Malawi’s HIV prevalence is one of the highest in the world, with 10.6% of the adult population (aged 15-64) living with HIV. Malawi accounts for 4% of the total number of people living with HIV in sub-Saharan Africa. An estimated 980,000 Malawians were living with HIV in 2015 and 27,000 Malawians died from HIV-related illnesses in the same year. The Malawian HIV epidemic plays a critical role in the country’s low life expectancy of just 57 years for men and 60 years for women.

Over the last decade, impressive efforts to reduce the HIV epidemic have been made at both national and local levels. New infections have dramatically declined from 98,000 new infections in 2005, to 28,000 new infections in 2015/2016. Malawi has also witnessed a reduction in children acquiring HIV, with New 4,800 new infections in 2015, a decline from 16,000 in 2010.

The Malawian HIV epidemic varies greatly across the country. HIV prevalence and density is high in the urban districts of Lilongwe, Blantyre and Zomba and in the southern region of the country. Prevalence is also higher in urban areas than rural ones with marked differences observed in the northern and central regions of Malawi.

Key affected populations in Malawi

Malawian HIV epidemic plays a critical role in the country’s low life expectancy - just 57 years for men and 60 for women.
The Malawian National AIDS Commission’s (NAC) 2013 Modes of Transmission (MoT) study, the most recent available, found unprotected heterosexual sex between married/co-habiting partners accounts for 67% of all new HIV infections in Malawi while unprotected casual heterosexual sex accounts for 12%.8 Beyond this, there are several key populations that are increasingly vulnerable to HIV infection.

**Women and HIV in Malawi**

HIV disproportionately affects women in comparison to men in Malawi. A national assessment of the impact of HIV on the population, carried out by the Malawian Ministry of Health in 2015-2016, found HIV prevalence among adult women (aged 15-64) to be 12.8%, compared to 8.2% among Malawian adult men.9 This disparity is especially prominent among young people, with 3.7% of young women aged 15-17 living with HIV compared to 0.4% of their male counterparts.10

Sexual violence is also an issue with 22% of women and 15% of men experiencing sexual violence before the age of 18 years. Most of the perpetrators of sexual violence against women were spouses, boyfriends or romantic partners.11

**Young people and HIV in Malawi**

Young people account for 50% of new HIV infections in Malawi, with HIV prevalence higher among some young populations, such as 15-17 year olds.12 In total, 3.6% of young women and 2.5% of young men (aged 15-24) are living with HIV in Malawi.13

Early sexual activity is high in Malawi with around 15% of young women and 18% of young men (aged 15-24) reporting having sex before the age of 15.14 Furthermore, girls aged 15-19 are 10 times more likely to be married than their male counterparts.15
With young people engaging in sex at an early age, addressing the sexual and reproductive health needs of this population is critical. It is hoped the enactment in 2015 of the Marriage Law, which has increased the minimum age of marriage from 15 to 18, may indirectly assist in reducing the age at which people start having sex. However, as of 2016 the law had not yet been assented by Malawi’s President.16

Socio-cultural factors such as initiation ceremonies and rituals have been found to lead to unprotected sex, increasing young people’s vulnerability to HIV, especially among girls. One study found that the transition period from childhood to adulthood in Malawi within many communities is defined by initiation ceremonies and rituals that can often encourage unprotected sex.17

Young people’s knowledge of HIV prevention is also low with only 41% of women and 44% of men (aged 15-24) having sufficient knowledge of HIV prevention in 2015.18 There has been a decrease in young men’s knowledge of HIV prevention as NAC reported this figure at 51% in 2014.19 For both genders, the comprehensive knowledge generally increases with age, educational attainment, and wealth. Urban young people are more likely than rural young people to have knowledge of HIV prevention.20

Condom use is low among sexually active 15-to-19-year-olds, with only 25% of married females and 30% of sexually active unmarried females from this age group using any form of modern contraception. Young people often face obstacles to accessing contraceptives and health services, which increases their risk of acquiring HIV and other sexually transmitted diseases.21

Sexual violence is also an issue for young people. Around 23% of females and 13% of males aged 13-17 surveyed by UNICEF in 2013 reported experiencing sexual violence in the past 12 months.22

Men who have sex with men (MSM) and HIV in Malawi

Men who have sex with men (sometimes referred to as MSM) have been identified as a key affected population within the Malawian HIV epidemic.

Nearly one in five men who have sex with men live with HIV, a prevalence rate that remains two times higher than the rest of the adult male population in Malawi.

Although HIV prevalence tends to be higher in older men, recent records from 2017 show that 11.8% of 18-19 year-old men who have sex with men are already infected. This highlights the importance of targeting young people for HIV prevention and testing services, regardless of their gender or sexual orientation.23
The 2017 study also confirms findings of an earlier 2013-14 study, with results indicating that rural areas generally have much higher rates of HIV prevalence - such as Mulanje which presented a prevalence of 24.5% - compared to well-resourced urban areas. This geographical disparity can be explained by better linkages to care in urban areas and suggests that the targeting of high burden cities in national plans to tackle HIV should not come at the expense of services in rural areas. 

Worryingly, 80% of those questioned in the original 2014 study incorrectly reported that anal sex carries a lower risk of HIV transmission than vaginal sex and only 23% reported receiving targeted HIV prevention information.

Also of concern is the fact that, in seven out of the 28 districts surveyed, 30% to 45% of men who have sex with men did not know their HIV status. High-risk behaviours were common, including multiple sexual partnerships, inconsistent condom use and exchanging sex for money.

Until 2012, efforts to address the increased vulnerability to HIV of men who have sex with men were limited by laws that rendered homosexuality illegal. Criminalisation of homosexuality was suspended in 2012 and it is hoped that this legal change will eventually bring more support for this underserved, high-risk population.

Nevertheless, prosecution of men who have sex with men still happens with varying levels of enforcement - for example a police officer may still prosecute someone involved in same sex acts under the provision that they are ‘breaching the peace’. These continuing acts of discrimination create barriers to the national and international efforts to provide HIV services to this population.

Furthermore, any men who have sex with men face increased levels of stigma and violence in Malawi. A 2016 survey of around 200 men who have sex with men found 39% had experienced a human rights abuse in some form. Around 12% reported being raped and 18% had been blackmailed.

Stigma and violence experienced by men who have sex with men can be responsible for difficulties in accessing HIV testing, prevention and treatment services and disclosure of HIV status. For example, in the 2016 survey mentioned above, 17.5% of respondents reported being afraid to seek healthcare of any kind.

### Sex workers and HIV in Malawi

**Sex work** is criminalised in Malawi, limiting the amount of available data on this key population.

Comparisons of the Biological and Behavioural Surveillance Surveys (BBSS) conducted in 2006 and 2014 indicate a major decrease in HIV prevalence (from 77% to 25%) among female sex workers. Despite these encouraging results, it is clear that HIV prevalence among sex workers remains unacceptably high.

Data from the BBSS 2014 suggest positive trends in the adoption of safer behaviours by female sex workers that may help to further reduce HIV transmission in the coming years. For example, the proportion of female sex workers reporting using a condom with their most recent client was extremely high (85%).

Sex workers in Malawi face high levels of discrimination and stigma when seeking HIV services further increasing their vulnerability to HIV, especially from police when seeking victim support services.
**Children, orphans and HIV in Malawi**

An estimated 84,000 children (0-14 years) were living with HIV in 2015 of whom 61% (51,487) are receiving antiretroviral treatment.\(^{34}\)

Malawi has shown immense progress in reducing child HIV infection rates. In 2013, the country had achieved a 67% reduction in children acquiring HIV, the largest country decline across sub-Saharan Africa.\(^{35}\) Children and vulnerable children are identified as a key target group by NAC’s 2015-2020 HIV strategy.\(^{36}\)

There is estimated to be 530,000 orphans in Malawi as a result of AIDS.\(^{37}\) Supporting the needs of orphans and other children made vulnerable by AIDS is identified as a main element of the national Malawian HIV response.\(^{38}\) Factors such as poverty are preventing the roll-out of adequate support and services for these children.

**HIV testing and counselling (HTC) in Malawi**

HIV testing and Counselling (HTC) services have increased over the last few years in Malawi, surpassing national targets.

During 2014, more than 1.8 million people accessed HTC services compared with around 1.7 million in 2013, representing an increase of 11%. However, of the people receiving HTC in 2014, only 31% were newly tested whereas 69% were repeat tests.\(^{39}\)

The majority (66%) of people being tested were women. Nevertheless, when pregnant women were excluded, there was no significant difference between men and women with 40% of men and 43% of women (aged 15-49) testing for HIV in the past 12 months and knowing their results. Of those tested, 9% were under 15-years-old, 40% were between 15 and 24 and 52% were older than 25.\(^{40}\)

HTC services are provided in two ways in Malawi, client initiated HTC, which is Voluntary Counselling and Testing (VCT), and provider initiated HTC, which encompasses a variety of methods including static sites; mobile testing units; home-based testing and national HTC events.\(^{41}\)

**HIV prevention programmes in Malawi**

The National HIV and AIDS Strategic Plan 2015-2020 has developed various prevention policies and strategies for reducing HIV incidence. Some of these strategies are outlined below.

**Preventing mother-to-child transmission (PMTCT)**

Malawi has demonstrated an unprecedented commitment to preventing transmission from HIV-positive mothers to their infants in recent years. Major achievements include the expansion of sites providing prevention of mother-to-child transmission (PMTCT) services. In July 2011 Malawi became the first country to implement the Option B+ approach, which means all pregnant women living with HIV are offered antiretroviral treatment (ART) for life - irrespective of CD4 count.

The impact of this has been huge. Between 2011 and 2015, the proportion of women with HIV who were diagnosed went from 49 to 80%, and the proportion who were virally suppressed jumped from 2 to 48%.\(^{42}\) In 2014, of the more than 520,700 women receiving HIV test results, 7.7% were HIV positive.

PMTCT sites have increased across Malawi since the implementation of the Option B+ approach, with 638 PMTCT sites available as of September 2014, although this is still short of the target of 700.\(^{43}\)

The percentage of mothers receiving ART to prevent mother-to-child transmission (MTCT) has dramatically increased from 17% in 2009 to 80% in 2015.\(^{44}\) Around 73% of women on Option B+
were still receiving treatment after 12 months and around 71% after 24 months. This is mostly due to the fact that up to 15% of pregnant women who were diagnosed with HIV did not then go on to start treatment. This could be due to poor counselling of newly diagnosed HIV-positive pregnant women in health facilities, poor male involvement in PMTCT issues and a lack of disclosure to spouses and family.45

**Case study: Clara’s story**

Clara was 25 when she noticed she had the same symptoms as her parents. But despite knowing she had HIV, guidelines at the time only allowed access to antiretroviral treatment if her CD4 count had fallen below 200 (guidelines now recommend people start treatment as soon as they are diagnosed). She had to travel 400km just to get a CD4 count test, which confirmed she had advanced stage HIV and a CD4 count of only 32.

Today, with the right treatment, her viral load has been rendered undetectable and her oldest daughter, who also has HIV, is in good health. Her youngest daughter was born HIV negative, as a result of improved access to services to prevent mother-to-child transmission of HIV. Clara now co-ordinates national activities for women living with HIV, offers advice, encourages testing and works to combat stigma and discrimination46.

As a result of the impressive national efforts to reduce MTCT and the scale up of antiretroviral treatment for pregnant mothers, the transmission rate from mother to child has reduced from 32% in 2009 to 13% in 2013.47

The 2015 Malawi Progress Report identifies early infant diagnosis as a priority for the national HIV and AIDS response. In 2014, around 37% of infants received their diagnosis within the first two months of birth.48 Addressing the delay between birth and diagnosis is crucial for reducing infant mortality as a result of HIV.

**Voluntary medical male circumcision (VMMC)**

Another effective prevention strategy that has been scaled-up across Malawi is voluntary medical male circumcision (VMMC), which is now a key national prevention strategy.

The availability of VMMC has increased since 2012, with 80,419 circumcisions performed in 2014. However this is far short of Malawi’s target of 250,000.49

Overall, the proportion of circumcised men in Malawi has only increased marginally, from 21.5% in 2010 to 27.5% in 2014.50

A number of barriers limit the uptake of VMMC. Misconceptions about the efficacy and unintended consequences of this intervention are high. Malawi’s National AIDS Commission (NAC) reports how some men perceive VMMC as a guaranteed protection against HIV, which may promote high-risk sexual behaviour, while others have expressed concerns about its adverse effects on sexual pleasure and performance. Infections and gangrene have also been reported in some districts following VMMC, which are highly likely to have negatively affected demand.51

**Condom provision and programming**

The provision of free condoms has been a major element of Malawi’s National HIV Prevention Strategy.

In 2013/2014 more than 40.4 million condoms were distributed. However, only 24.1 million of these were free of charge. The remaining 16.3 million condoms were for sale (sometimes referred to as
'socially marketed'). Despite the total number of condoms distributed being double the amount distributed the year before, this figure still fell 40% short of Malawi’s yearly target. However, the yearly target for commercial condoms was surpassed by 64%.

Condom use remains low across Malawi. In 2015, 35.4% of men and women aged 15-49 who had more than one sexual partner in the last 12 months reported using a condom the last time they had sex.

Antiretroviral treatment (ART) in Malawi

Malawi’s ART rollout has significantly expanded, with 61% of adults living with HIV receiving ART in 2015, an increase of 10% from 2013. In 2015/2016 the Ministry of Health reported that, of the 900,000 adults (aged 15-64) living with HIV, 72.7% were aware of their status. Of these, 88.6% were on ART and 67.6% were virally suppressed. This is when levels of the virus are low in the body, which reduces the likelihood of transmission.

As a result of the expanded access to treatment, there has been a 50% decline in AIDS-related deaths between 2004 and 2014 with more Malawians living healthy lives on ART than ever before.

The 2013 World Health Organization (WHO) guidelines on HIV treatment have been encompassed into the Malawian treatment, care and support plans, with new CD4 count thresholds for ART initiation. This has meant that more people living with HIV are eligible for ART. To cope with this, there is now greater access to treatment services at a local level, with many ART sites becoming decentralised to primary care facilities.

The number of static antiretroviral sites increased significantly from 300 sites in 2011 to 706 in 2014.

A further important element of the antiretroviral programme in Malawi is ensuring effective follow-up procedures. As of September 2014, 78% of people living with HIV who had been initiated on ART were still on it after 12 months. At 24 and 60 months, the proportion of people living with HIV who remained in care was 73% and 59% respectively. These levels are lower than the survival rate of 85% recommended by WHO.

Recent studies have found that ART follow-up procedures are inconsistent, with patients exhibiting late and missing treatment sessions. Issues surrounding follow-up procedures can have implications for adherence to ART, emphasising the importance of monitoring and follow-up.

Adherence levels are lower among adolescents in Malawi than among adults. Recent research found 45% of adolescents living with HIV reported missing ART in the past month. The most commonly reported reason was forgetting (more than 90%), travel from home (14%) and busy doing other things (11%). Alcohol use, violence in the home and low treatment self-efficacy were all associated with worse adherence.

Barriers to HIV prevention programmes

A number of barriers to HIV prevention that range from cultural, social and structural factors to legal and financial barriers further exacerbate Malawi’s HIV epidemic.

Cultural barriers

Cultural practices

Malawi’s National HIV & AIDS Strategic Plan 2015-2020 recognises that certain cultural norms are a barrier to HIV prevention. For example, in some remote southern regions of Malawi, it's traditional for girls to be made to have sex with a paid sex worker known as a ‘hyena’ once they reach puberty.
**Multiple and concurrent sexual partners**

Multiple and concurrent sexual partners, which can increase the transmission of HIV, is a feature of Malawian culture. The 2015-2016 MDHS found that 13% of men had two or more partners during the 12 months prior to the survey, compared to 1% of women. These rates are double the rates recorded by the MDHS 2010. For married men, this figure increases to 16%.66

**Gender inequality**

The low socioeconomic status of women and gender inequalities also drive the HIV epidemic in Malawi. Power relations between men and women are reinforced through sex, with men usually dominating and initiating sex.67

A 2013 study based on in-depth interviews with around 70 women found marriages in Malawi to be characterised by such stark gender inequalities that marriage itself is a risk factor for HIV infection in women. Respondents generally reported they had remained faithful while their husbands had girlfriends or had taken an additional wife within a polygamous marriage, which is legal in Malawi. Perceiving that men cannot control their sexual appetites, women linked this to unfaithfulness and subsequent HIV infection.68

Other behaviours which women described as nkhaza (domestic abuse or violence) included forced sex (which never involved the use of condoms) and abandonment, often after a wife was diagnosed with HIV, perhaps during pregnancy.69

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My husband had a child with me and then he left me... sometimes just beating me up... he finds another woman and then I accept him until he gives me a second pregnancy and after the child is born, he leaves me again and goes to find another woman . . . Until I have given birth to all those children while he was doing all of this so I just strengthened my heart that I should just leave this.

- Survey respondent70

**Funding**

Malawi’s national HIV response is still largely funded by external sources. However, the country’s domestic contribution increased from 1.7% in 2010/2011 to 8.1% in 2011/12 and is estimated at 14.3% for 2013/2014.

In 2013/2014, 2.1% of overall funding for Malawi’s HIV response came from private sources while 83.6% came from the international community.71 However, issues of corruption within the government have severely affected overseas development aid provisions. Sometimes, funds are not available or inconsistently disbursed, impeding the roll-out of HIV prevention programmes and the provision of treatment.

The majority of funding (47%) is spent on treatment and care, leaving gaps in financial support for non-biomedical interventions. Only 5% of 2014 expenditure went on PMTCT and 23% went on prevention.72 Additionally, funding gaps are present that limit opportunities to effectively provide HIV services and fully implement the National HIV and AIDS Strategic Plan.73
Legal barriers

Malawi has no legal restrictions that discriminate against people living with HIV entering and residing in the country. However, punitive laws are hindering an effective response for key affected populations, particularly sex workers and men who have sex with men.

Although homosexuality has now been decriminalised in Malawi, formal recognition of the rights of men who have sex with men remains limited. This can result in increased levels of stigma and discrimination towards these vulnerable populations. Sex work remains an illegal occupation in Malawi, limiting the support and services to these vulnerable populations.

The future of HIV and AIDS in Malawi

Malawi has made impressive progress in responding to its HIV epidemic, particularly in regards to PMTCT which has dramatically reduced.

In its 2015-2020 HIV strategy, NAC states that Malawi will aim to meet UNAIDS’ 90-90-90 treatment targets, with the aim of controlling its HIV epidemic by 2030. By the end of 2020, NAC has committed to:

- Diagnosing 90% of all people living with HIV
- Starting and retaining 90% of those diagnosed on ART
- Achieved viral suppression for 90% of patients on ART

If it reaches these goals by 2020, the NAC estimates that 760,000 (73%) of the projected 1,042,000 people living with HIV will be virally suppressed, leading to a dramatic reduction in sexual transmission and further reductions in MTCT.74

However, a number of gaps in the country’s response may lessen Malawi’s ability to reach these goals. Of particular concern is the rate of infection among young people, something behaviour change programmes have been failing to address. More programmes that effectively target young people are needed to increase prevention and knowledge of HIV and AIDS within this group.

Malawi also faces challenges with regards to ensuring adequate funding, a challenge shared by many countries across sub-Saharan Africa.

A number of key affected groups exist in Malawi such as sex workers and men who have sex with men. Greater effort is required to support them via comprehensive prevention programmes and campaigns that challenge the high levels of stigma and discrimination facing these populations. Unless these groups’ needs are properly addressed, significant gaps in Malawi’s HIV response will remain.

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