HIV and AIDS in Malawi

KEY POINTS

- Malawi has one of the highest HIV prevalences in the world despite the impressive progress the country has made in controlling its HIV epidemic in recent years.

- Young people are particularly at risk, due to early sexual activity and marriage, with around a third of all new HIV infections in Malawi in 2018 occurring among young people (ages 15-24). Despite this around 60% of young people do not have sufficient knowledge of how to prevent HIV.

- Stigma remains a key barrier to progress, particularly among men who have sex with men and sex workers.

- Malawi is close to achieving the 2020 UNAIDS 90-90-90 targets, which include 90% of people with HIV knowing their status, 90% of these accessing ARVS and 90% of those on treatment being virally suppressed.

Explore this page to read more about populations most affected by HIV in Malawi, HIV testing and counselling, prevention programmes, antiretroviral treatment availability, civil society’s role, HIV and tuberculosis (TB), barriers to prevention, funding and the future of HIV in Malawi.

Malawi’s HIV prevalence is one of the highest in the world, with 9.2% of the adult population (aged 15-49) living with HIV. In 2018, an estimated one million Malawians were living with HIV and 13,000 Malawians died from AIDS-related illnesses. The Malawian HIV epidemic plays a critical role in the country’s life expectancy of 61 years for men and 67 for women.

Over the last decade, impressive efforts to reduce the HIV epidemic have been made at both national and local levels. In 2018, 90% of people living with HIV in Malawi were aware of their status, of whom 87% were on treatment. Of these people, 89% were virally suppressed, meaning the country is very close to reaching the UNAIDS 90-90-90 targets. This equates to 78% of all people living with HIV in Malawi on antiretroviral treatment (ART) and 69% of all people living with HIV virally suppressed.
Among children (0-14 years) treatment coverage is lower at only 61% of HIV-positive children accessing ART.\(^5\)

New infections have dramatically declined from 66,000 new infections in 2005, to 38,000 in 2018.\(^6\) An impressive prevention of mother-to-child transmission (PMTCT) programme in Malawi has also driven down new HIV infections among children (ages 0-14). In 2018 there were 3,500 new paediatric infections, compared with 15,000 in 2010.\(^7\)

Malawi’s HIV epidemic is generalised, which means it affects the general population as well as certain high-risk groups. Unprotected heterosexual sex between married or co-habiting partners accounts for the majority of all new HIV infections (67% in 2015), although unprotected casual heterosexual sex also accounts for a significant proportion of transmission (12% of new cases in 2015).\(^8\) Beyond this, several populations groups such as adolescent girls and young women, sex workers and men who have sex with men are particularly vulnerable to HIV.

The Malawian HIV epidemic varies greatly across the country, ranging from 4.9% of adults living with HIV in the Central East region to 17.7% of adults living with HIV in Blantyre City. HIV prevalence is also high in the urban districts of Lilongwe and Zomba and in the southern region of the country.\(^9\) In March and April 2019, Cyclones Idai and Kenneth caused huge damage in Malawi and lead to widespread flooding. This has left many people without healthcare, reducing access to HIV services. It is also increasing HIV risk, with reports of displaced women and girls being exposed to higher levels of sexual and gender-based violence in camps set up for those affected by the disaster.\(^10\)

**Groups most affected by HIV in Malawi**

**Women**

HIV disproportionately affects women in Malawi. A national assessment of the impact of HIV on the
population, the Malawi Population-Based HIV Impact Assessment (MPHIA) 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 with 8.2% among adult men. This disparity is especially prominent among 25- to 29-year-olds, as HIV prevalence is three times higher among women than men in this age group (13.6% vs 4.7%).

Sexual violence is also an issue. Around 4% of married or ever-partnered women (ages 15-64) participating in MPHIA had experienced physical or sexual violence in the 12 months preceding the survey. Among adolescent women (ages 15-19) the proportion is higher at just under 6%. Most of the perpetrators of sexual violence against women are spouses, boyfriends or romantic partners (sexual violence is also known as ‘intimate partner violence’).

Young people

Just under one-third of all new HIV infections (14,000 out of 38,000) in Malawi in 2018 occurred among young people (aged 15-24). Roughly two-thirds of new infections among young people were among young women (9,900 new infections among young women, compared to 4,200 among young men). In 2018, 4.3% of young women were living with HIV, compared to 2% of young men.

Awareness of status is particularly low among HIV-positive young people, with around 67% of HIV-positive men aged 20-24 and 58% of HIV-positive women aged 15-19 unaware of their status.

In 2015/16, the latest available data, it is estimated that 54% of young people living with HIV had been diagnosed (45% of HIV positive young men and 58% of HIV-positive young women). Among those diagnosed, 86% were on treatment, of whom 81% were virally suppressed.

In an attempt to deal with this issue, Malawi increased the minimum age of marriage in 2017 from 15 to 18 for males and females, criminalising child marriage. However, many child marriages still occur.

“...my father was given MK20,000 ($28 USD) and two mobile phones [as payment for the marriage]. I was so angry when my father told me to stop school and prepare for marriage. I had never thought of getting married before. My dream was to continue with my education and become self-reliant.” – Eliza, 16, who was offered for marriage at the age of 14.
With young people engaging in sex at an early age, addressing the sexual and reproductive health needs of this population is critical. However, knowledge of HIV prevention among young people is poor, with just 40% of young people demonstrating sufficient knowledge of HIV prevention in 2016, with little variation between men and women.\textsuperscript{22}

For both sexes, comprehensive knowledge about HIV generally increases with age, educational attainment, and wealth. Urban young people are more likely than rural young people to have knowledge of HIV prevention.\textsuperscript{23} Around 40% of 15 to 19-year-olds who had sex with a non-martial, non-cohabiting partner did not use a condom, a higher proportion than other age groups. Young people often face obstacles to accessing contraceptives and health services, which increases their risk of acquiring HIV and other sexually transmitted infections (STIs).\textsuperscript{24 25} 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.\textsuperscript{26}

**Sex workers**

Sex work is criminalised in Malawi, limiting the amount of available data on this key population, as well as the support and services sex workers are able to access.

In 2018, 55% of sex workers were estimated to be living with HIV. Although this is a decrease from 2014 when prevalence stood at 63%, this remains an unacceptably high level.\textsuperscript{27}

There is evidence of growing positive trends in the adoption of safer behaviours by female sex workers that may help to further reduce HIV transmission in the coming years. In 2018, 65% of female sex workers reported using a condom with their most recent client and 91% of sex workers diagnosed with HIV were on treatment. However, it is estimated that around a quarter of HIV-positive sex workers (23%) were unaware of their status.\textsuperscript{28} Sex workers in Malawi face high levels of human rights abuses, including discrimination and stigma when seeking HIV services, further increasing their vulnerability to HIV. They also experience high levels of violence, discrimination and abuse from police, intimate partners, clients and members of the public.\textsuperscript{29}
In addition, sex workers in Malawi may be evicted from their homes and denied housing due to their occupation. Sex workers living with HIV have also reported being denied access to loans, bank accounts, property and social services due to their HIV status.\(^{30}\)

**Men who have sex with men (MSM)**

Although data is limited, it is estimated that around 7% of men who have sex with men in Malawi are living with HIV.\(^{31}\) Although HIV prevalence tends to be higher in older men, a study published in 2017 found 11.8% of 18- to 19-year-old men who have sex with men were already living with HIV. This highlights the importance of targeting young people for HIV prevention and testing services, regardless of their gender or sexual orientation.\(^{32}\)

Homosexuality is illegal in Malawi, punishable by up to 14 years in prison, although prosecutions were suspended in 2012.\(^{33}\) Nevertheless, men who have sex with men still face varying levels of punishment. For example, a police officer may still prosecute someone involved in same sex acts under the provision that they are ‘breaching the peace’.

Men who have sex with men experience assault, arbitrarily arrest and detainment as the hands of the police, sometimes without legal basis. Men who have sex with men may also be arrested if their sexual orientation is exposed when seeking healthcare, causing many to shun HIV and other sexual health services.\(^{34}\)

Many men who have sex with men also face increased levels of stigma and violence from members of the public. A 2016 survey of around 200 men who have sex with men found that 39% had experienced a human rights abuse in some form, including 12% who had been raped.\(^{35}\)

All of these factors create a hostile environment that increases men who have sex with men’s vulnerability to HIV while lessening their ability to access HIV prevention and treatment services.

High-risk behaviours are common, including multiple sexual partners, inconsistent condom use and exchanging sex for money.\(^{36}\) It is estimated that around 55% of men who have sex with men do not regularly use condoms.\(^{37}\)

**Children and orphans**

An estimated 74,000 children (aged 0-14) were living with HIV in 2018 of whom 61% were receiving antiretroviral treatment.\(^{38}\) Thanks to a successful PMTCT programme, 9,600 new HIV infections among children were averted in 2018, with transmission rates from mother-to-child reduced to 8.8% at 12 months after birth.

There are an estimated 500,000 orphans in Malawi (ages 0-17) as a result of AIDS.\(^{39}\) Supporting the needs of orphans and other children made vulnerable by AIDS is identified as a main element of the national Malawian HIV response.\(^{40}\) 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.

HTC services are provided in two ways: through client-initiated HTC (also known as ‘voluntary counselling and testing’), and provider-initiated HTC. Provider-initiated testing, which is when a healthworker offers an HIV test to a patient, occurs in a wide variety of settings, including healthcare facilities, mobile testing units, people’s homes and at national health events. In clinical settings, HIV testing is available in adult and paediatric inpatient wards, nutritional clinics, antenatal care, maternity and postnatal wards, out patient departments and sexual health clinics. In comparison, 1.8 million people accessed HTC services in total during 2014. This suggests HIV testing services have significantly expanded in recent years.

Of the 1 million people that tested for HIV between April and June 2017, 37% were men and 63% were women. One in five of all people testing (20%) accessed HTC as part of a couple. Around half (48%) of those testing were aged 25 or above, 38% were aged 15-24 and 13% were under the age of 15.

The testing discrepancy between men and women means women living with HIV are more likely to be aware of their status. In 2018, 94% of HIV-positive women diagnosed, compared to 89% of HIV-positive men.

An analysis of HIV testing data collected through Malawi’s 2015/16 HIV Impact Assessment suggests that HIV testing programmes need to specifically target younger, unmarried men aged 15–19, men with poor education levels, and men who live in the central and southern regions of the country.

Although HIV self-testing kits are not widely available, UNITAID’s 4-year Self-Testing Africa (STAR) project is trialling self-testing in the country. Initial results from 2016 suggest that, when HIV self-testing is provided as part of a community-based approach, it can increase uptake of testing services, particularly among men and adolescents, and connect people to HIV treatment, particularly among individuals who are at high risk of HIV infection. For example, 26% of those using the self-testing kits in 2016 were first-time testers, 26% were aged 16-24, and 49% were men (aged 16-65). Overall, testing coverage among men in areas where STAR operated increased by 24%.

The 2015/16 HIV impact assessment survey found that 76% of men and 68% of women questioned said they would use an HIV self-test kit if it was available.

Case study: Using community health workers to increase HIV testing

In 2015, Malawi piloted the HIV Diagnostic Assistant (HDA), a cadre of community-based, non-professional health workers who work to encourage others from their communities to test for HIV. A study measuring the impact of the lay healthcare workers found their presence significantly increased the number of people testing for HIV, leading to an increase in HIV diagnoses. It also helped to increase testing for other STIs, such as syphilis.

The number of tests conducted during the intervention increased by around 35,500. Rises in testing were seen across all sex, age, and testing subgroups. Of the 7.4 million people tested for HIV in the post deployment period, 2.6 million (34%) were attributable to the intervention.
HIV prevention programmes in Malawi

In 2018, 38,000 people became newly infected with HIV in Malawi. Malawi’s National HIV and AIDS Strategic Plan 2015-2020 has various prevention policies and strategies for reducing new HIV infections. Some of these strategies are outlined below.

The country’s draft replacement HIV prevention strategy includes guidance on intervention packages for adolescents and young women and a number of key affected populations, such as sex workers and men who have sex with men, but does not mention people who use drugs and transgender people.

Condom availability and use

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

In 2017, it was estimated that 77 million male condoms were required to meet need in Malawi, 59 million of which needed to be supplied by the public sector. The Global Fund to Fight AIDS, Tuberculosis and Malaria procured the bulk of publically-provided male condoms that year, totalling around 70 million, which suggests a shortage of approximately 16 million.

Malawian men demonstrate one of the highest rates of condom use at last high-risk sex (with a non-marital, non-cohabiting partner) in Eastern and Southern Africa, at 76% (in 2016). However, condom use among Malawian women engaging in high-risk sex is significantly lower at 50%.

HIV education and approach to sex education

Raising awareness about how to prevent HIV is a key part of Malawi’s prevention strategy. This is covered in life skills education (LSE) for young people who are both in-school and out-of school. LSE subjects include the promotion of mutual faithfulness and the use of male and female condoms.

Before 2010, LSE for young people in school was irregular. By 2014, still the most recent data available in 2019, all students in primary and secondary schools were exposed to LSE. However, only 53,600 of a target of 150,000 young people out-of school had received LSE.

A study investigating LSE in four primary schools in the Zomba district, Malawi found the quality of lessons on offer are affected by a number of factors. These include poor teaching conditions, inaccessible language in teachers’ LSE guides, a lack of community support for sex education and teachers feeling that it is inappropriate to teach sexual education to 9 and 10-year-olds.

Radio shows are also used to raise awareness of HIV prevention in Malawi. For example, Health Policy Plus (HP+) is helping young people produce local weekly radio programs on HIV and family planning, which have the potential to reach around 3.3 million people. Around 200 adolescents (ages 14 to 19) have been trained to produce the shows and others run clubs that encourage other young people to listen. In the programme’s first three listening areas, after eight months, 60% of young people and parents surveyed were aware of the radio show and the government’s youth-friendly health services policy that the show’s presenters had discussed.
Prevention of mother-to-child transmission (PMTCT)

Malawi has demonstrated an unprecedented commitment to preventing transmission from mothers living with HIV 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 that all pregnant women living with HIV are offered antiretroviral treatment for life – irrespective of CD4 count.

The impact of this has been huge. Between 2011 and 2018, the proportion of women with HIV who were diagnosed went from 49% to 94%. As of 2018, more than 95% of pregnant women were tested for HIV and more than 95% of those testing positive were on treatment. In the same year, more than 95% of at-risk newborns were tested for HIV within the first six weeks of life (known as ‘early infant diagnosis’). In addition to protecting the health of mothers, this has enabled Malawi to avert an estimated 71,000 new infections among children between 2010 and 2018, equating to a more than 70% decline in new HIV infections among infants and children during that time period.

Clara was 25 when she noticed she had the same symptoms as her parents. But despite knowing she was living with 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 infection and a CD4 count of only 32.

Today, treatment has made her viral load undetectable and her oldest daughter, who also lives with HIV, is in good health. Her youngest daughter was born HIV-negative, as a result of improved access to PMTCT services. Clara now co-ordinates national activities for women living with HIV, offers advice, encourages testing and works to combat stigma and discrimination.

The 2015 Malawi Progress Report identifies early infant diagnosis as a priority for the national HIV and AIDS response. In 2016, around 31% of infants were diagnosed within the first two months of birth. However, this is a decline from 2014 levels when 37% received early infant diagnosis. Addressing the delay between birth and diagnosis is crucial for reducing infant mortality as a result of HIV infection.

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. Around 199,400 circumcisions were conducted in 2018, more than double the number carried out in 2014, and up from just 589 in 2008. However, this is still below the country’s stated target of 250,000.

Overall, the proportion of circumcised men in Malawi has increased marginally, from 21.5% in 2010 to 27.8% in 2016. 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.

Malawi has been successful in recruiting circumcised men from communities targeted for VMMC to encourage other men to be circumcised. A study among men living in three districts in southern Malawi found 90% of those undertaking VMMC had heard about it from a community mobiliser.65

Pre-exposure prophylaxis (PrEP)

Pre-exposure prophylaxis (PrEP) is not widely available in Malawi, although a clinical trial among HIV-positive pregnant adolescents and young women (ages 16-24) and an implementation study for at-risk adults and adolescents are underway. As a result of these programmes, as of 2019 between 100-300 people were using PrEP, a figure that is projected to increase to around 1,000 by the end of the year.

In May 2018, the Minister of Health Atupele Muluzi described the government’s approach to PrEP as one of “caution”, suggesting national roll-out is not imminent.66AVAC/PReP Watch (2019) ‘Ongoing and Planned PrEP Open Label, Demonstration and Implementation Projects, July 2019’ [pdf]

Antiretroviral treatment (ART) availability in Malawi

Malawi has a ‘test-and-treat’ strategy, which calls for all people living with HIV to begin antiretroviral treatment (ART) as soon as possible, irrespective of their CD4 count.67Malawi’s ART rollout has significantly expanded, with 78% of all adults living with HIV receiving ART in 2018, an increase of 28% since 2015.68In 2018, 89% of people diagnosed with HIV and on treatment were virally suppressed.69

In 2018, the percentage of men living with HIV who were on ART and virally suppressed was significantly lower than that of women (61%, compared to 79%). This is a direct result of the majority of Malawian men living with HIV being unaware of their HIV status and the success of Malawi’s PMTCT programme.
As a result of expanded access to treatment, AIDS-related deaths decreased by 55% between 2010 and 2018, with more Malawians living healthy lives on ART than ever before.\textsuperscript{70}

In 2015, just 40% of children (aged 0-14) living with HIV were on ART. To improve treatment coverage for this age group, in 2016 Malawi began piloting easier-to-take ARV formulations for infants and young children.\textsuperscript{71} This has had an impact, with 61% of HIV-positive children on ART as of 2018.\textsuperscript{72}

Despite these successes, treatment adherence levels in Malawi are lower than the rate of 85% recommended by the World Health Organization (WHO). In 2018, 65% of people living with HIV who had begun ART were still on it after 12 months, the lowest rate recorded since 2011.\textsuperscript{73} This is potentially due to the rapid expansion of the number of people on treatment. Adherence levels are lower among adolescents than adults. Recent research found that 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.\textsuperscript{74}

Drug resistance

Data on HIV drug resistance (HIVDR) in Malawi is limited, but globally prevalence of HIV drug resistance is now estimated to be 9%. In 2016, WHO estimated that pre-treatment resistance to NNRTIs (a type of antiretroviral treatment drug) had reached 11% in Southern Africa. Weak health systems, limited viral load monitoring, and low levels of adherence are key issues for Malawi in addressing drug resistance.

A 2017 study among HIV-positive pregnant women in Malawi found that, among those who were not virally suppressed, 35% tested positive for drug-resistant HIV, mainly due to NNRTIs.\textsuperscript{75}

To respond to emerging HIV drug resistance, in 2018 the Malawi Ministry of Health began changing its first-line treatment regimen to include dolutegravir, an antiretroviral that has fewer side effects than other ARVs.\textsuperscript{76}

Civil society’s role in Malawi

In Malawi, the law protects civil society, although government intimidation and policing sometimes impede activism and the work of civil society organisations (CSOs). Fears exist that the independence of CSOs will be further eroded by the restrictive 2017 NGO (Amendment) Bill.\textsuperscript{77}

Non-government organisations (NGOs) play a vital role in representing the most vulnerable in society in a number of areas, including health. NGOs have made strides in furthering human rights by raising awareness against negative cultural traditions and beliefs such as child marriage. However, NGOs working on issues relating to men who have sex with men and other people who are LGBTI have had less of an impact.\textsuperscript{78}

I wish for the day Malawians will accept us as we are. Being gay or lesbian in this country, you risk being excommunicated from church, fired from work, banished from home and even
getting arrested.

- James, a gay man from Malawi

HIV and tuberculosis (TB) in Malawi

HIV remains the most important risk factor for developing active TB in Malawi: in 2015/16, 47% of people with living with HIV who tested for TB were diagnosed as positive.80

TB is the leading cause of death among people living with HIV, accounting for around 3,700 AIDS-related deaths in 2018, around a quarter of all AIDS-related deaths that year.81 Despite high levels of TB/HIV co-infection, until the mid 2010s TB and HIV were traditionally treated under separate programmes. However, Malawi’s National TB Control Program (NTP) and the Malawian Ministry of Health are increasingly working together to integrate TB and HIV services.82

This strategy is having an impact. In 2017, 65% of people co-infected with HIV/TB were on treatment for both diseases, compared to 45% in 2015.83 However, only half of all people living with HIV were offered preventative TB treatment when they enrolled in HIV care.84

Barriers to the HIV response in Malawi

Cultural barriers

Malawi’s National HIV and AIDS Strategic Plan 2015-2020 recognises that certain cultural norms are a barrier to HIV prevention. 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.85

Multiple and concurrent sexual partners, which can increase the transmission of HIV, is a feature of Malawian culture. The 2015-2016 health survey found that 13% of men had two or more partners during the 12 months prior to the survey, compared to 1% of women.86 For married men, this figure increases to 16%.87

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.88

Legal barriers

Malawi has no legal restrictions that discriminate against people living with HIV entering and residing in the country. A long deliberated HIV Bill was rejected by parliament in December 2017, which would have made HIV testing and treatment mandatory for certain populations and sought to criminalise HIV exposure and transmission.89

However, punitive laws are hindering an effective response for key affected populations, particularly sex workers and men who have sex with men. In Malawi, same-sex sexual relations are illegal,
punishable with up to 14 years in prison. Although a moratorium on arrests and prosecutions was issued in 2012, something the Malawi High Court later ordered to be overturned, pending judicial review by the Constitutional Court.

Stigma and violence experienced by key populations, linked closely to their criminal status under Malawian law, often prevents these groups from accessing HIV testing, prevention and treatment services. For example, in a 2016 survey of Malawian men who have sex with men, 17.5% reported being afraid to seek healthcare of any kind. A report by Human Rights Watch in which 45 lesbian, gay, bisexual and transgender (LGBT) people were interviewed found evidence of routine discrimination and stigma in healthcare settings, coupled with high levels of abuse and violence in everyday life, meant many LGBT people did not seek HIV services and treatment.

HIV-related stigma is also an issue. In Malawi’s 2015/16 national HIV impact assessment survey, 11% of adults held discriminatory attitudes towards people living with HIV. Those with low levels of education were significantly more likely to hold such attitudes.

Data issues

While Malawi’s current national HIV reporting system is robust, until 2018 it produced limited age-and sex-disaggregated data. This has impeded the country’s response as it means there is a lack of information about which population groups are being reached with services effectively and which populations are currently under-served. In 2018, the US President’s Emergency Plan for AIDS Relief (PEPFAR) helped to improve data collection, and the Ministry of Health now has accesses to near real-time age-, sex-, and region-disaggregated data. However, as of 2018 no national data on people who inject drugs and very little on transgender people was available.

Structural and resource barriers

Gains made in addressing the HIV epidemic in Malawi are threatened by key weaknesses in the country’s overall health system. Malawi has one of the most severe health workforce crises in Africa, with the lowest physician-to-population ratio at 2:100,000 and second lowest nurse to population ratio at 28:100,000.

In 2017, of the 719 functioning health facilities across the country, 81% were in rural areas. Rural clinics are unevenly distributed, forcing many people to walk more than 10km to access services. In addition, 40% of public health facilities had no regular electricity supply, only half have running water, and two thirds do not have toilet facilities.

Another key issue is a lack of adequate infrastructure to meet the needs of HIV testing services as well other HIV treatment services. In 2016, 11% of facilities reported a stock-out of HIV testing kits. Laboratory systems are also weak and cannot efficiently support viral load testing.

In addition, although the Ministry of Health has sanctioned the use of community-based structures to implement and deliver HIV services interventions, resources for community-based organisations are scare.

Funding for HIV in Malawi

In 2017, Malawi received more than 95% of funding for its HIV response from international donors, the
biggest of which are the Global Fund to Fight AIDS, Tuberculosis and Malaria and PEPFAR. There is concern about how sustainable Malawi’s HIV response will be should international donors continue to reduce funds.

As in most other countries, there are also issues around how the country’s HIV budget is allocated. For example, under the 2017 Global Fund spending allocation, US$214 million was provided for ARVs and US$71.7 million for other HIV care and treatment services, making HIV treatment and care the biggest expenditure. In contrast, just US$29.8 million was allocated for HIV prevention among key populations and US$15.4 million for HIV testing. While it is unclear just how much of the Malawi’s total HIV budget is allocated to prevention, civil society organisations report that the proportion has been reducing in recent years.

Issues of corruption within the government have severely affected overseas development aid provision. Sometimes, funds are not available or inconsistently disbursed, impeding the rollout of HIV prevention programmes and the provision of treatment.

The future of HIV in Malawi

Malawi has made impressive progress in responding to its HIV epidemic, particularly PMTCT which has dramatically reduced infections in new-born babies.

In its 2015-2020 HIV strategy, NAC states that Malawi will aim to meet the UNAIDS 90-90-90 treatment targets. However, a number of gaps in the country’s response may lessen its ability to reach these goals. In particular, reaching the first target on testing, especially among men and young people, represents the country’s greatest challenge. In addition, an increase in spending on HIV prevention in needed to fund a number of important initiatives, such as effective behaviour change programmes for young people to increase HIV prevention knowledge and condom use.

Malawi faces challenges with regard to ensuring adequate funding for both its HIV response and its healthcare system in general, a challenge shared by many countries across sub-Saharan Africa. A severe shortage of health workers, poorly-equipped healthcare facilities and laboratories unable to carry out viral load testing continue to restrict progress.

Greater effort is also required to support sex workers, LGBTI people and men who have sex with men via comprehensive prevention programmes and campaigns that challenge stigma and discrimination. Unless these groups’ needs are properly addressed, significant gaps in Malawi’s HIV response will remain.

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