police officers and their families. The project, funded by the Southern Africa AIDS Training Program, is deploying peer educators and is training HBC volunteers. In early 2002, the project was working in Zomba and Blantyre districts, with plans to expand.
- Development Aid from People to People and Project Hope manage several workplace HIV/AIDS education programs.

## Links

### Government

  - Community Health Sciences Unit
- National Tuberculosis Control Program
- National Malaria Program [mailto:wdodoli@nmcpmw.malawi.net]
- National Statistical Office [http://www.nso.malawi.net/]
- Ministry of Information [http://www.maform.malawi.net/]

### Academic and Research Institutions

- University of Malawi [http://www.unima.mw/]
  - College of Medicine [http://www.medcol.mw/]
  - College of Health Sciences
  - Kamuzu College of Nursing [http://www.unima.mw/]
  - Center for Social Research [http://www.csr.org.mw/]
- Lilongwe Central Hospital
- Queen Elizabeth Central Hospital, Blantyre
- Medical Council of Malawi
  - Malawian Medical Journal [http://www.inasp.org.uk/ajol/journals/mmj/about.html]
- Medical Association of Malawi
- Nurses and Midwives Council of Malawi
- Malawi Institute of Management [http://www.malawi.net/mim]
- Karonga Prevention Study, Chilumba
- Malawi-Liverpool-Wellcome Trust Research Program, Blantyre [http://www.liv.ac.uk/lstm]
- Liverpool School of Tropical Medicine [http://www.liv.ac.uk/lstm]
- London School of Hygiene & Tropical Medicine [http://www.lshtm.ac.uk]
- School of Oriental and African Studies, University of London [http://www.soas.ac.uk]
- University of Southampton [http://www.soton.ac.uk]
- University of North Carolina Chapel Hill Malawi Project [http://www.med.unc.edu]
- Rutgers University [http://www.rutgers.edu]
- Howard University [http://www.howard.edu]
- University of Maryland School of Medicine [http://medschool.umaryland.edu]
- Michigan State University [http://www.msu.edu]
- University of Illinois at Chicago [http://www.uic.edu/index.html]

**NGOs and CBOs**

- Banja La Mtsoqolo (BLM) [mailto:banja@malawi.net] Manages Health in Prisons Project.
- Blantyre Christian Center
- Catholic Commission for Justice and Peace
- Catholic Development Cooperation of Malawi
- Catholic Development Commission of Mzuzu Diocese
- Catholic Diocese of Malawi
- Center for Research and Rehabilitation
- Community-based Options for Protection and Empowerment (COPE) Funded by Save the Children, supports orphans and OVC in Dedza and Mangochi.
- Council for NGOs in Malawi (CONGOMA)
- Commission for Human Rights and Rehabilitation
- Christian Health Association of Malawi (CHAM) Operates mission hospitals and health training schools.
- Dedza Youth Alive
- Episcopal Church of Malawi
- Evangelical Association of Malawi
- Family Planning Association of Malawi
- Foundation for Hospices in Sub-Saharan Africa [http://www.fhssa.org]
- Friends of AIDS Trust Based in Nsanje District.
- Friends of Malawi [http://www.friendsofmalawi.org]
- Herbalist Association of Malawi
- Human Rights Consultative Committee
- Kanengo AIDS Support Organization
- The Lighthouse Based at Lilongwe Central Hospital and a model for integrated HIV/AIDS care. Provides home-based care and VCT. It is also providing HAART to about 400 patients. Will play a major role in the national response to HIV/AIDS, with particular focus on the strategy of introducing HAART using the DOTS model. Malawi AIDS Counseling and Resource Organization (MACRO) Offices in Lilongwe, Blantyre, and Mzuzu.
- Malawi CARER Human rights NGO that provides counseling services on civil and political rights.
- Malawi Council of Churches
- Malawi Economic Justice Network
- Malawi Institute of Management
- Malawi Network of People Living with HIV/AIDS (MANET+) Malawi Network of AIDS Service Organizations (MANASO)
- Malawi Project Builds the capacity of Malawian NGOs to respond to HIV/AIDS through training and information dissemination. Partners include NGO Networks for Health, Save the Children, PATH, CARE, Plan International, and Adventist Development and Relief Agency.
- Malawi Red Cross Society
- Mchinju Mission Orphanage
- Mponela AIDS Information and Counseling Center (MAICC)
- National Association of People with HIV/AIDS in Malawi (NAPHAM)
- National Association of Traditional Healers
- National Initiative for Civic Education
- National Youth Council
- Open Arms Orphanage Works in Zomba district.
- Salima AIDS Support Organization (SASO)
- Umoyo Network Builds the capacity of Malawian NGOs to respond to HIV/AIDS through training and information dissemination. Partners include NGO Networks for Health, Save the Children, PATH, CARE, Plan International, and Adventist Development and Relief Agency.
- Youth Net & Counseling Works in Zomba district.

**International NGOs**

- ActionAid
- Adventist Development and Relief Agency (ADRA)
- Africare
- American Red Cross
- Amnesty International
- Catholic Agency for Overseas Development
- CARE International
- Catholic Relief Services
- Canadian Interagency Coalition on AIDS and Development
- Canadian Physicians for Aid and Relief
- Canadian Public Health Association <http://www.cpha.ca/>
- Concern Worldwide <http://www.concernusa.org>
- Global AIDS Interfaith Alliance (GAIA) <http://www.thegaia.org> With funding from the Gates Foundation, manages the Malawi Women's Empowerment Project, which trains rural Malawian women in HIV/AIDS prevention and care.
- Humana People to People <http://www.humana.org/Where_are_we1.asp?Country=Malawi&CountryID=32>
- International Eye Foundation <http://www.iefusa.org>
- Médecins sans Frontières <http://www.accessmed-msf.org/photos/wad2001/indexmalawi.html>
- NGO Networks for Health <http://www.ngonetworks.org/country/highlights.html#malawi>
- Norwegian Church Aid <http://www.nca.no/article/archive/40>
- Oxfam <http://www.oxfam.org>
- Plan International <http://www.plan-international.org/wherewework/eastafricaeurope/malawi/>
- Project Hope <http://www.projecthope.org>
- Royal Dutch Tuberculosis Association <>
- Salvation Army <http://www1.salvationarmy.org/>
- Save the Children <http://www.savethechildren.org/malawi.shtml>
- World Council of Churches <http://www.wcc-coe.org>
- World Medical Fund <http://www.worldmedicalfund.org/malawi.html>

**UN Agencies**

- UNAIDS <http://www.unaids.org>
- WHO <http://www.who.int/country/mwi/en>
- UNDP <http://www.undp.org.mw/>
- UNFPA <http://www.unfpa.org/regions/africa/countries/malawi/1mlw0206.doc>
- UNICEF <http://www.unicef.org>
- World Food Program <http://www.wfp.org/country_brief/indexcountry.asp?country=454>
- FAO <http://www.fao.org>
- UNHCR <http://www.unhcr.ch>
- Roll Back Malaria Initiative <http://mosquito.who.int/cgi-bin/rbm/dcountryprofile.jsp?BV_SessionID=@@@@1177841901.1037672282@@@@&B
**Bilateral Aid Agencies**

- Canadian International Development Agency (CIDA) [http://www.acdi-cida.gc.ca/cidaweb/webcountry.nsf/VLUDocEn/Malawi-Storiesfromthefield]
- Commonwealth [http://www.thecommonwealth.org]
- Danida [http://www.um.dk/english/dp/ba.asp]
- DFID [http://www.dfid.gov.uk/DFIDAroundWorld/africa/Malawi.htm]
  - British Council: [http://www.britishcouncil.org/]
  - John Snow International [http://www.jsiuk.com/services/current.htm#mal]
- European Commission: [http://europa.eu.int/comm/index_en.htm]
  - EC Southern Malawi Nutrition Outreach Project [mailto:nop-sr@sdnp.org.mw]
- GTZ: [http://www.gtz.de/home/english/]
- Ireland Aid: [http://www.irlgov.ie/iveagh/irishaid/default.asp]
- JICA: [http://www.jica.go.jp/]
- Netherlands Development Organization (SNV)
- Royal Danish Embassy [mailto:DENMAL@Malawi.net]
- NORAD
- Republic of China
- SIDA [http://www.sida.se]
- USAID [http://www.usaid.gov/regions/afr/country_info/malawi.html]
  - Funds:
    - AIDSMark/Population Services International [http://www.psi.org/where_we_work/malawi.html]
    - Famine Early Warning Systems Network (FEWS NET) [http://www.fews.net]
    - Horizons Project/Population Council [http://www.popcouncil.org/africa/malawi.html]
    - Peace Corps [http://www.peacecorps.gov/countries/malawi/index.cfm]
    - POLICY Project/The Futures Group International [http://www.policyproject.com/countries.cfm?country=Malawi]
Other Donors

- Bill and Melinda Gates Foundation <http://www.gatesfoundation.org/>
- Rockefeller Foundation <http://www.rockfound.org/>

Subregional Organizations

- Catholic Institute for International Relations/International Cooperation for Development <mailto:ciir@mango.zw>
- Health Systems Research in the Southern African Region <http://www.healthnet.org/afronets>
- Horn of Africa Region Women's Knowledge Network (Hawknet) <http://www.acwict.or.ke/Hawknet/default.htm> Includes Eritrea, Malawi, Somali, Sudan, Tanzania, Uganda and Kenya.
- International Federation of Red Cross and Red Crescent Societies Southern Africa AIDS Campaign <http://www.ifrc.org>. Support to orphans and OVC.
- Media For Development Trust <http://site.mweb.co.zw/mfd/> Assists local NGOs to develop capacity to use film and video in their work.
- Organization of African Instituted Churches <mailto:oaic@skyweb.co.ke> Provides support to orphans and OVC.
- Panos Southern Africa AIDS Program <http://www.panos.org.zm/> Based in Lusaka. Works with media and other information actors to enable developing countries to shape and communicate their own development agendas through informed public debate; particular focus on amplifying the voices of the poor and marginalized. Numerous HIV/AIDS-related activities and publications.
- Project Support Group <mailto:psg@gmx.net> Assists southern African districts, municipalities, nonprofits, and faith-based partners to develop, manage, and sustain HIV/AIDS prevention and mitigation projects in priority migrant communities and areas.
- South African Civil Military Alliance to combat HIV/AIDS <> Based in Lusaka.
- Southern Africa Communications for Development <http://www.sacod.org.za/default.htm> Coalition of filmmakers and organizations that produce and distribute socially responsible films and videos, including those related to HIV/AIDS.
- Southern Africa Flood and Drought Network <http://edcw2ks40.cr.usgs.gov/sa_floods/>
- Southern Africa Orphanage Hope Foundation <>
- Southern African Development Community (SADC) <http://www.sadc.int/>
  - SADC AIDS Network for Nurses and Midwives (SANNAM) <>
- Southern African AIDS Training (SAT) Program <mailto:info@satregional.org> Based in Harare.
- Southern African Network of AIDS Service Organizations (SANASO) <mailto:sanaso@mango.zw> Based in Harare.
- Steps for the Future <http://www.steps.co.za> Collection of films about life in southern Africa in the presence of HIV/AIDS.
- Women in Law in Southern Africa Research and Education Trust (WLSARET) <mailto:wildaf@mango.zw> Manages an HIV/AIDS research project.
- Women In Need, Inc. < > Provides support to women and children affected by HIV/AIDS.
- Women's Media Watch <http://www.womensmediawatch.org.za> NGO that conducts training, research, and advocacy to combat sexism, racism, classism, and homophobia in the southern African media.

**News Services**
- AllAfrica.com: Malawi <http://allafrica.com/malawi/>

**Other Resources**
- University of Pennsylvania Malawi Page and Search Engine <http://www.sas.upenn.edu/African_Studies/Country_Specific/Malawi.html>

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<http://www.policyproject.com/pubs/countryreports/MalSS.pdf>
7 Manda SOM. "Describing heterogeneity in HIV prevalence in Malawi using sentinel surveillance data." Abstract no. WePeC6102. XIV International Conference on AIDS, Barcelona, July 7-12, 2002.
9 Personal communication with Dr. Sandy Schwarcz, director, HIV/AIDS Statistics and Epidemiology Section, San Francisco Department of Public Health, November 15, 2002.
<http://www.policyproject.com/pubs/countryreports/MalSS.pdf>
11 Personal communication with Dr. Johnstone Kumwenda and Dr. Newton Kumwenda, Malawi College of Medicine, Blantyre, January 8, 2003.
<http://www.policyproject.com/pubs/countryreports/MalSS.pdf>
<http://www.policyproject.com/pubs/countryreports/MalSS.pdf>
<http://www.policyproject.com/pubs/countryreports/MalSS.pdf>
<http://www.policyproject.com/pubs/countryreports/MalSS.pdf>
17 Personal communication with Dr. Sandy Schwarz, director, HIV/AIDS Statistics and Epidemiology Section, San Francisco Department of Public Health, November 15, 2002.
<http://www.unaids.org/epidemic_update/report/Table_E.htm>


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304 Kanyenda JT, Kumwenda NI, Lema VM. "The impact of HIV infection on maternal morbidity and mortality at Queen Elizabeth Central Hospital, Blantyre, Malawi." Abstract no. B10193. XIV International Conference on AIDS, Barcelona, July 7-12, 2002.


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Personal communication with Ms. Monica Djupvik, junior professional officer, UNAIDS/Lilongwe, December 18, 2002.

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"Access to HAART in Medecins Sans Frontieres programs." Abstract no. WePeF6674. XIV International Conference on AIDS, Barcelona, July 7-12, 2002.

