
# HIV Response Sustainability Roadmap for Malawi

**Final Draft**



**January 2025**

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**List of Abbreviations and Acronyms**

| | |
|---|---|
| AIDS | Acquired Immuno-deficiency Syndrome |
| ART | Antiretroviral therapy |
| AGYW | Adolescent Girls and Young Women |
| CLHIV | Children Living with HIV |
| CMA | Community Midwifery Assistants |
| COVID | Corona Virus Disease |
| CSO | Civil Society Organization |
| DHA | Department of HIV and AIDS, and Viral Hepatitis |
| DHMIS | District Health Management Information Systems |
| DPPD | Directorate of Planning and Policy Development |
| DSD | Differentiated Service Delivery |
| eHIN | Electronic Health Information Network |
| eMTCT | Elimination of Mother to Child Transmission |
| FSW | Female Sex Workers |
| GBV | Gender-Based Violence |
| GDP | Gross Domestic Product |
| HIV | Human Immune Virus |
| HMIS | Health Management Information System |
| HRH | Human Resources for Health |
| HSSP | Health Sector Strategic Plan |
| KP | Key Population |
| M&E | Monitoring and Evaluation |
| MoH | Ministry of Health |
| MSM | men who have sex with men |
| NAC | National AIDS Commission |
| NASA | National AIDS Spending Assessment |
| NGO | Non-governmental Organization |
| NCD | Non-communicable Disease |
| NHA | National Health Accounts |
| NSP | National Strategic Plan for HIV and AIDS |
| OPC | Office of the President and Cabinet |
| LMIS | Logistics Management Information System |
| ORT | Other Recurrent Transaction |
| OVC | Orphans and Other Vulnerable Children |
| ABYM | among adolescent boys and young men |
| PEP | Post exposure prophylaxis |
| PLHIV | People living with HIV |
| PMTCT | Prevention of Mother to Child Transmission |
| PPP | Public-Private Partnerships |
| PrEP | Pre-exposure Prophylaxis |
| PFM | Public Financial Management |
| PWIUD | People Who Inject and Use Drugs |
| TB | Tuberculosis |

| | |
|---|---|
| THE | Total Health Expenditure |
| TMA | Total Market Approach |
| UHC | Universal Health Coverage |
| U=U | Undetectable=Untransmutable |
| VMMC | Voluntary Medical Male Circumcision |
| YFHS | Youth Friendly Health Services |

## Executive Summary

### *Introduction*

Malawi has made remarkable strides in its fight against HIV/AIDS, preventing over 1 million new infections since 2002 and reducing adult HIV incidence to 0.1% by 2023. These achievements, including early attainment of the 95-95-95 UNAIDS Fast Track Targets and the 95% ART coverage for HIV-infected pregnant women, underscore the country's position amongst global leaders in the HIV response. However, this progress has been heavily dependent on donor funding, which accounted for 78% of the national HIV response in 2022, with only 22% financed domestically, largely for health worker salaries.

As donor fatigue sets in and global HIV financing priorities evolve, Malawi faces a pivotal challenge: transitioning from donor reliance to increased domestic financing, without undermining access, quality, and efficiency of its HIV response. Ineffective management of this transition risks reversing hard-won gains, with severe implications for public health and development. This HIV Response Sustainability Roadmap provides a strategic framework to mitigate these risks, strengthen systemic resilience, and secure Malawi's progress, while ensuring a sustainable, equitable, and integrated HIV response, amid shifting financial landscapes.

### *Methodology for the Roadmap (PART A)*

The roadmap was developed through a multi-stakeholder participatory and inclusive process, led by the Ministry of Health. A taskforce comprising bilateral and multilateral partners, civil society, key population groups, and private sector actors provided technical guidance and coordination of the process. A Steering Committee, including representatives from the Ministries of Health, Finance, Education, Gender, Youth and Local Government, oversaw the process. The technical process involved a review of legal, policy, and strategic frameworks, including the HIV Prevention and Management Act (2018) and the National Strategic Plan for HIV and AIDS (2023-2027), among others. A national HIV response assessment and co-development workshop; stakeholder consultations, including with District Councils and Key Population Networks; and, a validation workshop, informed the development process.

### *HIV Response Sustainability Vision and Change Framework*

The vision of the HIV/AIDS Sustainability roadmap is ***"a healthy and prosperous nation free from HIV and AIDS,"*** with four core goals namely: 1) Increased domestic funding and improved efficiency in HIV resource utilization; 2) Integrated HIV services within broader health systems for improved efficiency, access and quality of service delivery; 3) Strengthened health systems to ensure equitable, effective and efficient delivery of health and HIV services; and 4) Expanded community-led interventions to reach key and vulnerable populations. Malawi will sustain and build on the significant gains made in the fight against HIV and AIDS amid diminishing donor support and shifting priorities, by fostering innovative, inclusive, and resilient strategies that integrate domestic financing and empower communities. The roadmap has five sustainability pillars namely; political leadership and governance, enabling legal and policy environment, sustainable and equitable financing, services and solution, and strengthening health systems. The following summary highlights the change framework for the roadmap.

*Political Leadership and Governance:*

Malawi's governance framework faces persistent challenges that threaten the sustainability of its HIV response, particularly in the context of donor fatigue and the potential withdrawal of external funding. With over 95% of HIV financing historically sourced from donors, Malawi's ability to maintain effective coordination, transparency, and accountability is at risk as donors reduce their

contributions. Weak inter-ministerial coordination, limited district-level capacity, and slow decentralization exacerbate these vulnerabilities, hindering the integration of HIV efforts into broader health policies and resulting in fragmented service delivery. Additionally, the proliferation of uncoordinated civil society organizations (CSOs), often competing for limited resources, undermines efforts to streamline service delivery and optimize resource utilization. The lack of robust governance structures capable of independently managing the HIV response threatens long-term efficiency and equity as donor reliance diminishes.

To address these structural inefficiencies, the roadmap prioritizes strengthening governance mechanisms to create a resilient and self-reliant HIV response. Short-term actions focus on leveraging political leadership to enforce critical accountability mechanisms, such as the 2% other recurrent transactions (ORT) HIV allocation, and aligning governance structures to ensure a unified approach. Medium-term strategies aim to institutionalize financial oversight frameworks, improving transparency and efficiency in resource allocation at both national and district levels. Long-term efforts emphasize empowering local councils with fiscal and operational autonomy, equipping them with the capacity to manage HIV services sustainably.

*Enabling Legal and Policy Environment:*

Malawi has enacted progressive legislation, including the HIV Prevention and Management Act (2018) and the Gender Equality Act (2013). However, punitive laws criminalizing same-sex relationships, aspects of sex work, and drug use continue to create significant barriers for key populations, while weak enforcement of gender equality laws exacerbates inequalities and vulnerability of some sub-population groups. Without sustained external advocacy and financial support, the government may deprioritize or hesitate to implement politically sensitive reforms that are essential for sustaining progress in HIV prevention and treatment. This creates a sustainability issue where inadequate legal protection and policies risk reversing gains, particularly for marginalized groups.

To address these challenges, the roadmap emphasizes leveraging donor influence during the transition period to secure commitments to legal reforms and foster domestic accountability. Short-term priorities include advocating for the repeal of punitive laws, through high-level engagements with government and civil society and integrating stigma-free pre-service training for healthcare workers. Medium-term efforts focus on expanding gender-based violence focused interventions and disseminating enabling laws at the grassroots level, to empower communities. Long-term strategies aim to harmonize conflicting laws, ensuring a cohesive legal framework that promotes equity and sustainability. Collectively, these reforms will build a policy environment that not only sustains HIV progress, but also strengthens local ownership as donor influence diminishes.

*Sustainable and Equitable Financing:*

Malawi's over-reliance on external funding for its HIV response, coupled with persistently low GDP per capita and limited fiscal space, present a formidable sustainability challenge. Government per capita annual spending on health remains critically low, reflecting the country's constrained fiscal capacity. Accommodating donor-supported interventions—particularly in areas such as ART, prevention, and healthcare infrastructure—will remain an immense challenge without significant, sustained economic growth. Domestic allocations to health, at approximately 10% of national budget, consistently fall short of the Abuja Declaration target of at least 15%, underscoring the health budget prioritization challenge in the national budget. Even achieving the target allocation would provide limited relief in the face of donor support withdrawal, given the low absolute levels of domestic revenue. These structural constraints intensify the system's vulnerability to external financial shocks and limit the government's ability to absorb donor-funded

programs into domestic systems. Furthermore, competing demands for scarce public resources, such as education and infrastructure, add pressure, leaving the HIV response heavily reliant on external funding to sustain its progress.

The roadmap outlines a comprehensive approach to address these challenges, emphasizing both revenue generation and resource allocation and utilization efficiency. Short-term priorities include enforcing the 2% ORT HIV allocation and implementing innovative financing mechanisms, such as health-specific taxes, earmarked revenues, and public-private partnerships (PPPs). These efforts are designed to bridge immediate funding gaps, while stimulating domestic contributions. Medium-term strategies focus on integrating donor funds into the national health financing architecture under the "One Plan, One Budget, One Report" principle, to reduce fragmentation and improve coherence. Long-term measures aim at expanding fiscal space by strengthening tax collection systems, institutionalizing co-financing agreements, and enhancing public financial management, to ensure efficient allocation and utilization of resources. By addressing inefficiencies, diversifying funding streams, and prioritizing high-impact investments, these strategies aim to reduce Malawi's dependency on external funding and establish a resilient financial foundation, capable of sustaining the HIV response in the face of economic and donor transitions.

*Services and Solutions:*

While Malawi has made substantial progress in scaling up ART coverage and achieving high levels of viral suppression, significant challenges persist in ensuring sustainable HIV treatment and expanding prevention programs. Key populations and rural communities face limited access to tailored interventions, while structural barriers like stigma, discrimination, and poor infrastructure exacerbate inequities. Interventions addressing these limitations have been developed and implemented beyond the mainstream public service delivery system. The growing number of people living with HIV (PLHIV) on lifelong ART creates sustainability pressures, as maintaining uninterrupted treatment and care for an aging population, with rising non-communicable disease (NCD) burdens, requires integrated and resilient service delivery systems. Additionally, prevention interventions, such as PrEP, voluntary medical male circumcision (VMMC), and condom distribution, almost fully rely on external financing and are inadequately integrated into the broader health systems.

To address these challenges, the roadmap emphasizes a strategic shift towards integrating HIV services with broader health platforms, while strengthening community-led interventions. Short-term strategies include scaling up differentiated service delivery (DSD) models, such as multi-month ART dispensing, and expanding access to combination prevention tools like PrEP, VMMC, and the Total Market Approach (TMA) for condoms. These measures aim at enhancing access and retention, while optimizing resource use. Medium-term actions focus on integrating community-led programs with facility-based care, improving linkages between community and clinical systems, and addressing systemic barriers to service delivery, including stigma and discrimination, and inadequate infrastructure. Long-term efforts prioritize integrating HIV services with NCD and maternal and child health (MCH) platforms to create holistic, sustainable systems, capable of adapting to changing epidemiological dynamics. By strengthening coordination between community and facility-based services and embedding HIV interventions into national health strategies, these solutions seek to propagate treatment gains and ensure prevention coverage in the face of declining donor support.

*Strengthening Health Systems:*

One of the hallmarks of Malawi's globally recognized HIV and AIDS program is the robust systems that underpin its success. These include systems for planning, monitoring, evaluation, and learning (PMEL); financial management; procurement, supply chain management and logistics; and, service delivery leadership and oversight. These systems have been largely enabled and sustained by donor financial and technical support, creating parallel mechanisms that operate more effectively than the broader health system. While the integration of HIV and AIDS systems into mainstream health systems is a national priority, significant challenges related to feasibility, capacity, and political economy must be addressed to avoid undermining access, quality, and efficiency.

To address these challenges, the roadmap outlines a phased, systems-focused approach that prioritizes strengthening workforce and health system equipment and infrastructure capacity, while ensuring effective integration. Short-term strategies emphasize transitioning donor-supported health workers to government payrolls, aligning remuneration across funding sources to promote equity, and establishing a Logistics Management Unit (LMU) to govern integrated supply chain systems. Enhancing the functionality of the Central Medical Stores Trust (CMST) and ensuring consistent availability of essential medicines are also critical priorities to maintain service delivery continuity.

Medium-term strategies focus on leveraging digital health technologies to improve efficiency and integration. This includes scaling up interoperable health information systems (HIS) to facilitate data-driven decision-making, reduce duplication, and integrate HIV/AIDS services into broader health platforms. Investments in community-level digital solutions, such as the Integrated Community Health Information System (iCHIS), aim at enhancing service delivery, monitoring, and patient outcomes. Long-term strategies focus on the development of resilient health infrastructure, capable of supporting integrated, high-quality services, including HIV, maternal and child health, and non-communicable diseases. Strengthening supply chain infrastructure through regional hubs and digital tracking systems will improve efficiency and reduce wastage.

***Conclusion***

The HIV Response Sustainability Roadmap provides a strategic blueprint for sustaining Malawi's HIV progress, while reducing donor dependency. By focusing on strengthened political leadership, sustainable financing, integrated service delivery, and resilient health systems, the roadmap sets a clear path for Malawi to maintain its leadership in HIV response, while aligning with broader health reforms under the HSSP III. Achieving these goals will require continued collaboration among government agencies, development partners, civil society, the private sector and community structures. If fully implemented, the roadmap will ensure a sustainable, resilient health system and contribute to Malawi's goal of ending AIDS as a public health threat by 2030.

## 1. Introduction

Over the past two decades, Malawi has made significant progress in the fight against HIV/AIDS. Through comprehensive national efforts and strong support from global partners and Civil Society organizations (CSO), the country has significantly reduced new HIV infections and AIDS-related deaths, improving health outcomes for people living with HIV (PLHIV).

ART coverage among HIV infected pregnant women for PMTCT was estimated at 95% in 2023. Driven by the high levels of population viral suppression, HIV incidence in adults (15-49 years) has declined to 0.1% (1 new infection in 1,000 adults in 2023). Before this background of significantly decreased incidence, primary prevention interventions, offered as combination prevention packages, have been targeted geographically and for population groups with elevated vulnerability and risk to maximize impact and cost-effectiveness (sex workers, men who have sex with men (MSM), transgender, people who inject and use drugs (PWIUD) and adolescents and young people).

Malawi's HIV response has relied heavily on international development partners including the Global Fund and United States President's Emergency Plan for AIDS Relief (PEPFAR), which accounted for 78% of the national HIV response in 2022, with only 22% financed domestically, largely for health worker salaries[1] Meanwhile, global trends show decreasing donor support for HIV programs and health, overall. This highlights the urgent need to boost local health investments.

This HIV Sustainability Roadmap defines the framework for actionable strategies to sustain and build upon achievements in HIV prevention, treatment, and care. It addresses the critical dependence on unpredictable donor funding and persistent gaps in domestic financing. The roadmap emphasizes the importance of strong political leadership, enhancing domestic resource mobilization, simplification and improved efficiency from integrating HIV services into the essential services, and ensuring efficient program management across government and development partners.

Together, these efforts provide a comprehensive plan to secure the health and well-being of future generations. Crucially, the roadmap aligns with the sustainability objectives outlined in the Health Sector Strategic Plan III (HSSP III: 2023-2030) and is bolstered by the 11 transformative HSSP III reforms currently underway, positioning Malawi to lead a robust and resilient HIV response well into the future.

## 2. Methodology

### 2.1 Coordination and Management Structure

The development of the HIV Response Sustainability Roadmap began with the establishment of a robust coordination and oversight structure to guide the process. A multi-sectoral taskforce, comprising of the Ministry of Health [MoH- Planning and Policy Development Directorate (DPPD); Department of HIV and AIDS (DHA)]; National AIDS Commission (NAC); Multi-lateral partners; Bi-lateral partners; Network for PLHIV; Key Population (KP) networks; Private Sector and, Network of CSOs, was set up to manage the technical aspects of the process. The DPPD served as the secretariat, and the taskforce was co-chaired by the DPPD, DHA and NAC.

[1] NASA 2024, MoH

To ensure strategic direction and policy oversight, an inter-ministerial Steering Committee was established, comprising representatives from the Ministries of Health, Finance, Education, Local Government, Youth and Gender. This committee was responsible for process oversight, policy and strategic direction, as well as approving the final roadmap.

### 2.2 Technical Process

The methodology for developing the HIV Response Sustainability Roadmap Part A was guided by the 2024 UNAIDS HIV Response Sustainability Roadmap Part A Companion Guide, which clearly outlines the steps to be undertaken by countries when developing HIV Sustainability Roadmaps. This process involved a review of existing legal, policy, and strategic frameworks, including the HIV Prevention and Management Act (2018), other relevant legal instruments, Health Sector Policy (2018), the HSSP III, HIV and AIDS Policy (2022), National HIV and AIDS Strategic Plan (NSP- 2023-2027), and the HIV Prevention Framework (2023-2030), among others, to identify gaps and areas requiring strengthening for long-term sustainability. The five sustainability domains, namely Political Leadership and Governance; Enabling Legal and Policy Environment; Sustainable and Equitable Financing; Services and Solutions; and, Systems were the main thematic areas that guided the information gathering process. This was then analyzed into the following sub-themes under each of the domains: the current status, achievements, challenges and gaps, strategies in place to address the challenges and gaps, and opportunities for sustainability.

The process officially commenced in June 2024 with a taskforce meeting, where the scope of work, timelines, and the need for technical assistance were discussed and agreed upon. In October 2024, two consultants— Mr. Davie Kalomba (Team Lead and Biomedical Consultant) and Dr. Dominic Nkhoma (Health Economist/Planner) were engaged to facilitate and drive the process forward. Another task force meeting was held in October 2024, which deliberated on the national vision, high-level outcomes, key challenges, barriers and priorities.

The first stakeholder engagement was facilitated through the HIV response assessment, using the Joint United Nations Program on HIV/AIDS (UNAIDS) Sustainability Assessment Tool v1.5. This was conducted in November 2024 and participants were drawn from the key constituencies outlined earlier. This also served as a co-development workshop with implementers, where prioritized high-level outcomes and pathways to address the challenges, barriers and risks were explored, focusing on integrating HIV services with broader health systems, reducing donor dependency, and enhancing domestic resource allocation and utilization. Another stakeholder engagement meeting, involving district councils and key population organizations, was held in December 2024 and participants were provided an opportunity to identify challenges, barriers, opportunities, and pathways to address them at implementation level.

Following these engagements and the assessment, a draft HIV Response Sustainability Roadmap was developed and shared with all stakeholders for their review. A stakeholder validation meeting was held in January 2025, after which the roadmap was finalized for endorsement by the Steering Committee, and subsequent approval by the MoH Senior Management Team.

## 3. The Global and Country Context

### 3.1 Economic Situation and Health Financing

Over the past decade, the global economy has faced a series of challenges. The global economy grew at an average rate of **2.7%** per year between 2010 and 2019, with fluctuations caused by regional recessions and declining trade volumes (WorldBank, 2023). The 2008 financial crisis, prolonged economic stagnation in various regions, and most recently, the COVID-19 pandemic, have led to budget constraints and fiscal austerity in many countries. As a result, governments have had to make difficult spending decisions including on Oversees Development Assistance (ODA) on health, which in fact, has been on the decline (only masked by the COVID 19 financing since 2020)[2].

Donor financing continues to play a crucial role in the global HIV response, with major contributors including the Global Fund, the PEPFAR, and the UNAIDS. Collectively, these organizations have channelled billions of dollars to support HIV prevention, treatment, and care across low- and middle-income countries. For instance, between 2010 and 2020, PEPFAR alone contributed approximately **USD100 billion** to combat HIV/AIDS globally[3]. The evidence of plateauing development assistance suggests need for countries with heavy donor dependence on health and HIV/AIDS financing to rethink the sustainability of donor financed interventions.

Malawi's economy has performed dismally since 2011/12. The Gross Domestic Product (GDP) per capita in 2023 was USD554, and according to the World Bank, 70% of the population lived on less than USD2.25[4]. The economic growth is inadequate to create the much-needed fiscal space. In 2023, the economy grew by a modest **1.5%**. As a result of low GDP per capita, Malawi's ability to finance health has been limited, with per capita total health expenditure (THE) remaining under USD40 since 2010, causing serious health financing gaps across Health Sector Strategic Plans since 2011[5]. As a consequence, Malawi's health sector continues to rely heavily on off-budget development assistance, with donor funds accounting for approximately 54.5% of THE. Coordination and governance of these investments has been challenging and resulted in serious fragmentation with 166 financing sources and 265 implementing partners.[6] This has led to an ongoing reform of "One Plan, One Budget and One Report" that aims to achieve a sector wide focus taking into account the need to strength public financial management (PFM) systems at all levels.



[2] https://data.one.org/data-dives/the-troubling-hidden-trend-in-health-aid/
[3] https://www.hiv.gov/federal-response/pepfar-global-aids/pepfar
[4] World Bank ttps://databankfiles.worldbank.org/public/ddpext_download/poverty/987B9C90-CB9F-4D93-AE8C-750588BF00QA/current/Global_POVEQ_MWI.pdf
[5] https://dms.hiv.health.gov.mw/dataset/malawi-health-sector-strategic-plan-iii-hssp-iii
[6] Sharma L, Heung S, Twea P, Yoon I, Nyondo J, Laviwa D, Kasinje K, Connolly E, Nkhoma D, Chindamba M, Tebeje MT, Brady E, Gunda A, Chirwa E, Manthalu G. Donor coordination to support universal health coverage in Malawi. Health Policy Plan. 2024 Jan 23;39(Supplement_1): i118-i124. doi: 10.1093/heapol/czad102. PMID: 38253443; PMCID: PMC10803193.

*Table 1: Key health financing indicators (2022)*

| **General indicators** | |
|---|---|
| Population | 20.4 million |
| GDP per capita (constant 2015 US$) | $554.20 |
| Income classification | Low |
| **Health financing** | **Average 2017–2022** |
| Per capita total expenditure on health (US$) | $39.90 |
| Government per capita THE (US$) | $9.60 |
| THE as % of gross domestic product | 8.80% |
| Government expenditure on health as % of THE | 24.10% |
| Donor expenditure on health as % of THE | 54.50% |
| Government THE as % of total government expenditure | 8.40% |
| Total private health insurance spending as % of THE | 9.10% |
| OOP on health as % of THE | 11.90% |
| Total expenditure on primary healthcare as % of THE | 39.70% |
| Percentage of THE pooled under government financing scheme | 40.30% |
| Percentage of THE managed by government agents | 39.40% |
| Percentage of THE spent on HIV/AIDS | 40.00% |

*Notes*: THE denotes total health expenditure; OOP denotes out-of-pocket. *Source*: National Health Accounts (2022)

### 3.2 Implications for Future Financing of HIV/AIDS

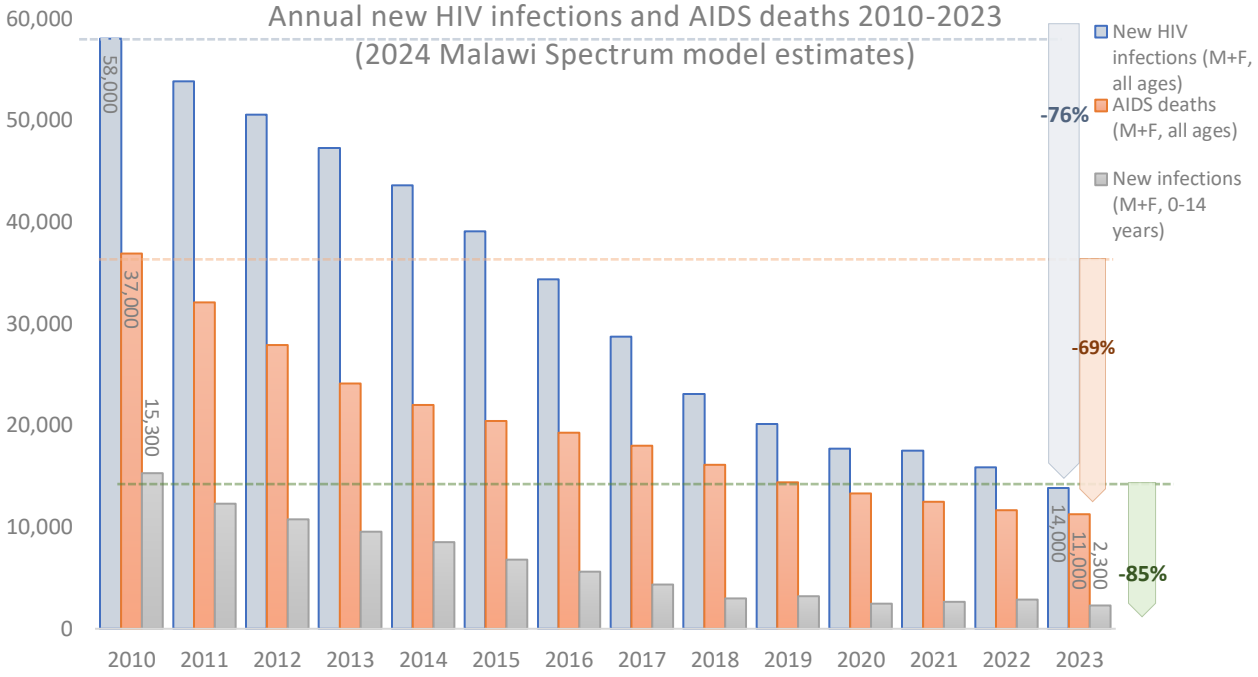
In its 2024 report "The Urgency of Now: AIDS at a Crossroads", the UNAIDS has warned that without increased investments, the progress made over the past two decades could be undermined, with the number of people who will need life-long support potentially rising to 46 million (compared to 39.9 million in 2023) by 2030, if current funding gaps are not addressed.[7] Malawi's economic fragility underscores the critical need for a coordinated approach to address the financial sustainability of its HIV response. Additionally, the Global AIDS Strategy for 2021-2026 emphasizes the importance of political leadership and the need for countries to take ownership of their HIV responses to reduce dependency on external donors. This approach not only ensures a more sustainable HIV response, but also strengthens the whole health system, contributing to broader health goals and Universal Health Coverage (UHC).

### 3.3 HIV/AIDS Context

Malawi has achieved substantial progress in its HIV response. Between 2010 and 2023, the annual number of new HIV infections and AIDS deaths declined by **76%** and **69%**, respectively. Child infections declined by **85%** from **15,300** to **2,300** over the same period (See Figure 1).

[7]https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2024/july/20240722_global-aids-update

*Figure 1: Annual new HIV infections and AIDS deaths 2010-2023*




The HIV program has prevented an estimated 1,051,000 HIV infections between 2002 and 2023,; 63% of this impact came from adult antiretroviral therapy (ART), 17% from condoms, 12% from prevention of mother to child transmission (PMTCT), 6% from voluntary medical male circumcision (VMMC), 2% from child ART and <1% from pre-exposure prophylaxis (PrEP).[8] ART and PMTCT coverage have stabilized at very high levels over the last years.[9]

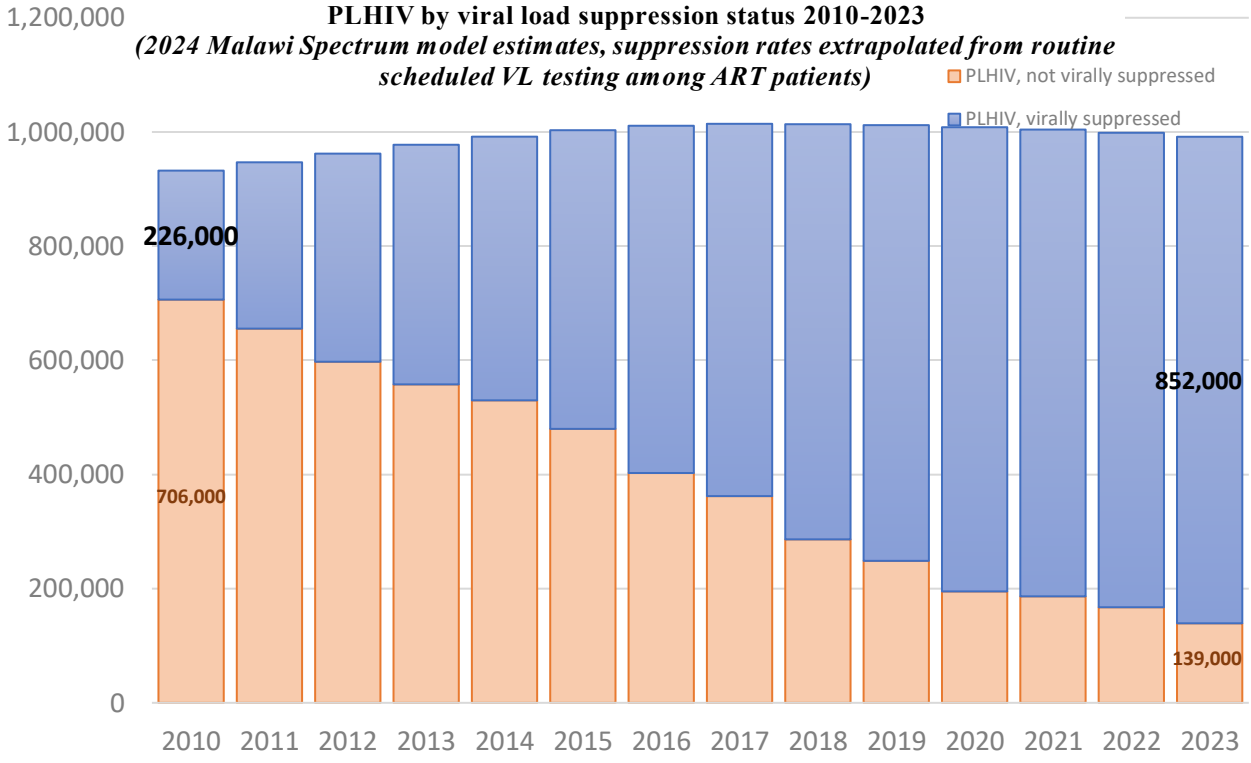
The drop in new infections was largely driven by the dramatic decline of untreated PLHIV with unsuppressed viral load. This group is the source for all new infections, both sexually and vertically (from mother-to-child). Due to successful ART scale-up and treatment regimen optimization, the number of unsuppressed PLHIV declined from **706,000 in 2010 to 139,000 in 2023** (See Figure 2).



[8] 2024 Malawi Goals Model analysis for impact and cost-effectiveness of HIV interventions. MOH, NAC, Avenir Health

[9] 2024 Malawi Spectrum model estimates for the year 2023. MOH, NAC, UNAIDS

*Figure 2: PLHIV by viral load suppression status 2010-2023*




A 2023 modeling study of HIV incidence trends showed that the transmission rate from untreated adults has remained stable throughout 2000-2021.[10] Throughout this period, **untreated men were 3.9-times** more likely to transmit HIV than untreated women. There was no indication that other prevention measures reduced transmission rates during this period.

In 2023, HIV incidence in the general population was **0.11%** (men and women, 15-49 years). Young women (**20-29 years)** were estimated to have the highest incidence (**0.2%**) in 2023, albeit at much reduced overall levels compared with previous years. New HIV infections have continued to decline from **14,500 in 2023 to 13,000 in 2024**. In 2024, **7,300 (56%)** of new infections were among women 15+ years, **4,000 (31%)** among men 15+ years and **1,700 (13%)** among children 0-14 years from vertical transmission. Adolescent Girls and Young Women (AGYW) 15-24 years accounted for **3,500 (27%)** of all new infections. Although relatively small, key and vulnerable populations continue to be disproportionately affected by HIV. KP include sex workers, MSM, PWUID and transgender. Incidence remained higher in female sex workers (FSW) (7.7%), MSM (0.5%), trans gender (0.5%), and PWIUD at 1.1%, respectively.

The country has also made notable strides in reducing mother-to-child transmission, achieving rates **below 2.1% at six weeks and 6.5%** at the end of the breastfeeding period, which is a significant milestone in the national effort to eliminate paediatric HIV. These achievements have facilitated early attainment of the UNAIDS Fast Track targets: 95% of PLHIV knew their status;

[10] Wolock et al. 2023 https://doi.org/10.1101/2023.02.02.23285334

95% of those diagnosed with HIV were on treatment; and 95% of those on treatment were virally suppressed by 2023.

Despite the significant gains registered in the response to the pandemic, HIV was estimated to remain the leading cause of disability adjusted life-years lost in 2021[11]. As Malawi strives to sustain its achievements, there is an urgent need for a strategic approach that ensures the long-term sustainability of HIV programs and services.

**Adult (15+ years) HIV prevalence was estimated at 7.7%** for 2023.[12] Prevalence remained higher among women (**9.2%**) than in men (**6.0%**). About **1 million people were living with HIV**. HIV prevalence is closely correlated with population density in Malawi. In 2024, two-thirds of all PLHIV and all new HIV infections were located in the densely populated southern districts (Blantyre, Chiradzulu, Mulanje, Phalombe, Mangochi, Thyolo, Zomba, Chikwawa) and in the rapidly growing capital city of Lilongwe.

While treatment cascade targets have been met for adults, child treatment indicators remain unsatisfactory. By the end of 2023, an estimated 87% of 51,000 children living with HIV (CLHIV) had been diagnosed, 83% of whom were on ART and 84% of children on ART had achieved VL suppression. This implies a treatment gap of about 20,000 CLHIV who were not virally suppressed. The key programmatic challenges for child treatment are related to diagnosis (case-finding) and medication adherence. Due to the rapid decline in new child infections over the last 15 years, over half of the estimated 51,000 CLHIV in 2023 were 10-14 years old. Most of these were infected more than a decade ago during the breastfeeding period. Disease progression is much slower in such children compared with perinatally infected infants.

Among the long-term survivors, many are thought to have grown up with few clinical symptoms, making identification through facility-based testing very challenging. The 2020 transition to dolutegravir-based regimens for all children has resulted in a marked improvement of VL suppression rates from around 65% to 85% due to the more "forgiving" nature of this regimen. However, unavailability of a single-pill once-daily formulation for children under 30kg, coupled with weak care-giver support and a challenging home environment continues to pose significant challenges for daily medication adherence for many of these children.

Malawi's HIV response comprises several critical components, each playing a vital role in combating the pandemic:

- **Treatment and Care**: Malawi has significantly scaled up its antiretroviral therapy (ART) program, achieving the **95%** coverage among diagnosed PLHIV by 2023. Adherence initiatives and community-based support systems have further contributed to maintaining high levels of treatment adherence and viral suppression. Differentiated service delivery models have also facilitated improved and sustained access to treatment and monitoring of outcomes.
- **Integration with Broader Health Systems:** Efforts to integrate HIV services with maternal and reproductive health, tuberculosis (TB) care, and non-communicable disease

[11] Global Burden of Disease 2021. Institute for Health Metrics and Evaluation 2024. https://vizhub.healthdata.org/gbd-compare/

[12] 2024 Malawi Spectrum and Naomi model estimates. MOH, NAC, UNAIDS

(NCD) management have improved service delivery, ensuring that PLHIV receive holistic and continuous care.

- **Strengthening Health and Community Systems:** There have been ongoing efforts to improve the human resources development, recruitment, deployment and retention of health workers, including multi-skilling of various cadres to address HIV service needs. The MoH and partners have over the years worked together to improve governance and operational frameworks and information management systems to improve efficiency and management of the procurement and supply chain management system for the health sector.

  Infrastructure improvement, procurement and routine maintenance of equipment have been important elements of quality of care and access to services improvement efforts. The MoH has also progressively invested in innovative technologies to improve efficiency in laboratory diagnosis and HIV sample, as well as essential health commodities and products transportation. Digital health technology improvements have also been incrementally improved to enhance disease surveillance and program performance monitoring.

  Community-led organizations and peer networks continued to play a crucial role in reaching marginalized groups, raising awareness, and providing support for treatment adherence. These groups are vital in addressing stigma and discrimination, which remain significant barriers to accessing HIV services.

- **Strengthening Social Enablers:** Apart from the rights and freedoms guaranteed by the Malawi Constitution, there are a number of other legislative instruments (discussed in detail under section 5.2 below) that support attainment of equitable access to HIV and related services, access to redress for those whose rights have been infringed and creation of stigma free health care delivery environments. These are also complemented by sector specific policy and strategic frameworks, including for social protection (also discussed in detail under section 5.2 below), that support the general, key and vulnerable population groups. There are also a number of community structures that aim at protecting the rights of children, women, girls, including those living with HIV. They also service as immediate points of call for referral and linkages to appropriate services.

Malawi's HIV response faces several critical challenges that threaten the sustainability of current programs and these include:

- **Funding and Resource Constraints**: The country remains heavily dependent on external donor funding. The 2024 Global AIDS Monitoring Report for Malawi showed that in 2023, about 98% of total AIDS spending was contributed by PEPFAR (62%) and the Global Fund (35%) alone, underscoring the significant challenge to sustaining the HIV response.
- **Service Delivery and Health System Barriers**: Limited workforce capacity (in terms of numbers and skills, including for KP service delivery), infrastructure limitations, and logistical challenges have hindered the efficient delivery of HIV services, particularly in remote and underserved regions. The emerging climate change related disasters, such as cyclones, flooding and landslides, as well as disease pandemics pose a significant threat on the health and community systems' resilience to sustain delivery of routine HIV services, especially ART and prevention interventions.
- **Stigma and Discrimination**: Stigma and discrimination remain major obstacles to accessing HIV services, particularly for key populations. Despite efforts to address these

issues, social and cultural barriers continue to deter individuals from seeking HIV testing and treatment services.

- **Adherence and Retention in Care**: Maintaining high levels of ART adherence and retaining patients in long-term care are ongoing challenges. Factors such as stigma and discrimination, side effects, logistical barriers and lately natural disasters and pandemics, often lead to interruptions in treatment, which can compromise the overall effectiveness of the HIV response.

## 4. HIV Sustainability Vision and Goals

The vision of the HIV Response Sustainability Roadmap fully aligns to the HIV NSP and remains:

***'To achieve a healthy and prosperous nation free from HIV and AIDS.'***

This also aligns, and contributes to the UNAIDS Global Strategy's goal 'to end AIDS as a public health threat by 2030'. The Malawi Roadmap aims at achieving four main goals and these are:

i) Improved domestic funding and enhanced efficiency in utilization of HIV program resources;
ii) Integrated HIV services within broader health systems to improve efficiency, access and quality of service delivery;
iii) Strengthened systems for health that facilitate equitable, effective and efficient delivery of health and HIV services; and,
iv) Strengthened community-led interventions to reach key and vulnerable populations.

By leveraging political leadership to mobilize both domestic and international resources, ensuring efficiency in utilization, and ensuring equitable access to integrated high-quality services, Malawi can secure a sustainable future for its HIV response. This approach will not only continue to save lives and control the epidemic but will also contribute to a stronger and resilient health system, better resource allocation, and progress towards UHC. Achieving these goals will require coordinated efforts between government agencies, local communities, healthcare providers, and international partners, ensuring that resources are effectively managed, and services are accessible to all Malawians. The Roadmap will therefore commit political and government leadership to influence actions of both national and international actors to mobilize resources that can support a more sustainable HIV response.

## 5. HIV Sustainability Roadmap and Change Framework

This chapter synthesizes the key findings under each sustainability domain by analyzing the current status, key challenges and barriers that are likely to affect the HIV response gains and sustainability beyond the year 2030. This leads into outlining of the prioritized high-level outcomes and strategies/pathways to achieve sustainability under each sustainability domain. These high-level outcomes were largely drawn from existing strategic frameworks, such as the HSSP III, the NSP and HIV Prevention Framework. This followed a prioritization process of the program elements of the HIV response, guided by the Sustainability Assessment Tool. The strategies/pathways were extensively discussed among stakeholders outlined above and prioritized based on existing evidence of impact and consensus.

### 5.1 Political Leadership and Governance

#### 5.1.1 High-level Leadership and Advocacy

Malawi's HIV/AIDS response has long benefitted from strong political will and leadership Recognizing the multi-dimensional nature of both the HIV pandemic and its impact, Government raised the profile of the leadership and oversight role, by initially placing it under the Office of the President and Cabinet (OPC), where a fully-fledged Nutrition, HIV and AIDS Department was domiciled. In the interest of integration, streamlining and operational efficiency, the function was moved to the MoH, and the roles and responsibilities were consolidated under the DHA. The country also has a national multi-sectoral HIV coordinating agency, the NAC, that has been in existence over the past two decades and its role was further enhanced through enactment of the HIV Prevention and Management Act (2018). High-level leadership has also been evident through the Malawi HIV and AIDS Partnership Forum (MPF), which is the highest mutual accountability and decision-making platform for the national response, and the Global Fund Country Coordinating Mechanism (MGFCC), whose secretariat is housed under the Ministry of Finance and chaired by the Secretary to the Treasury.

Apart from institutionalizing and supporting the above outlined structures, the country's political leadership has been evident through presiding over high-level advocacy, as well as major HIV donor events, such as Global Fund grant signing ceremonies, at ministerial and the President's office level. In addition, Malawi has several political platforms that are championing the engagement of the civil society on sustainable financing of health, for example, through the Parliamentary Committee on HIV and Nutrition, which has been merged with the Parliamentary Committee on Health.

In addition, Government institutionalized implementation of HIV and AIDS Workplace programs in all ministries, departments and agencies, and put in place a policy to allocate 2% of Other Recurrent Transaction (ORT) funding towards HIV and AIDS interventions that include HIV prevention interventions.

#### 5.1.2 Challenges and Barriers

Despite existence of well-established institutional leadership structures, gaps remain in aligning HIV-related efforts with broader health policies and governance structures. Governance structures at both the national and district levels are often weak, leading to inefficiencies in service delivery and resource management. For example, recent assessments indicate that most of district health offices report difficulties in managing budgets and coordinating services, due to limited administrative and technical capacity. Furthermore, the decentralization process, which is intended to empower local councils to take a more active role in managing health services, has been slow to fully materialize. Although the decentralization policy has been in place for over a decade, local councils often have inadequate capacity, authority, and resources to manage HIV services effectively, resulting in inconsistent service quality across regions[13].

Weak inter-ministerial coordination between the Ministries of Health, Gender, Education, Youth, and Finance, outside the budget process, can impede critical policy reforms. In addition, the

[13] https://www.unicef.org/esa/media/11161/file/UNICEF-Malawi-NLGFC-IGF-%20Fiscal-Decentralisation-Situational-Analysis-2022.pdf

absence of streamlined accountability structures across national and local levels could lead to inefficiencies in governance and service delivery. On the other hand, there is a proliferation of networks of CSOs, competing in the HIV and AIDS, and related conditions space, usually motivated by resource mobilization objectives for their relevance and existence. This poses a threat to the already well established and recognized constituency-based network organizations, in terms of resource mobilization and membership. CSOs remain a critical partner in the HIV space at all levels. Therefore, their coordination mechanisms need to be streamlined and strengthened, in order to minimize duplications and multiple accountability lines from network affiliate organizations.

There is therefore need for stronger governance at the district level, particularly in terms of engaging local councils and leadership in the planning and delivery of HIV services. This involves increasing local ownership of HIV programs and ensuring that district-level health systems are adequately resourced and supported. For instance, empowering district councils to manage their budgets independently, coupled with comprehensive training in health service management, could improve local accountability and responsiveness.

To improve political leadership, it is essential that Malawi rationalizes existing frameworks for coordination and strengthens multisectoral governance. This will require not only sustained political commitment at the national level, but also greater accountability from district and local governance structures.

**High Level Outcomes**

i) Enhanced political leadership, governance and coordination mechanisms to ensure that multiple sectors work collaboratively towards shared goals.
ii) Strengthened financial accountability mechanisms for the sustainability of Malawi's HIV response.
iii) Streamlined CSO structures for a more integrated HIV response.

| **Short-term strategies/pathways (1-3 Years)** | **Medium-term strategies/pathways (3-5 Years)** | **Long-term strategies/pathways (6+ Years)** |
|---|---|---|
| • Advocate for a strong, sustained, and visible role of political leaders in the HIV response at the national and subnational levels consistent with Malawi's global commitments to end the HIV epidemic by 2030.<br>• Strengthen the coordination and implementation of the response to the HIV and AIDS epidemic at national and sub-national levels in line with the 3 Ones Principle.<br>• Strengthen the governance system of institutions and offices responsible for managing the HIV and AIDS response in line with the provisions of the HIV and AIDS Prevention and Management Act of 2018. | • Enhance HIV response sustainability at national and local levels, by introducing accountability for Controlling Officers to the OPD at the national level, and to the District Commissioners (DC) at the district level.<br>• Strengthen capacity for district health officials for effective management of the HIV response at that level.<br>• Improve monitoring, enforcement and accountability of the 2% ORT HIV budget allocation across all ministries, | • Ensure autonomy of local councils by allocating necessary resources to manage health services.<br>• Improve the fiscal capacity of decentralized structures. |

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| • Strengthen capacity for district health officials for effective management of the HIV response at that level.<br>• Improve monitoring, enforcement and accountability of the 2% ORT HIV budget allocation across all ministries, departments and agencies, as well as local councils. | departments and agencies, as well as local councils. | |

### 5.2 Enabling Legal and Policy Environment

#### 5.2.1 Legal, Policy and Strategic Frameworks

Malawi has a strong Constitution and progressive laws, such as the HIV and AIDS Prevention and Management Act (2018), which protects people living with HIV from stigma and discrimination, as well as facilitate HIV prevention efforts. The HIV Prevention and Management Act has strong anti-discriminatory provisions that re-enforce the protection of basic human rights enshrined in the Constitution. Other important legal instruments in this regard include the Gender Equality Act (2013); Prevention of Domestic Violence Act (2006); Marriage, Divorce and Family Relations Act (2015); Deceased Estates (Wills, Inheritance and Protection) Act (2011); and, Trafficking in Persons Act (2015). Another key milestone in the legal arena was the declaration as unconstitutional of the 'Rogue and vagabond' clause of the Penal Code by the High Court of Malawi- a provision that was previously used to arrest sex workers.

There are also policy and strategic frameworks that offer a basis for addressing barriers and protecting rights in the HIV response and these include the National Health Policy 2018 – 2030, National HIV and AIDS Policy (2022), Sexual and Reproductive Health Rights Policy (2017), National Gender Policy 2015, HSSP III (2023-2030), the NSP (2023-2030), the HIV Prevention Framework (2023-2030), and National Action Plan Against Rape and Defilement (2020-2025). The review of the 1991 National Drug Control Policy provides an opportunity to improve services for people who use drugs.

The HIV response has also allowed key constituencies space to participate in national policy dialogue and other national advocacy processes. KP, youth and PLHIV constituencies are well represented in all key HIV decision-making bodies at the national level. Several strong KP, youth and PLHIV CSOs are able to engage national authorities in policy dialogue and advocacy, including challenging punitive laws and policies, to ensure that services are being accessed by the everyone.

#### 5.2.2 Challenges and Barriers

The major challenge is to ensure that these pieces of legislation are effectively enforced and that the policies and strategies are fully implemented. There is limited legal awareness and access to justice, with the situation more pronounced at the grassroots level. While there are a number of legal instruments that could advance HIV prevention, care and support services, legal and social barriers persist for KPs. Same-sex relationships are still illegal in Malawi, punishable by up to 14 years imprisonment. Certain aspects of commercial sex work are also illegal. Drug use or possession for personal use is criminalized. Current policies prohibit the distribution of condoms and PrEP in prisons.

The Government of Malawi has not endorsed the Southern Africa Development Community (SADC) Protocol on Comprehensive Sexuality Education, a framework that would facilitate effective mainstreaming of this intervention in schools. There is also a growing anti-rights movement in the country, especially from religious and some social circles that has made the government hesitant to act on critical issues, such as repealing laws that criminalize key populations. KP-led organizations also face challenges when registering under the NGO Act. All these factors potentially leave these sub-populations underserved.

Harmful gender and social norms, and inadequate enforcement of mandatory school enrollment for girls perpetuate gender inequalities. Furthermore, fragmented disaster-response coordination and limited HIV-responsive social protection mechanisms leave the vulnerable populations, including women and girls, unprotected during crises, exposing them to a higher risk of HIV infection.

There has been slow progress in sensitizing health care workers and other social service providers about rights of key populations, in order to effectively deliver integrated services to them. A large proportion of health facilities do not deliver KP-responsive services, with limited training for healthcare workers, and insufficient community-level awareness campaigns. As a result, stigma and discrimination against KP is still unacceptably high. This is also compounded by high levels of self-stigma among KP. In addition, many of the human rights trainings and other initiatives to reduce stigma and discrimination, and gender-based violence (GBV) are limited to donor-funded programs, which in itself limits sustainability.

There is also general limited institutional and governance capacity for KP organizations that affect their potential to plan, implement and sustain impactful programs. Unlike at the central level, there is both weak involvement and capacity of KP, youth and PLHIV representation at district and lower levels to meaningfully influence resource allocation and program implementation.

The delay in repealing punitive laws may worsen health outcomes for criminalized populations. Inconsistent application of gender equality laws could undermine progress in addressing GBV, which is a significant risk factor for HIV transmission and infection. Persistent stigma and discrimination may discourage KPs from accessing HIV services, and weak mechanisms for disseminating legal frameworks at the community level could hinder meaningful engagement, knowledge and informed decision-making at that level. Resource constraints, especially insufficient investments in AGYW-specific programs, could further deepen vulnerabilities and exposure to HIV infection.



**High Level Outcomes**

i) Supportive legal and policy environment that removes barriers to HIV services.
ii) Improved access to, and utilization of health care services by KP and PLHIV.
iii) Equitable access to HIV services and sustainable stigma and discrimination free healthcare settings, especially for key and vulnerable populations.
iv) Reduced levels of harmful gender norms, stereotypes, and gender-based violence in the communities to facilitate behavior change and access to combination HIV prevention services.
v) Increased secondary completion rate among girls.

| Short-term strategies/pathways (1-3 Years) | Medium-term strategies/pathways (3-5 Years) | Long-term strategies/pathways |
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| | | **(6+ Years)** |
| ● Advocate for legal reforms that decriminalize sex work, same-sex relationships, and drug use.<br>● Promote high-level advocacy with government, parliaments, judiciary and gate keepers for the implementation of relevant regional and national commitments on HIV and SRH.<br>● Mobilize more political support for a rights-based approach to HIV prevention and health, including from constitutional bodies such as the MHRC.<br>● Improve access to and coverage of HIV and sexual and reproductive health and rights (SRHR) services for adolescent girls and young women (AGYW), sex workers and their partners.<br>● Scale up evidence-based social support and economic empowerment programs targeting AGYW and other vulnerable populations.<br>● Ensure availability of up-to-date size estimates (including all key population groups) to guide national policy-making decisions and funding allocations.<br>● Strengthen capacity of healthcare workers for effective delivery of stigma-free health services delivery.<br>● Engage community champions to raise awareness on KP rights, stigma and discrimination.<br>● Optimize effective coordination, linkages and referral systems, including high level case management for highly vulnerable PLHIV | ● Enhance inter-agency coordination and collaboration on legal and policy framework development, dissemination and implementation.<br>● Domesticate and disseminate enabling laws and policies at the grassroots to empower communities.<br>● Develop and implement detailed, decentralized dissemination plans for existing and future policies and strategic information documents, so that they are more widely understood, used and implemented at a national and sub-national level.<br>● Institutionalize regular national stigma index studies to track progress on stigma and discrimination against PLHIV.<br>● Expand and decentralize one-stop centers for GBV survivors.<br>● Integrate HIV/GBV into educational curricular.<br>● Enhance cross-sector collaboration, by leveraging on strategies such as the AGYW Strategy and "Keeping Girls in School" initiative, as platforms for holistic interventions.<br>● Scale up peer educator micro planning approach. | ● Harmonize existing laws and policies to minimize conflict of the laws.<br>● Provide a supportive and inclusive environment that ensures smooth registration processes for all organizations, regardless of gender and sexual orientation.<br>● Introduce sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC) curriculum and KP competent module in pre-service training for health care workers. |

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| and/or those at risk of acquiring HIV.<br>● Integrate HIV services into disaster preparedness plans, tools and mechanisms. | | |

### 5.3 Sustainable and Equitable Financing

#### 5.3.1 HIV Financing Landscape

Financial sustainability is perhaps the most pressing challenge facing Malawi's HIV response, as the country is dependent on external donor funding to cover its HIV/AIDS expenditures. A reduction in donor funding could lead to service disruptions, scaling back of prevention programs, and reduced availability of ART, all of which threaten to reverse the progress made in controlling the epidemic.

The MoH recently launched its Health Financing Strategy 2023-2030, which provides a framework to achieve a fully functional healthcare financing system that supports the UHC aspirations. The Government of Malawi has set a goal of increasing domestic resources to cover 30% to 50% of HIV funding by 2030. To meet this target, innovative financing solutions and more efficient budget allocation and utilisation strategies are urgently needed. One potential solution is the integration of HIV financing into broader health financing mechanisms currently being pursued under the broader health financing reforms in the MoH. Additionally, the government must continue to explore mechanisms for stronger public-private partnerships (PPP), for instance, through strategic health purchasing.

It is also essential to improve the efficiency of existing resources. This includes reducing duplication of efforts, streamlining donor contributions, and ensuring that funds are directed towards high-impact, cost-effective interventions. In addition, effective financial management of health and HIV funds will be critical in building trust among donors and encouraging continued international support. By implementing robust transparency and accountability systems through auditing processes, publicly reporting expenditures, and enhancing the oversight of health budgets, Malawi can demonstrate responsible stewardship of resources, which will be essential for attracting future investments.[14]

#### 5.3.2 Challenges and Barriers

Malawi's HIV financing landscape is heavily constrained by barriers in domestic and international funding, efficiency, and equity. **Domestic financing** is limited by a low tax base, which falls short of the recommended 15% benchmark for health sector budgetary allocation. While Malawi is a signatory to the Abuja Declaration—which calls for allocating at least 15% of the national budget to health—the country has consistently fallen short, with recent allocations averaging 9.25% from 2019/2020 to 2024/2025 fiscal year (AFIDEP, 2024). Government contributions to HIV spending and allocations to the minimum health package remain insufficient, and budget execution is uneven, especially for donor-funded projects. Procurement of essential commodities and supplies

[14] https://documents1.worldbank.org/curated/en/241411624431388240/pdf/Public-Financial-Management-in-the-Health-Sector-An-Assessment-at-the-Local-Government-Level-in-Malawi.pdf

has also been hampered by continuous scarcity of forex, against other competing priorities in other social and service sectors.

In addition, insufficient domestic allocations may compromise the delivery of essential services and stall the scale-up of innovative financing mechanisms, like PPPs. Weak monitoring frameworks for new initiatives, such as optional paying services in public hospitals, could also limit their scalability and impact. Furthermore, weak enforcement and monitoring of workplace HIV programs and the allocation of 2% of ORT funding has not yielded the policy objective of raising HIV funding in the public sector. High donor dependency continues to undermine national autonomy in financing the HIV response.

On the **international financing** front, heavy reliance on external funding creates vulnerabilities to numerous external shocks, with limited government capacity to fully assume financial responsibilities. Limited adherence and enforcement of public financial management systems remains a concern to both Government and donors to fully decentralize and streamline funding mechanisms into the public system.

**High Level Outcomes**

i) Increased domestic resources for the health sector to optimally deliver essential health services.
ii) Increased health budget allocation to at least 15% of the national budget.
iii) Increased domestic financing of HIV programming to 30% by 2030, with an ultimate target of at least 50% beyond 2030.
iv) Increased total health expenditure from the current USD39.9 to the WHO's recommended levels for public resource expenditure (USD86 per capita) for low-income countries like Malawi.
v) Improved strategic resource allocation and utilization across the healthcare delivery system.

| **Short-term strategies/pathways (1-3 Years)** | **Medium-term strategies/pathways (3-5 Years)** | **Long-term strategies/pathways (6+ Years)** |
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| • Expand the tax base and leverage on non-tax revenue, through earmarked taxes, health funds, and mandatory health insurance cover for all formal workers<br>• Formulate a single project coordination unit in the health sector to coordinate and align donor aid to national and local authority priorities.<br>• Institutionalizing bi-annual inter-ministerial meetings to prioritize HIV and health financing beyond the usual budget processes.<br>• Finalize the compendium of investment cases to inform decisions on optimal utilization of resources in the health sector.<br>• Promote financial prudence, efficiency, transparency and accountability in the use of available resources at all levels.<br>• Strengthen use of programmatic and epidemiological data to facilitate resource allocation for key HIV program interventions. | • Enhance domestic revenue generation and management capacities for the sub-national level.<br>• Mobilize the private sector for investment into health and HIV programs through provision of tax incentives.<br>• Expand optional paying services in public facilities to diversify funding sources.<br>• Institutionalize regular implementation of the National Health Accounts (NHA) and National AIDS Spending Assessments (NASA) to | • Introduce mutually binding co-investments between Government and donors for impactful investments in the health sector (infrastructure, health products, medical equipment).<br>• Strengthen PPP, especially for co-morbidities and non-communicable diseases, such as renal dialysis and cancer treatment. |

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| | consistently track progress in health and HIV financing and expenditures. | |

### 5.4 Services and Solutions

#### 5.4.1 The HIV response progress

Malawi has made remarkable progress in scaling up HIV, through a number of strategies that include integrating HIV services into routine health care service delivery; differentiated care models; community-based and community outreach service delivery. A range of combination HIV prevention, treatment, care and support services are widely available across the country at health facilities and community levels. The country has achieved commendable success in scaling up ART coverage, for both prevention and treatment of HIV. The high levels of ART coverage and viral load suppression in Malawi provide a good basis for the Undetectable=Untransmittable (U=U) approach.

Similarly, commendable progress has been registered on different fronts for HIV prevention. PMTCT coverage rates have been on the increase over the years. HIV testing services have been widely scaled up, using different modalities and adapted for specific population groups such as couples, pregnant women and infants, children, adolescents, and at high-risk groups. The National Condom Strategy was revised. Condom coverage has improved due to adoption of innovative approaches, such as the Total Market Approach (TMA) to ensure that each audience is able to access condoms based on their needs. Malawi is reaching more men through VMMC programming, although the country is falling short of the 2025 target. Malawi has made progress on rolling out oral PrEP since 2020 with 51% of facilities providing this in 2022.[15] Malawi is also introducing community delivery of PrEP services, which will help address challenges of acceptability and support PrEP uptake. There are minimum service packages in place for all key populations, except people who use drugs. A package for people who use drugs is under development.

Malawi has made several efforts to promote service integration, through the revised NSPs and the HSSP III. HIV and SRH integration is being encouraged in one-stop centres, mobile health vans offering primary healthcare and joint TB, viral hepatitis and HIV planning, and service delivery. Guidelines to facilitate high quality delivery of the services have progressively been developed, through the leadership of MoH. Such models improve patient adherence to treatment, reduce the stigma associated with accessing care, and lead to better treatment outcomes.

#### 5.4.2 Challenges and Barriers

Despite the registered program progress, challenges remain, particularly in ensuring that these services are context-specific, people-centered, and sustainable in the long-term. While Malawi has made significant strides in reducing HIV incidence and mortality rates, ensuring the sustainability of these achievements requires continued focus on controlling the epidemic, preventing new infections, and maintaining high levels of treatment adherence. The epidemiological landscape is

[15] https://hivpreventioncoalition.unaids.org/en/resources/malawi-hiv-prevention-and-accountability-community-perspective-2023

shifting, with increasing numbers of PLHIV now on lifelong ART. However, sustaining these rates of viral suppression is critical to curbing transmission, and it presents long-term challenges, particularly given the need for reliable, uninterrupted treatment and care services.[16] The long waiting times for viral load testing results also need to be addressed.

The aging population of PLHIV introduces new complexities in managing comorbidities, such as non-communicable diseases (NCDs) including hypertension and diabetes, which will require integrated health services beyond just HIV care. Currently, about 50% of PLHIV are over the age of 40, and the prevalence of NCDs within this group is rising (2023 HIV Spectrum Estimates). As epidemiological dynamics evolve, it is crucial for Malawi's health system to be adaptable and prepared to meet the changing needs of its population.

In terms of HIV prevention, several issues also present challenges. Condom accessibility for women remains a challenge, and therefore, calls for fast tracking of the TMA to ensure better access, including for hard-to-reach areas. Despite the multi-sectoral nature of the AGYW program and recent efforts to implement a multi-sectoral AGYW Strategy, it still remains donor-led, raising fears for its sustainability. Community led HIV prevention interventions have lagged behind, largely owing to capacity constraints by the civil society and community organizations. Capacity gaps are evident through inadequate systems for financial management, procurement, monitoring and evaluation, as well as program technical knowledge and skills. This limits their capacity to mobilize donor funding and also effectively implement interventions at that level.

Geographical service coverage, particularly for KPs in rural areas is a challenge. Many youth-friendly service delivery points for AGYW are non-functional, and legal and cultural barriers limit access for vulnerable and marginalized populations. Structural challenges, such as stigma and discrimination, also perpetrate the inherent inequities. While policy and strategic integration is propagated at national level, the actual service integration at facility level remains weak due to health system gaps, in terms of trained health personnel, poor infrastructure, lack of equipment and essential medical supplies, and limited supportive supervision.

There are also gaps in the integration of community-based HIV services with facility-based care. Community-led HIV programs, which play a critical role in prevention, treatment adherence, and care, are often not fully integrated into the broader health system. This fragmentation leads to missed opportunities for more holistic care and creates barriers for patients who rely on both community support and clinical services. For example, community health workers may not have access to patient records from clinics, complicating follow-up and continuity of care. Strengthening the coordination between community health workers and facility-based staff is essential to ensure continuity of care, improve patient outcomes, and optimize the use of resources. Models of integrated care, where community and clinical services operate in tandem, have been shown to enhance patient adherence to ART, reduce stigma, and improve early diagnosis rates.

In addition, community systems are underfunded and lack government support for social contracting mechanisms to effectively contribute to the HIV response. The mid-term review of the NSP 2020-2025 also identified a number of issues that included: lack of coordination among community health workers and volunteers working across various sectors (Health Surveillance Assistants, Community Child Protection Workers and Agriculture Extension Workers); poor reporting of non-biomedical interventions at community-level; and, limited capacity of traditional and religious leaders to engage with community members and address harmful social norms and

[16] https://www.unaids.org/en/regionscountries/countries/malawi

practices (including GBV), dispel false claims of AIDS cure and support treatment adherence and retention in care.

**High Level Outcomes**

i) Reduced HIV incidence among children, AGYW and, key populations (Sex workers, MSM, transgender persons, PWIUDs, Prisoners).
ii) Reduced HIV incidence among adolescent boys and young men (ABYM), orphans and other vulnerable children (OVC)-including street kids, children of female sex, clients of sex workers
iii) Reduced incidence of morbidity and mortality in TB/HIV co-infected patients.
iv) Reduced mother-to-child transmission of HIV, syphilis, and hepatitis B in pregnant and breastfeeding women
v) Reduced morbidity and mortality among PLHIV on ART and community transmission of resistant virus.
vi) Improved viral load suppression and retention among clients (children and adults) on ART.
vii) Positive behavioural change and social norms for reduced HIV incidence in all population groups.

| **Short-term strategies/pathways (1-3 Years)** | **Medium-term strategies/pathways (3-5 Years)** | **Long-term strategies/pathways (6+ Years)** |
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| • Increase access, uptake, and quality of both male and female condoms and lubricants among high-risk populations, focusing on high HIV-prevalence geographical areas of the country using the TMA.<br>• Increase access to, uptake of, and quality of PrEP services, targeting high risk and priority populations in all high incidence districts.<br>• Scale up integration of PrEP into community and maternal and neonatal child health (MNCH) platforms.<br>• Increase access to, uptake of, and quality of VMMC services targeting high risk and priority populations in all high incidence districts.<br>• Increase access, uptake and quality of HIV, syphilis and Hepatitis B testing and counselling services among AGYWs, ABYMs, OVC, high-risk key and priority populations, through proven innovative and differentiated service delivery (DSD) approaches.<br>• Strengthening bi-directional linkage pathways between health facility and community to ensure effective access to prevention, counseling and testing for KPs, AGYWs, ABYMs and OVC.<br>• Engaging PWIUDs networks to increase service coverage.<br>• Intensify peer to peer support for KP Interventions.<br>• Intensify and scale-up DSD testing models to general populations. | • Intensify targeted prevention interventions and harm reduction strategies for PWUID.<br>• Leverage community-based interventions, such as peer support models, to address stigma and discrimination and improve access.<br>• Improve the quality of planning for KP interventions through increased generation and use of relevant evidence.<br>• Strengthen and scale up psychosocial and economic or livelihood support among OVC in districts with high | • Enhance the engagement of traditional and community leaders to lead HIV advocacy efforts and to support the delivery of community-based services. |

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| • Increase access to, and coverage of combination HIV prevention, and treatment for AGYW and their male sexual partners.<br>• Increase linkage to care and treatment services by making public facilities KP friendly (safe space and capacity building).<br>• Increase access to, and uptake of quality STI, SRH services, including family planning, cervical cancer, syphilis, GBV and post-sexual violence care, targeting high risk and priority populations in all high incidence districts.<br>• Increase access to, uptake of, and quality of elimination of Mother to Child Transmission (eMTCT) services targeting women of childbearing age in all districts.<br>• Scale up community provision of eMTCT services, through Community Midwifery Assistants (CMAs) and other community health workers.<br>• Scale up treatment, care and support to infected mothers and infected and exposed infants.<br>• Effectively link individuals and their families to appropriate treatment, care, and support as well as prevention services.<br>• Increase coverage of high-quality integrated HIV and other related diseases (NCD, Viral Hepatitis, and cancer services).<br>• Intensify DSD models (community ART, multi-month dispensing, family models, intensified care for ART clinic) for sustained ART service delivery.<br>• Strengthen welcome care services, including treatment literacy.<br>• Increase access to, uptake of, and quality of VL testing services in all districts.<br>• Improve viral load suppression and retention among clients on ART<br>• Third line referral for drug resistance testing.<br>• Strengthen the capacity of community support groups on treatment literacy and adherence support.<br>• Improve lab capacity to support clinical care services.<br>• Improve the availability, quality, and management of blood transfusion services.<br>• Sustain integration of HIV services with existing platforms, such as MNCH, SRH, youth friendly health services (YFHS), as well as mental health services. | HIV disease burden.<br>• Foster positive behavioral change and social norms that reduce HIV incidence among adolescents, young women, and other vulnerable populations.<br>• Integrate mental health and psychosocial support into HIV services.<br>• Intensify capacity building for health workers in appropriate knowledge and skills set for effective service delivery.<br>• Strengthen use of programmatic and epidemiological data to address gaps in HIV programming for key populations.<br>• Integrate HIV and health services into national disaster preparedness and climate change strategies.<br>• Scale up HIV sensitive child protection case management in high HIV burden districts.<br>• Scale up a robust system for coordinating | |

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| | programs implemented by community-based volunteers and organizations. | |

### 5.5 Systems

#### 5.5.1 Strengthening Health Systems

Existence of robust health systems is a backbone to delivery of effective and efficient health care services, including HIV related ones. Among the eight priority areas, the National Health Policy prioritizes investing in human resources for health; medicines, medical supplies, medical equipment and infrastructure; and, health information and research, as essential elements of health systems. Guided by the HSSPs, Government has over the years directed its efforts towards improvements in human resources development, recruitment, and retention of health workers; performance management; enforcement of public service policies, regulations and procedures; improving quality and coordination of training; and strengthening human resources planning process to incorporate evidence-based planning. Following the COVID-19 pandemic, the Ministry has continued to recruit health workers, although vacancy rates still exist and vary across cadres-ranging from 11% for Medical Assistants, to 81% for Pharmacy Technicians.[17]

In order to strengthen governance frameworks in health products procurement and supply chain management, government enacted the Pharmacy and Medicines Regulatory Authority Act No. 9 of 2019 that regulates medicines and medical technologies. The MoH reviewed the Malawi Standard Treatment Guidelines and essential medicines list and also developed the Malawi Supply Chain Transformation Plan. In addition, the MoH continued improve on health technologies, through strengthen of the USAID supported Logistics Management Information System (OpenLMIS). The UNDP funded electronic Health Information Network (eHIN) was also adopted in 2020, to facilitate real time end-to-end commodity tracking.

The MoH continued to construct, rehabilitate and equip health facilities across all levels of the health care delivery system, from the primary (community) to the tertiary level, to improve access to quality health care. Specialized therapeutic and diagnostic equipment, such as gas cylinders, digital x-ray machines and CT scans, were also procured and installed across these levels of care, as appropriate. Medical drone technology was introduced in selected districts across the country, to improve efficiency in transportation of laboratory sample and results, essential and urgent drugs, blood products and other health commodities, between hard-to-reach health centres and district hospitals. This technology has facilitated emergency deliveries of essential medicines and significantly reduced the turn-around time of laboratory samples and results from one week to less than two days or even hours.

MOH's has fully embraced the digital health reform as a means to enhance efficiency in health service delivery. There is currently a functional Digital Health Division that has facilitated development of a digital health strategy, to provide digital health governance, coordination, and leadership in the country. There has been substantial expansion of digital health infrastructure at national, district and selected health facilities, including solar power backup systems to support

[17] The Health Sector Strategic Plan III 2023-2030

the use of digital health solutions, as well as improved internet connectivity to health facilities. Another significant milestone was the development and functionality of the interoperability of digital health systems. Using various software, this architecture is facilitating data sharing between a number of platforms, such as the Health Management Information System (HMIS) District Health Management Information Systems 2 (DHIS 2) and OpenLMIS (Drugs and Essential Medicines data platform); HMIS DHIS 2 and Department of HIV and AIDS management Information System (DHA MIS); and, HMIS DHIS 2 and Integrated Supportive Supervision System, among other systems.

The MOH and partners have also developed the integrated Community Health Information System (iCHIS), a digital system that supports informed decision-making and action by community health workers. This is considered as a game-changing digital health intervention that has been locally conceived and will provide solutions in addressing local needs sustainably and cost-effectively. Partners have collaborated to roll this out to 14 districts across the country. In addition, a Central Data Repository (CDR) for patient level data has been established. This will facilitate sharing of patients' electronic health records across facilities and enhance patient-centered health care.

Monitoring and Evaluation (M&E) and Research are a critical source of evidence for policy and programmatic decision-making, as well as routine performance monitoring. The MoH has continued to strengthen capacity by recruiting Statistical Clerks, providing Information, Communication Technology (ICCT) equipment, and training of relevant staff in data management, using the DHIS2 platform. A mobile DHIS2 was introduced and rolled out to districts, to facilitate data capturing and transmission. The MoH has also strengthened disease outbreak surveillance, in order to effectively and efficiently respond to such occurrences, and minimize the adverse impacts on health care delivery, including HIV services. The Public Health Institute of Malawi has been responsible for strengthening District Health Emergency Response Teams in all the districts of the country, in order to deal with pandemics, such as COVID-19, cholera, measles and polio.

### 5.5.2 Challenges and barriers

Delivery of effective, efficient and quality health care is highly dependent on the availability of skilled and well qualified HRH; good quality essential medicines and medical supplies; adequate, good quality and safe medical equipment; and health infrastructure that meets minimum standards for service provision. There are a number of challenges in each of these areas as described below.

The key challenges for HRH include low output from training institutions, low absorption of graduates into service, leading to high vacancy rates across cadres. There is also inequitable recruitment and deployment and distribution of staff at different levels. This is compounded by limited incentives and capacity to attract and retain health workers, especially in rural and hard-to-reach areas, further compounding the high vacancy rates and resultant attrition rates to other more attractive labour markets, within and out of the country. Ineffective policies across the core human resource functions, such as staff development, recruitment, deployment, performance management and incentive schemes have not helped matters. HRH management systems have lagged behind in terms of effective use of digital and other existing technological platforms to facilitate availability of data and effective decision making.

Another major challenge is the over-reliance on external donors for financing human resources as a key component of the HIV response. According to 2021 Malawi Sustainability Index and Dashboard Summary; over 95% of HIV-related health workers are either partially or fully funded

by external partners, such as PEPFAR and the Global Fund. 18 These workers, including community health workers, play a critical role in the delivery of HIV services, yet their roles are often not integrated into the formal government workforce. This dependency poses a significant risk; should donor funding decrease, Malawi could face a severe shortage of skilled health workers, leading to service disruptions and setbacks in HIV treatment coverage.

The procurement and supply chain management system has been characterized by limited availability of essential medicines, against the backdrop of inefficient and unsafe utilization of available medicines and medical supplies at health facility level. This is a result of multiple factors that include: insufficient funding allocation, coupled with erratic disbursement of funding to the Central Medical Stores Trust (CMST); inefficient warehousing and distribution of medicines and medical supplies; sub-optimal distribution and use of medicines, and medical technological services. Weak policy and regulatory framework for quality assurance of medicines and medical products has also led to procurement of sub-standard commodities. Capacity issues at lower levels of the health care system have also led to sub-optimal decentralization of critical supply chain management functions, leading to protracted decision-making processes. There are also general weaknesses in the quantification, costing, budget execution and monitoring for medicines and medical supplies, culminating in overall inefficiency in procurement of health commodities.

There is generally limited availability and poor quality of medical equipment due to: inadequate resources; inadequate and ineffective procurement; weak procurement planning; limited procurement coordination and management; weak enforcement of medical equipment standards; and theft of medical equipment at health facilities. Inadequate standardization and regulation of donations also contributes to proliferation of sub-standard equipment.

The rapid population growth and disease burden, compounded by recent disease outbreaks and emergencies have exerted higher demand and the need for adequate numbers, space and high quality of health infrastructure. These have fallen short of the need due to limited domestic financing; weak infrastructure procurement and management practices; weak planning, coordination and implementation of infrastructure development plans; poor quality workmanship for construction, rehabilitation and maintenance; and the lack of scheduled and routine maintenance of health infrastructure.

There are a number of challenges that affect digital health technology scale up and these include: limited resources to invest in digital health; limited coordination of digital health investments in the health system by multiple partners; lack of reliable and context appropriate ICT infrastructure to enable utilization of digital health systems at all levels; lack of capacity among communities and very limited capacity among health workers to utilize digital health investments; limited use of shared electronic health records for continuity of care; inadequate and sometimes ineffective alignment between monitoring and evaluation needs of health sector strategies, and the digital health solutions currently being developed and deployed. In addition, there is a general lack of capacity in terms of M&E staff numbers and technical skills across all levels.

**High Level Outcomes**

i) Strengthened health systems for effective delivery of high-quality combination HIV prevention, treatment, care and support services.

[18] https://www.state.gov/wp-content/uploads/2022/06/Malawi.pdf

ii) Improved planning, monitoring, and management of human resources for health at all levels.
iii) 90% of essential diagnostic lab services are available at each designated level of health care service delivery.
iv) Integrated supply chains for essential medicines and programs (HIV, TB, malaria, and family planning)
v) Cost efficient and optimal functioning lab network and system
vi) Cost efficient and responsive management information system.
vii) A cost-effective, flexible, interoperable health information system (HIS) that addresses the needs of the HIV program and reduces costs by 40-50% and is available at all service delivery points.
viii) Standardized salary structures across donor-funded HRH, followed by absorption by government.

| **Short-term strategies/pathways (1-3 Years)** | **Medium-term strategies/pathways (3-5 Years)** | **Long-term strategies/pathways (6+ Years)** |
|---|---|---|
| • Strengthen capacity-building initiatives to ensure that health workers are equipped with the necessary skills to provide effective and context-specific HIV services.<br>• Support the on-going transitioning of donor-supported health workers into the public sector payroll.<br>• Improved enforcement by regulatory bodies (discipline etc.) including enforcement of standards at all levels of the health care system.<br>• Establish a Logistics Management Unit (LMU) to govern integrated supply chain systems.<br>• Improve the functionality and leadership of the CMST.<br>• Improve budgetary allocation and funds disbursements to the CMST.<br>• Strengthen post-market surveillance for quality assurance of commodities.<br>• Increase availability of basic medical and non-medical equipment for effective detection | • Integrate core HIV service intervention, co-morbidity and NCD management modules in pre-service curricular.<br>• Align donor-funded human resource remuneration with government pay scales, to promote standardization.<br>• Improve policies, systems and procedures (staff recruitment, deployment, retention policies, performance management and continuous professional development) for effective HRH planning and management.<br>• Development of functional and utilize HR management information systems.<br>• Ensure cost efficient and optimally functioning logistics management information systems.<br>• Improve health products warehousing infrastructure.<br>• Accelerate the implementation of infrastructure development interventions in the HSSP-III that support the delivery of quality integrated HIV-related services.<br>• Developing cost-effective and interoperable health information | • Improve health products warehousing infrastructure.<br>• Transition to a government led cost efficient procurement and logistics management system through service level agreements/all-inclusive pricing mechanisms.<br>• Strengthened laboratory governance and management structures, through the introduction of quality assurance programs.<br>• Scale up PPP initiative, focusing on impactful investments in infrastructure |

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| and management multi-morbid conditions associated with HIV.<br>• Optimize the functionality of the lab information systems.<br>• Facilitate the timely generation of quality data for evidence-based decision-making in HIV-related programs, especially at lower levels.<br>• Improve M&E capacity (number of staff and technical skills) within the HIV program.<br>• Maintain close collaboration of the UNAIDS global experts and the Malawi HIV program strategic information team.<br>• Scale-up the implementation of community-led monitoring. | systems (HIS) that reduce costs and improve HIV program management.<br>• Harmonize and simplify the M&E tools in the HIV space, including reducing indicators and reporting frequency.<br>• Ensure scaling up of appropriate and context-friendly solutions and technologies to meet the local M&E and surveillance needs. | and service delivery.<br>• Strengthen community systems for HIV epidemic control, child protection and GBV prevention.<br>• Fully integrate strategic information systems into national frameworks to enhance efficiency and reduce costs.<br>• Institutionalize evidence-based planning, with at least 5% of health budgets allocated to monitoring, evaluation, and research. |

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## 7. Annexes

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**Date: 18th December 2024**

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