Managing HIV/AIDS at the Local Level in Africa

Project outputs and achievements

Malawi Local Government Association (MALGA)

2006

- MALGA summary
- Lilongwe:
  - Lilongwe City Profile
  - Lilongwe HIV AID Workplace Policy
- Mzuzu:
  - Mzuzu HIV AIDS City Profile
  - Mzuzu Workplace Policy
- Zomba:
  - Zomba HIV AIDS City Profile final
  - Zomba Munici Assembly HIV AIDS work-place policy

MANAGING THE HIV AND AIDS PANDEMIC AT THE LOCAL LEVEL

EXPERIENCE FROM THE MALAWI LOCAL GOVERNMENT ASSOCIATION (MALGA) IN LILONGWE, MZUZU AND ZOMBA

A. INTRODUCTION

As a part of the UN-HABITAT programme to address HIV/AIDS at the Local Level in Africa, and following the successful activities that took place in the five cities of Kisumu, Kenya; Abengourou, Cote d'Ivoire; Markudi, Nigeria; Louga, Senegal; and Blantyre, Malawi, the Malawi Local Government Association (MALGA) AMICAALL chapter put forward a proposal to take undertake further work in the country of Malawi. These would be focused in particular on the City Assemblies of Lilongwe, Mzuzu and Zomba.

The major activities undertaken were to conduct an HIV/AIDS situation analysis for the three cities, to have each city develop with workplace policy on HIV/AIDS and to work to institute interventions to address the problems.

B. ACCOMPLISHMENTS

Since the programme commenced MALGA AMICAALL has accomplished a number of objectives. A two-day planning meeting for the three cities of Zomba, Lilongwe and Mzuzu was held in Lilongwe in February 2006. The objectives of the workshop were to consolidate gains the Blantyre City Assembly has achieved in managing HIV/AIDS at city level and to reduce the negative impact on people affected and infected by HIV/AIDS, to replicate the Blantyre city experience in managing HIV/AIDS in the three cities of Lilongwe, Zomba and Mzuzu and to share experiences and develop a work-plan on how to replicate this experience in the three cities.

At the meeting, it was agreed that each city would undertake an HIV/AIDS profile exercise and develop a work place policy, including undertaking some activities to address the identified priorities. Each city has completed their work and the documents are attached, and some details of the achievements and activities in each city are listed below.

Zomba Municipality

Zomba has conducted an HIV/AIDS situational analysis and the report is complete. The HIV/AIDS work place policy has been developed. This has been a vigorous exercise and Zomba has owned ownership of the activity. Zomba has done very well compared with the rest. Zomba Municipal used national trainers, based in Zomba, to train the members of Zomba Municipality workers with their spouses from 15th May to 20th May 2006 for two sessions of 10 families for three days per session. This was a very successful activity and Zomba will continue with these trainings for their staff and spouses.

Mzuzu City Assembly

Mzuzu has done well; the HIV/AIDS situation analysis is complete and the report has been submitted, as has the HIV/AIDS workplace policy. Meanwhile planning for peer educators training and community conversation is underway. Dr. Bandawe will organise facilitators for community conversation. The cities are preparing budgets for the said activities for submission to MALGA for funding. Funds have been committed for these activities.

Lilongwe City Assembly

Lilongwe City assembly has done relatively well, with back stopping from AMICAALL due to proximity of the two organisations. Lilongwe City Assembly went through the whole process with the assistance of AMICAALL and the reports on both the HIV/AIDS situation analysis and HIV/AIDS work place policy are complete. Training for staff and spouses was conducted and it was successful. Forty (40) members were trained. Meanwhile, the Assembly is finalising the budgets for community conversation.

Overall the programme was a success, and has facilitated interactions with all the three cities. It has also allowed AMICAALL to provide technical assistance and the transfer of skills to the local assemblies.

FINAL REPORT

LILONGWE CITY ASSEMBLY

CITY PROFILE & FORMULATION OF THE HIV/AIDS WORKPLACE POLICY

Submitted by

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July 2006

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EXECUTIVE SUMMARY

This report presents the findings during the facilitation process to develop an HIV and AIDS workplace policy for Lilongwe City Assembly. The summative findings indicate the following:

- there is a general knowledge about HIV and AIDS among Lilongwe City Assembly (LCA) employees.
- the epidemic has negative impact on not only LCA as an institution but also on its employees and their households.
- that Acquired Immune Deficiency Syndrome is a preventable disease.
- education and awareness should be the LCA's primary response to HIV and AIDS.
- however, recognizing that some staff will require treatment, the interventions must also address treatment, care and support options for employees infected and affected by HIV and AIDS.
- no discrimination on HIV and AIDS status within LCA.
- need for reviewing LCA policy environment.

The main deliverables for the assignments are:

- Policy document on HIV and AIDS, submitted separately
- Policy programme plan attached in this report

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-viral Therapy
CBO	Community Based Organization
HBC	Home Based Care
HIV	Human Immuno-Deficiency Virus
ILO	International Labour Organisation
LCA	Lilongwe City Assembly
NAC	National AIDS Commission
NGO	Non-Governmental Organization
PEP	Post Exposure Prophylaxis
PLWA	People Living With Aids
PMTCT	Prevention of Mother To Child Transmission
STIs	Sexually Transmitted Infections

1.0 INTRODUCTION

1.1 Background

HIV/AIDS is not just a public health issue; it is a workplace issue, development challenge and the source of widespread insecurity. Hard-won gains in employment and social protection are being reversed because of the epidemic. At the enterprise level, the effects of AIDS include loss of earnings, loss of skills, high cost of employee welfare, reduced productivity and the loss of markets, public confidence in case of public service provider, as the consumer or public base is whittled away. Just as enterprise experience due to HIV/AIDS, so too does a household when members are ill with the disease, there is a major drain on family savings and resources as it disrupts the work schedule. Therefore, the workplace must be on the front line of the fight against HIV/AIDS. By keeping employees and their dependants healthy is essential for the well-being of the enterprise in which they work. Keeping the enterprise healthy, in turn, is essential for the continued employment of employees (ILO, 2001; Occupational Health Services Convention, 1985, No. 161; Family Health International, 2004).

The impact of HIV/AIDS in workplace is not peculiar in Malawi, and more also is increasingly being felt in most local assemblies and yet the conditions of service which were developed before the era of the epidemic does not address ways of handling and supporting an employee infected or affected by HIV/AIDS. At national level, the Government of Malawi through its National HIV/AIDS policy is providing national leadership of a multi-sectoral response to HIV and AIDS, with the goals of preventing the further spread of HIV infection and mitigating the impact of HIV/AIDS on the socio-economic status of individuals, families, communities and the nation. The policy aims to reduce individual and societal vulnerability to HIV/AIDS by creating an enabling environment, and strongly affirms the importance of promotion and protection of human rights as a guiding principle (OPC and NAC, 2003).

It is with this background that the Lilongwe City Assembly through AMICAALL program and funding from UN habitant has planned to develop HIV/AIDS workplace policy. The policy will be expected to provide guidelines on the following keys areas of action:

- Prevention of HIV/AIDS
- Management and mitigation of the impact of HIV/AIDS in the workplace
- Care and support of employees and their relations infected and affected by HIV/AIDS
- Elimination of stigma and discrimination on the basis of real or perceived HIV status.

1.2 Purpose and Objectives of the Assignment

The purpose of this assignment is “to formulate HIV and AID workplace policy for the Lilongwe City Assembly.”

The specific objectives were:

- Conduct a literature review in relation to HIV and AIDS in workplace and guidelines in Malawi, Africa region and the International Community, and specifically literature review related to the legal framework on HIV and AIDS in workplace
- Facilitate awareness meeting and consultations with City Assembly members of staff and relevant stakeholders on HIV/AIDS in workplace

- Produce draft HIV/AIDS policy and policy programme plan document to be shared with City Assembly members of staff and relevant stakeholders for their input
- Submit the policy to the Assembly
- Produce and submit the final completed policy document to the Assembly

1.3 Methodology and approach

- The framework of the entire process, from entry to exit, is as presented in Appendix 2.
- The key methods used in the study were consultative sessions, employee survey, key informants interviews and a literature review.
- Consultative sessions were for individual within LCA who were purposively selected from all the directorates. Namely: Administration, Agriculture, Education, Engineering, Finance and Health. Also included were trade union representatives, health care employees and PLHAs. A list of employees consulted may be found in Appendix 3.
- A policy design team was instituted. Its membership recognised LCA demographics (Appendix 6). Its primary role was to appraise the subsequate formulation process.
- The key informants included LCA directorates' heads and individuals from selected institution across government, NGOs and donors, and private organisations. A list of people that were consulted may be found in Appendices 4 and 5.
- The checklists for the interviews and consultation are presented in Appendix 7 while the questionnaire is on Appendix 8. The questionnaire was translated to Chichewa in order to accommodate all categories of employees.
- Literature review mainly consisted of policies and legislations documents, budgets and on HIV/AIDS.
- The survey aimed at establishing employees' knowledge, attitudes and practices in relation to HIV and AIDS at workplace.
- Information from consultative sessions, interviews, survey and the reports was analysed to identify the gaps and proposals, and come up with the proposed policy outlined in this report.

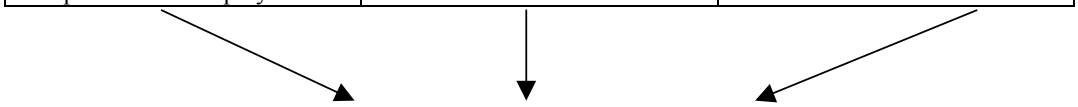
1.4 Assignment limitations

- Resource constraint made it impossible for an in-depth process considering that LCA has not less than 4,000 staff with the inclusion of urban primary school teachers; and second, deliberations were often interrupted as the meetings were taking place within the Assembly premises.
- Records on morbidity and mortality is not well maintained hence difficult analyse the two in relation to HIV and AIDS at LCA.

2.0 FINDINGS
2.1 Consultative Session

2.1.1 Impact of HIV and AIDS at LCA

Impact on LCA	Impact on employees	Impact on employees households
• Loss of skilled staff • Increase on funeral expenses • High absenteeism • High workload hence • Discrimination • Difficult to recruit and professional employees	Psychosocial dilemma due to loss of workmates **vs.** Employer's interventions on the epidemic	• Rising medical expenses • Increase of orphans • Marriage disintegration • Increase in diseases



Hence financial burden (on both the employee and LCA) leading to low productivity

2.1.2 Suggestions on the Principles and scope of the policy

Confidentiality
- Employer not to disclose employee's HIV status without informed consent
- Establish punishment for unlawful disclosure
- Establish incentives for disclosure

Grievance
- To establish a special office to deal with employees grievances

Safety and hygiene
- Training in safety and hygiene
- Avail first aid kits
- Avail appropriate protective uniform for particular work
- Proper management of sharp objects

Voluntary Counselling and Testing
- Advise on VCT
- Establish linkages

Discrimination
- No discrimination on occupational opportunities due to HIV and AIDS status

Accommodation and Social Support
- Introduction of Home Based Care
- Medical scheme for all staff or re-open the closed LCA clinic
- Establish HIV and AIDS committee
- Train peer counselors
- Avail transport to the sick
- Introduce a percentage to the salaries for HIV and AIDS support
- Introduce a nutritional support

- Reduce workload for HIV and AIDS staff

Prevention and Education

- Introduce recreation centre for staff
- Establish social clubs
- IEC on ART, care, nutrition etc
- Attitude care and education
- Controversies on whether condoms should be made available or not

HIV testing

- Not obligatory and its abuse of human right
- Permissible when required by external authorities

2.2 Key Internal Informants Interviews

2.2.1 Problems experience due to the epidemic

- Absenteeism high
- Loss of staff
- Funeral costs high, currently average funeral expenses are at MK50,000.00 per funeral. Presently, the Education Directorate is hardest hit with an average of one funeral per day.
- High recruitment costs

Note: most of the above are only accrued since there were no data to verify their significance except the instance of the Education Directorate.

2.2.2 Current programs

- Normal support, as prescribed by the terms of conditions of service, when off sick
- Condoms that were provided at least once sometime back
- School clubs for pupils in almost every primary school under LCA
- Workshop that was organized by MILGA sometime back

2.2.3 Suggested policy scope and its programme

Provision of ART for infected staff
Establishment of workplace HIV and AIDS clubs
Provide IEC materials
Provision of condoms on regular basis
Establish medical schemes for all LCA staff
Re-opening of the clinic situated at the City Hall (if the above medical scheme is not established) as its budgetary provision is still made despite its closure
Establish an office to coordinate HIV and AIDS workplace activities
Provide and maintain First Aid kits at all workplaces
Provide and maintain appropriate work uniform
Sensitisation on HIV and AIDS to all staff

2.3 Key External Informants Interviews

- As outlined by the table below, there are several organisations that could be approached for their assistance on particular interventions that LCA would want to implement. (*It should be noted that the list is not exhaustive, but only indicates the potential that exist within the Lilongwe City community*)

- The assistance could be in the area of IEC materials, possible funding, resources persons, actual health services, and as well as sharing of experience in HIV and AIDS in the workplace.

Organisation			**Services**		
	Resource persons	IEC materials	Health services	Possible funding	Shared experience in HIV and AIDS in workplace
NAC	√	√		√	
MACRO	√	√	√		
MANASO		√	√		
MANET+	√	√			
UNAIDS		√			√
UNDP		√			
Partners in Hope	√	√	√		
MILGA	√			√	
Business Coalition Against HIV/AIDS	√				√
PSI	√	√			
Ministry of Health	√	√	√		
CARE International					√
Nurses Council of Malawi					√

2.4 The Questionnaire Interviews

- The questionnaires were proportionally distributed to a total of 106 individuals from the 7 directorate of LCA. However only 75 questionnaires were responded, representing a 70.8% response rate. Members of the policy design team were responsible for these interviews. Out of these respondents, 57% were males, while 43% were females.
- The section presents selected findings of the conducted knowledge, attitudes and practice survey.

2.4.1 Knowledge of HIV and AIDS

- A majority of respondents, 98.6% (74 people) have heard of HIV and AIDS compared to 1.4% (1 individual).
- LCA staff has a good knowledge in terms how people can protect themselves from contracting HIV. A few people seemed to be ignorant about this issue as some responded that they would protect themselves from HIV by avoiding mosquito or other insect bites. In some cases it appears that there is a bit of confusion. Below is a table describing people knowledge on the issue.

Ways of avoiding HIV Infection	Responses		
	Yes	No	Don't know
Having only one uninfected partner	93.1	5.6	1.4
Avoiding public toilets	13.0	80.4	6.5
Avoiding blood transfusion	74.5	23.6	1.8
Using condoms during sex	87.5	12.5	0
Not sharing food with a person who has AIDS	2.3	95.5	2.3
Avoiding mosquitoes and other blood sucking insect bites	10.6	85.1	4.3
Ensuring that injections are given with sterile needles	92.1	6.3	1.6
Avoiding STD infections	89.1	9.1	1.8
Abstaining from sex	89.5	10.5	0
No way of avoidance	11.1	83.3	5.6

- Besides HIV and AIDS, when asked about their knowledge about other STIs, 95.9% said they have the knowledge while 4.1% said they do not.

2.4.2 Disclosure of HIV test results when diagnosed positive

- Interviews with external key informant revealed that their experiences concerning disclosure were a big challenge to the implementation of their workplace policy. They indicated that most people are willing to disclose their HIV status when found positive and end up using the benefits the policy has led down to assist them.
- A high percentage of LCA staff, likewise, is willing to disclose their HIV status to their employer as indicated by 65.6% of the respondents. About 26.6% indicated that they would not disclose while 7.8% was not sure.
- In terms of willingness to tell anyone apart from the employer, i.e a partner, relative or friends, 72.9% said yes they would while 27.1% said they would not
- The reasons highlighted for non-disclosure include; fear of losing their job (53.3%) of the respondents, fear of losing terminal benefits (27.3%), fear of losing their pension (27.3%), fear of stigma and discrimination (87.5%) and 33.3% felt that it was no use because there is no treatment for the disease as such they do not want to bother anyone. (*It should be noted that these selected unique responses hence cannot add up to 100%)*. These results are indication that the environment within which these people are operating is not conducive enough for HIV/AID infected people. There is need to create a better environment for such kind of people.
- The non-disclosure may be related to the fact that people's confidentiality is not respected as 24.6% of the respondents said that either themselves or somebody they know had experienced non-confidentiality concerning HIV status within LCA. On the other hand willingness shown by the 65.6% of some respondents may be an indication that people really are in need of help. However this reality can only be proven when the policy starts to operate.

2.4.3 Job risk

- The respondents were also asked whether the nature of their job puts them at risk of contracting HIV or not.
- About 40.6% indicated that yes, their job puts them at risk, while 59.4% said no. However the questionnaire did not ask did not ask details concerning how their job puts them at risk. This may have to be explored as LCA implements the policy.
- It should also be indicated that the percentage of respondents who said that their jobs put them at risk were from the directorate of education accounting for about 40%.
-

2.4.4 HIV/AIDS Discussions and Information

- A majority of the respondents (89.7%) indicated that they discuss about HIV/AIDS with their colleagues at work.
- Willingness to discuss with spouses and dependents, 90.0% said yes and 10.0% said no. Why not willing to share HIV/AIDS with spouse and dependents, 54.5% respondents said never had the knowledge while 45.5% were ashamed.
- In terms of availability of information on HIV/AIDS at workplace, about a 65% said that they have seen some information at LCA while the other 35% indicated that they had not seen any information on HIV/AIDS at work. It was however noted that all respondents from health and education directorate had seen some information on HIHV/AIDS. This could be due to the nature of their work. The types of the information that were commonly mentioned include; posters, leaflets, new letters, drama and teaching reference textbooks mainly from teachers.

2.4.5 Care and Support for the sick

- The general response from the people was that they are willing to provide care to a colleague who is sick with AIDS as shown by high percentage of 90% who indicated that they would do so. However there was still a small percentage of 10% that felt they cannot provide care to a colleague who is sick with AIDS. One reason that was indicated and is quoted "I feel disgusted when I see signs and symptoms naturally".
- People are also willing to work with somebody who has AIDS as indicated by 95.8% of the respondents.
- It was also discovered that 25% of respondents are burdened by caring of orphans whose parents died of HIV and AIDS related illness.

2.4.6 Some HIV and AIDS proposals at workplace

- The respondents were given some statements concerning how to deal with HIV/AIDS at workplace. They were asked to indicate whether they agree or disagree with each statement. The following table shows people's feelings on these issues.

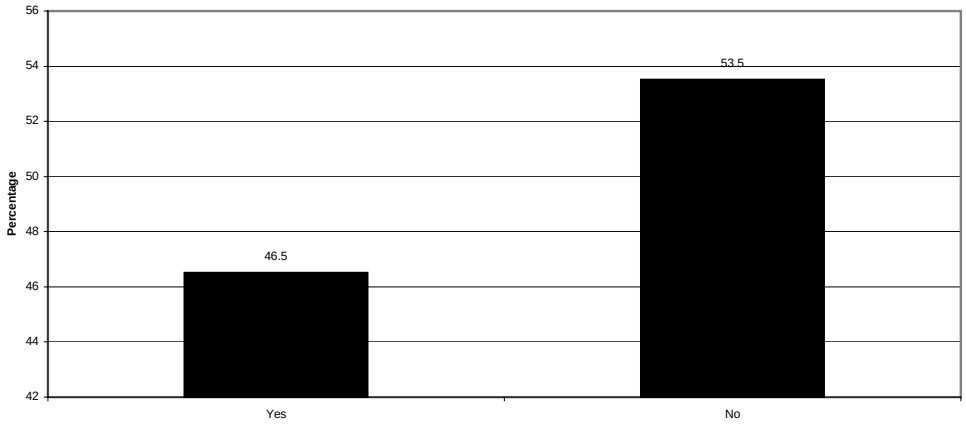
Statement	Percentage of Respondents				
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
a. There should be pre-employment HIV testing for all new employees	9	23.9	6	14.9	55.2
b. Employees should be required to inform their employers/managers/LCA of their HIV status when they become infected with HIV/AIDS	26.9	29.9	7.5	13.4	22.4
c. LCA should have a policy document on HIV/AIDS	66.2	24.6	6.2	1.5	1.5
d. LCA should provide health services, including ARV	76.6	20.3	0	1.5	1.5
e. LCA should contribute to cost of Nevirapine	64.1	34.4	0	0	1.6
f. LCA should contribute to the cost of PEP	61	30.5	5.1	1.7	1.7
g. LCA should encourage support groups for staff	62.9	33.9	3.2	0	0
h. HIV/AIDS prevention and counselling should be part of a LCA's general health policy	61.9	34.9	1.6	0	1.6
i. LCA should support household of its employees affected by HIV/AIDS	63.1	27.7	4.6	1.5	3.1
j. HIV/AIDS employees should have the same rights as other employees	64.1	21.9	4.7	6.3	3.1
k. HIV/AIDS is a private matter and management should not be involved	20	11.7	8.3	21.7	38.3
l. An employee should be dismissed if he/she is infected with HIV/AIDS	4.5	1.5	1.5	18.2	74.2

- Majority of respondents strongly disagreed with items ***a*** and ***l***, and strongly agreed with items ***c*** to ***j***.
- Majority of respondents are against pre-employment testing, dismissal on HIV and AIDS status, and they are for management involvement in promoting an open and supportive environment for HIV and AIDS infected and affected employees.

2.4.7 HIV Testing

- There is a small segment of employees who had a courage to get tested for HIV, but the encouraging hope is that of the many who have not tested before, 85.1% are willing to under go for a test while 14.9% are not

Percentage of Respondents who have Tested for HIV



2.4.8 LCA HIV and AIDS aspects for employees

- There seem to be some aspects of HIV and AIDS at LCA as indicated by the table on the right. The aspect that shows more certainty is the availability of condom to staff, that has 67.9% responses.

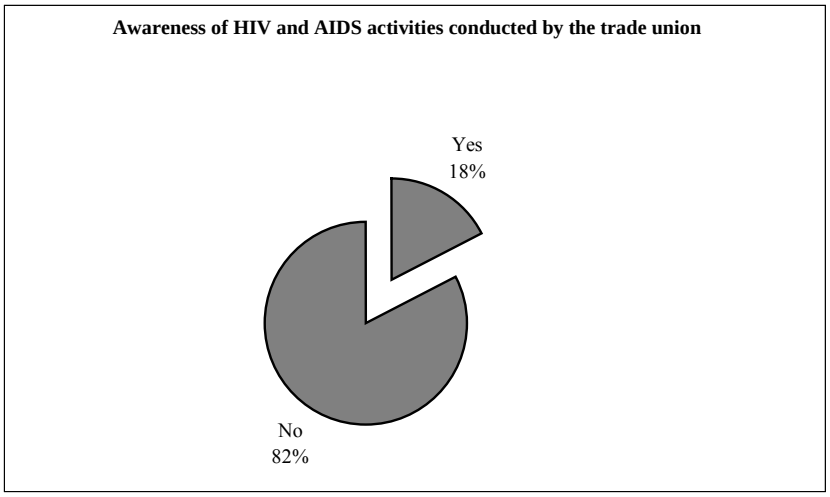
HIV and AIDS activity	**Percentage of respondents**	
	Yes	**No**
Workplace committee	23.6	76.4
HIV and AIDS education	23.1	76.9
HIV and AIDS counseling	19.2	80.8
Free HIV and AIDS treatment	19.6	80.4
Care of the sick	10	90
Peer Education	24.5	75.5
Condom supply	67.9	32.1
Voluntary counseling	24	76

- Despite the above, 95% respondents said they are willing to participate in HIV and AIDS workplace activities while 5% were not.

- There were a number of reasons for not participating in existing programmes, like not given such opportunity (75.5%) and not granted time off work (10.2%), and other specified reasons are as given in a table beside.

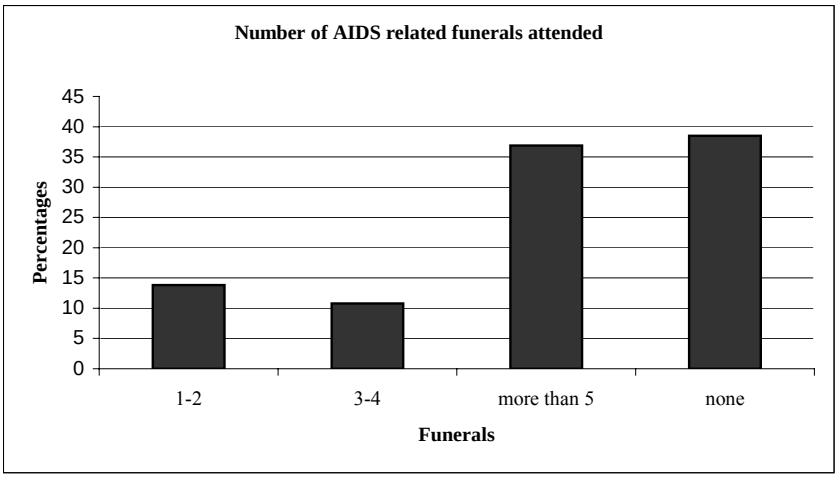
Reasons for not participating	% of respondents
worried about what people would think	2.04
not granted time off from work	10.2
too busy	8.1
not interested	4.1
no such opportunity	75.5

- Similarly, very few individuals are aware of HIV and AIDS activities at workplace that are conducted by trade union as shown in the figure below.



2.4.9 Number of AIDS related funerals attended

- There is quite a few number of AIDS related funerals attended by the respondents as presented in the table below. This has implication on time off work.



2.4.10 Learning needs

- Almost all the areas highlighted in the table indicate the learning needs.
- High priority learning needs are: how to talk to children about sex (90.6%), how to take care of patients (87%) and HIV and nutrition (85.4%).

Learning need	% of respondents	
	Yes	No
STIs	64.7	35.3
VCT	78.8	21.2
ART	67.4	32.6
Management of OIs	52.3	47.7
Coping with grief	61.4	38.6
Positive living	75.5	22.4
HIV and nutrition	85.4	14.6
How to talk to children about sex	90.6	9.4
Needs of orphans	77.1	22.9
PMTCT	78	22
How to take care of patients	87	13

3.0 DRAFTING POLICY AND ITS PROGRAMME PLAN

- Based on the findings, the consultants drafted the policy and its programme plan (Appendix 1) and presented it to the policy design team, trade union and the management for their comments before its final presentation.

4.0 CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

The main conclusions drawn from the findings presented in the report are as follows:

- HIV and AIDS contribute to human resources deficient, due to wastage and absenteeism, which compromises service delivery.
- LCA is burdened by HIV and AIDS due to deaths expenses and related cost.
- LCA is vulnerable to HIV and AIDS since its policy environment is not yet sensitive to the epidemic.
- Employees are burdened with HIV and AIDS due to a lot time spent on caring for sick relations, attending funerals and its related financial implications.
- Employees' skepticism with management commitment to the implementation of policy and its progarmme plan. Captured in these general sentiments:

"If LCA could close its most conveniently located clinic that catered forgeneral ailments what more with this HIV and AIDS?"

"It's been a while since the Government directed all organisations to allocate 2% of their ORT for HIV and AIDS workplace initiative. Year in and year out, no tambala has been spent on such initiatives here."

- There is indication of willingness to participate in well structured prevention programmes.
- There is indication of HIV and AIDS openness amongst employees.
- There is less stigmatization and discrimination tendencies at LCA, which needs sustaining.

4.2 Recommendation

- It is not too late for LCA to develop and adopt an HIV and AIDS workplace policy.
- Need for management commitment and visibility in articulating health, HIV and AIDS issues and supporting the implementation of the policy and its programme i.e consider scheduling policy programme implementation next financial year.
- Prevention should focus on education and awareness besides other initiatives such as availing condom and maintaining safe working environment.
- Explore possibility of providing ARV to its employees.
- Explore possibility of re-opening non-functional LCA clinics, and consider integrating VCT, STIs treatment and ARV for its staff and their families. Alternatively, LCA could consider offering medical scheme for its employees and their families.
- Establish linkages with health service providers in areas of VCT, STIs, ARV, PMTCT and PEP.
- Need for LCA to conduct monitoring and evaluation on HIV and AIDS impact on its service delivery.
- Need to establish efficient record keeping system that should include information on employee morbidity and mortality.
- Need for LCA to conduct review of its policy environment in recognition of HIV and AIDS policy.
- Need for LCA to establish policy procedures on such issues like disclosure.

5.0 KEY REFERENCE DOCUMENTS

These are the documents that were reviewed for the assignment.

City of Windhoek-Namibia (2004) *HIV/AIDS Service Directory*

Family Health International (2004) *Workplace HIV/AIDS Programs*

Government of Malawi (2000) *Employment Act*

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Government of Malawi (1997) *Occupational Safety, Health and Welfare Act*

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National Statistical Office (2005) *Malawi Demographic and Health Survey 2004*

SADC (1997) *SADC Code on HIV/AIDS and Employment*

UNICEF (2006) *Malawi Statistics on HIV/AIDS*

APPENDICES
Appendix 1: Draft HIV and AID Policy Programme Plan

Component 1: Preventing spread of HIV

	Objective	Activities	Duration	Budget
1.1	Provision of Information on HIV and AIDS	1.1.1 HIV and AIDS sessions for employees and their families	once every 6 months	
		1.1.2 Acquirement and distribution of IEC	on-going	
		1.1.3 HIV and AIDS sessions in the workplace	once every month	
1.2	Prevention of transmission within workplace	1.2.1 Procurement and distribution of First Aid Kits	Once every 6 months	
		1.2.2Train employees on First Aid and PEP	Once every 6 months	
		1.2.3 Establish linkages for PEP services	On-going	
		1.2.4 Procure and distribute condoms	On-going	

Component 2: Treatment, Care and Support

	Objective	Activities	Duration	Budget
2.1	Increase access to ART and treatment of STIs and OIs	2.1.1 Develop directory of ART sites and health services	Once every 6 months	
		2.1.2 Explore possibilities acquiring ART for staff	On-going	
		2.1.3 Explore possibilities to integrateSTIs, HIV and AIDS Services in LCA clinics	On-going	
2.2	Provision of support to the infected and affected employees	2.1 Counselling	on-going	
		2.2 Establishment of workplace support groups	1at quarter and on-going	
		2.3 Training on Home based care	3rd quarter and on-going	
		2.4 Procurement and distribution of Home based care kits	3rd quarter and on-going	
2.3	To facilitate access to Counselling and Testing Services	3.1 Establishing linkages with service providers	1st quarter and on-going	
		3.2 Training of workplace Counsellors	3rd quarter and on-going	
		3.3 Train workplace peer educator	2nd quarter and on-going	
		3.3 Awareness activities on conunselling and testing	1st quarter and on-going	

Component 3: Policy Management

	Objective	Activities	Duration	Budget
3.1	Promote awareness of the HIV and AIDS policy	3.1.1 Conduct dissemination sessions on the policy	1st quarter and on-going	
		3.1.2 Conduct orientation on the conditions of service for all Employees	1st quarter and on-going	
		3.1.3 Develop and incorporate HIV and AIDS for recruitment Orientation	On-going	
3.2	Re-align existing policies with the HIV and AIDS policy	3.2.1 Review the policy to existing policies and upgrade Accordingly	1st quarter and on-going	
3.3	Establish policy procedures	3.3.1 Identify procedures requirements	1st quarter and on-going	
		3.3.2 Formulate procedures	1st quarter and on-going	
		3.3.3 Induct employees on the procedure	2nd quarter and on-going	
3.4	Establish efficient records keeping system	3.4.1 Review existing records system	2nd quarter and on-going	
		3.4.2 Induct on new records system	2nd quarter and on-going	
3.6	Consolidation of Workplace programme	3.6.1 Identification of Workplace HIV and AIDS Committee Members	1st quarter and on-going	
		3.6.2 Development of workplace implementation plan	1st quarter and on-going	
		3.6.3 Monitoring and Evaluation of programmes	On-going	
		3.6.4 Launching of the Work place policy and its programme Plan	1st quarter	
3.7	Establish M&E	3.7.1 Identify areas for M&E	4th quarter and on-going	
		3.7.2 Schedule and operationalise M&E	4th quarter and on-going	

Appendix 2: Process Framework

PREPARATION PHASE

Activity	Participants
• Engage the LCA by meeting with the CEO • Meet with the Team Leader to plan the policy formulation process and deliverables i.e staff meeting, identifying stakeholders • Meeting the LCA Management Team to ask for the continued commitment on the task	Management, Team Leader and Facilitators

DESIGN PHASE

Activity	Participants
Desk Review • Existing policies both nation and LCA levels • Impact of HIV/AIDS at work place • Community resources Conduct policy design workshop • Collect information on HIV/AIDS work place issues • Select Policy Design Team Members Conduct KAP survey using questionnaire and KII Draft Policy & Devise HIV/AIDS program & indicators	Facilitators,, Team Leader & Policy Design Team

REVIEW PHASE

Activity	Participants
Conduct internal and external policy reviews (all stakeholders within and outside LCA who either participated in the policy design or NOT (incorporate suggested changes to the DRAFT)	Facilitators, Team Leader and Policy Design Team

LAUNCH PHASE

Activity	Participants
Launch the policy to reach every employee and encourage feedback	Management, Team Leader and Policy design Team

Appendix 3: List of Participants for the Consultative Sessions

Name	Directorate
Prof. D. Mkandawire	Chief Executive
Mr Bandawe	Administration
Mr. F. Chisambula	"
Mr A. Kamwendo	"
Mrs P. Chiunjiza	"
Mr P.S. Mhone	"
Mr. Kazembe	Agriculture
Mr M. Chunga	"
Miss C. Banda	"
Dr Magombo	Health and Social Welfare
Mrs L. Mlundira	"
Mrs E. Mlanjira	"
Mr D. Mtuwanjobvu	"
Mr P.E. Chimbalu	" (as well as a trade union representative)
Mr A. Tsilizani	Education
Mr K. Kachanje	"
Mrs M. Kujaliwa	"
Mrs D. Maere	"
Mrs E.N. Malikebu	"
Mrs L. Tembo	"
Mrs S. Mpulula	"
Mrs E. T. Yonas	"
Mr T.H.P. Kalumika	"
Mrs C. Mkumba	"
Mrs C. Fodya	"
Mr R. Mapulanga	Finance
Mr S. Mickel	"
Mr M.Haridi	"
Mrs N. Tembo	"
Mr A. Nyirenda	"
Mr W.C. Banda	Engineering
Mr G.Nyirenda	"
Mr K. Chunga	"
Mrs J.S.H Dumbo	"
Mrs E.P. Chasuwa	"
Mrs V. Chilumpha	"
Mr K. Waison	"
Mr. A. Katasefu	"
Mr. M. Kabondo	Facilitator
Mrs M. Lembani	Facilitator
(Apologies from Planning Directorate)	

Appendix 4: List of the External Key Informants

Name	Organisation
Doreen Msanje	National AIDS Commission
Nellie Kalulu	MACRO
Felix Manduka	MANASO
Victor Kamanga	MANET+
Jacqueline Kabambe	UNAIDS
Fred Mwathengere	UNDP
Deliwe Malema	MALGA
Steve Tchuka	Business Coalition Against HIV/AIDS
Agness Luphenzi	CARE International
Maureen Chirwa	Nurses Council of Malawi
Mr Kasamira	Ministry of Health

Appendix 5: List of the Internal Key Informants

Name	Directorate
Mr J. Hunga	Finance
Mr D. Mpoola	Planning and Development
Mr Bandawe	Administration
Mrs Mpulula	Education
Mr Chipepa	Education
Dr Magombo	Health
Mr Mtuwanjobvu	Health
Mr Kazembe	Agriculture
Mrs Namisingo	Agriculture as well as (trade union representative)
Mr Chirwa	Engineering

Appendix 6: List of Members for HIV and AID Policy Design Team

Name	Directorate
Mr Tsirizani	Education
Mr Banda	Finance
Mrs Namisingo	Agriculture (trade union representative)
Miss W.G. Nkosi	Planning and Development
Mr F. Chisambula	Administration
Mr Kachala	Engineering
Mr Chingana	Agriculture
Mr Chimbalu	Health (trade union representative)
Mr Mtuwanjobvu	Health
Dr Magombo	Health
Mr M. Kabondo	Rays Partnership (Facilitator)
Mrs M. Lembani	Rays Partnership (Facilitator)

Appendix 7: Checklists for Consultations

Checklist for Consultative Session

a. Clarify Participants' expectations and commitment
b. To introduce HIV/AIDS situation in Malawi
c. To discuss why is HIV/AIDS a business issue
d. To give an overview of laws/Policies governing HIV/AIDS in the work place
e. To identify HIV/AIDS policy proposals

Checklist for Internal Key Informants Interviews

a. How many people are employed in this directorate by section and by demographics
b. Do you think HIV and AIDS is a risk/potential risk to your Directorate and LCA at large (AND HOW)
c. What factors within LCA have a major effect on increase of HIV and AIDS
d. Does the Management (Trade Union, Staff) know about these factors
e. What is it doing
f. Any programs that exist as management response to HIV and AIDS
g. Any suggestions for interventions

Checklist for External Key Informants Interviews

a. Explain your organisation involvement in HIV and AIDS programs in the country
b. How do you relate with workplace programs/how do you support HIV/AIDS workplace policy initiative
c. What and How what would an organisation implementing HIV/AIDS policies/activities benefit from your services
d. Do you know of other organisations that support workplace programme
e. Most important to know from organisations implementing HIV/AIDS at their workplaces
f. How does your organisation deal with the following:

- Implementation process (from consultations to adoption)
- Grievance handling
- Punishment for unlawful disclosure
- Financial and nutritional support related to disclosure
- Availing condoms at workplace
- Management failure to comply with the policy implementation

g. Your organisation's experience and challenges

LILONGWE CITY ASSEMBLY

POLICY ON HIV AND AIDS

IN THE WORK PLACE

Prepared by:
Policy Design Task force

Facilitated by:

RAYS PARTNERSHIP

P.O. Box 31156,
Lilongwe.

July 2006

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1.0 INTRODUCTION

1.1 PREAMBLE

HIV and AIDS are of fundamental concern to the employment sector, because the great majority of people at risk of HIV infection and AIDS are of working age. AIDS will certainly have disastrous impact on the world of workplace now and beyond.

About 139 people in Malawi may die of AIDS every day. About 237 will probably get HIV during the same time, but will not yet be seriously ill[1].

Within workplaces, the loss of human potential due to premature death and active illness will negatively affect the core business of the organization. More specifically, high infection rates may cause increased absenteeism from work due to AIDS related illnesses and funeral, increased deaths at all levels, rising costs of occupational benefits, higher cost of recruitment, training and retraining, higher staff turnover, loss of skills and experience, increased difficulty in recruitment of skilled staff and increased workload on personnel who must cover for absent employees and fill multiple roles.

HIV and AIDS also influences the fundamental rights in the workplace, particularly with respect to discrimination and stigmatization aimed at employees and people living with and affected by AIDS and related diseases. The disease strikes hardest at women, thereby increasing existing gender inequalities. As a result of stigma and discrimination, some infected employees hide their status thereby compromising their own well-being and that of the organization. Hence, making national fight against HIV and AIDS difficult.

Keeping employees healthy and on the job is essential for the well-being of both families and an employer. Keeping employees is essential for the well-being of the business in which they work Keeping business healthy, in turn, is essential for continued employment of employees[2].

NOW THEREFORE, the Lilongwe City Assembly acknowledges the seriousness of the HIV and AIDS epidemic in Malawi and at workplace, and desires to reduce and manage its social, economic and developmental impact on the Assembly's service delivery and its employees.

AND the Lilongwe City Assembly, hereby adopt an HIV and AIDS workplace policy from the dual perspective of an employer and that of a good corporate citizen, thereby providing needed and sustainable civic services.

1.2 DEFINITIONS AND ACRONYMS

The following is by no means an exhaustive list of some of the terms and words which have been used in the document or which is associated with the concepts of HIV and AIDS. Unless the context dictates otherwise the following terms and words shall have the following meanings:

"Abstinence, Be faithful to one partner, Condomise, Plus" (ABC+) these are ethos that enable one to be protected from getting infected with and spreading HIV. Plus include considerations of testing for one's HIV status and transfusing only tested blood.

"Affected Employee" means an employee who is affected in any way by HIV and AIDS e.g. if they have a dependant who is HIV positive.

"Acquired Immune Deficiency Syndrome" (AIDS), a condition in which the body immune system is damaged or compromised from HIV infection so that the body immune system is unable to protect the body from germs e.g. bacteria, viruses, fungus and other threats, resulting in a cluster of medical conditions often referred to as opportunistic infections and cancers.

"Antiretroviral Therapy" (ART) means a combination of drugs used to inhibit the multiplication of retroviruses such as HIV.

[1] UNICEF (2006) *Malawi Statistics on HIV/AIDS*
[2] Family Health International (2004) *Workplace HIV/AIDS Programs: An Action For Managers*

"Dependant" unless the context otherwise means Assemblies employee's one legally recognized spouse, unmarried biological child or other dependants normally residing within the employees household and supported by the employee.

"Discrimination" means any form of differentiation, exclusion or restriction affecting a person, usually but not only, by virtue of an inherent characteristic, irrespective of whether or not there is any justification for these measures.

"Employee" shall mean any person employed on permanent or temporary basis at LCA, including an employee under probation.

"Gender" means social attributes and opportunities associated with being male or female and the relationship between women and men, girls and boys. These attributes, opportunities and relationships are socially constructed and are learnt through socialization processes.

"HIV" means the Human Immuno-Deficiency Virus, a virus that weakens the body's immune system and causes AIDS.

"HIV Positive" means the presence of HIV antibodies in the blood after a medical test.

"HIV Testing" means taking a medical test to determine a person's HIV sero-status or written or verbal questions inquiring about previous HIV tests, questions related to the assessment of risk behavior (for example questions regarding sexual practices, the number of sexual partners or sexual orientation); and any other indirect methods designed to ascertain an employee's or job applicant's HIV status.

"HIV infected employee" means an employee who has tested positive for HIV or who has been medically diagnosed as having AIDS.

"Informed consent" means that the employee has been provided with information, understands it and based on this has agreed to undertake the HIV test. It implies that the individual understands what the test is, why it is necessary, the benefits, risks, alternatives and any possible social implications of the outcome.

"Lilongwe City Assembly" (LCA) means the employer.

"Opportunistic Infection" (OI) means infection caused by organisms to which the body is normally immune. When the immune system is impaired, such as is the case in AIDS, opportunistic infections can occur, such as Tuberculosis, Karposis Sarcoma, fungal infections, Pneumocystic jerovice (carinii) pneumonia, diarrhea, etc.

"Post Exposure Prophylaxis" (PEP) means procedures followed and treatment given, to an employee who has been exposed to blood, or injured on the job, from needle stick injury, splash of human blood to the eyes, nose or mouth, or other similar event.

"Pre and Post Test Counseling" means a process of counseling which facilitates an understanding of the nature and purpose of the HIV test.

"Prevention of Mother To Child Transmission" (PMTCT) means prevention of transmission of HIV from a woman with HIV infection to her fetus/infant before or during birth or through breastfeeding.

"Reasonable Accommodation" means any modification or adjustment to a job or to the workplace that is reasonably practicable and will enable a person living with HIV or AIDS or other sickness to have access to or participate or advance or continue in employment.

"Sexually Transmitted Infections" (STIs) means a viral or bacterial disease transmitted between sexual partners. Common STIs include gonorrhea, herpes sores, chlamydia etc

"Shared Confidentiality" means sharing someone's private affairs entrusted to an individual, by virtue of one's position at work or in the family, with another person who has a common interest, following dual consent.

"Stigmatization" means any mark or attribute of shame or discredit, or negative thoughts or prejudice that result in the reduction of a person or group from a "whole and usual person to a tainted, discounted one".

“Termination of Employment” unless the context demands otherwise means and includes termination with notice, dismissal without notice, retrenchment, early retirement at the instance of the employer and constructive dismissal.

“Universal Precautions Protocol” means minimum standards of infection control used in the handling of blood and other bodily fluids, at all times to reduce the risk of transmission of blood borne infections. These include careful handling and disposal of sharps; hand washing with soap and water before and after all procedures; use of protective barriers such as gloves, masks, aprons, etc for direct contact with blood and other body fluids; safe disposal of waste contaminated with blood and other body fluids; proper disinfection of instruments and contaminated equipment; proper handling of soiled linen, etc.

"Voluntary Counselling and Testing" (VCT) means provision of testing facilities for HIV and AIDS, and counseling prior to and after testing.

“**Workplace”** means any place or premises in which one or more persons are employed and includes apprentices, casual, part and full time employment and all types of employment contracts. It applies to the workplace in the broad sense of the term.

1.3 POLICY OBJECTIVES

The policy sets out guiding principles that LCA and its employees must follow in addressing the HIV and AIDS issues in the workplace for effective prevention and management of the epidemic among employees and their families. In addition, the policy promotes a set of responsibilities as a mechanism to foster co-operation at all levels of LCA for effective implementation of the policy.

1.4 APPLICATION AND SCOPE

The policy of HIV and AIDS applies to all staff regardless of job level or probationary status, spouse and dependents.

1.5 LEGAL FRAMEWORK

The HIV and AIDS workplace policy shall be read with all relevant legislations, which include the following:

- Constitution of Malawi of 2001 - the Constitution gives all the employees the right to fair labour practices. Furthermore, the equality clause states that everyone is entitled to equality and freedom from unfair discrimination.
- Labour Relations Act No. 16 of 1996 - the Act regulates the relationship between employer and employees. It prohibits unfair discrimination and protects employees against arbitrary dismissal. This Act protects employees from being dismissed simply because they are HIV positive and from being discriminated against with regard to employee benefits, staff training and other work related opportunities.
- Workers' Compensation Act No. 7 of 2000 - The Act provides compensation for employees who are injured in the "course and scope" of their employment.
- Employment Act No. 6 of 2000: the provisions of the Act prohibit unfair discrimination either directly or indirectly on a wide range of the following grounds
    - i) Race, gender, pregnancy, marital status, ethnicity, color, sexual orientation culture and HIV etc
    - ii) Medical testing is not allowed unless it is an inherent requirement of the job. In addition HIV testing can only be carried out if required by the job and employee consent
    - iii) The employee has a common law right to privacy. This means that an employee does not have a legal duty to inform the employer of his or her HIV status nor may a health worker reveal his or her HIV status to the employer without their consent. Should an employee voluntarily divulge or disclose her/ his HIV status to management it cannot be used against him/her in a discriminatory manner.
- Occupational Health and Safety Act No. 21 0f 1997 - The act requires that employers, as far as is reasonably practical, create a working environment that supports health and wellness in the HIV/AIDS context. This means that universal precautions are adhered to at all times, and that every person is treated as potential HIV carrier.

The policy should also be read in conjunction with codes of good practice such as ILO and SADC codes of Practice on HIV/AIDS that may be available at both national and international levels.

The contents of these instruments should be taken into account when developing, implementing and reviewing any workplace policies or programmes.

2.0 POLICY STRUCTURE AND PRINCIPLES

The following are the guiding principles for the implementation of the policy:

2.1 PREVENTION AND BEHAVIOURAL CHANGE

2.1.1 Education and Awareness

2.1.1.1 LCA shall support implementation of ongoing education and awareness programmes for all its employees and their families so as reduce the spread of HIV and to manage AIDS. The nature and extent of a workplace programmes shall among other issues cover:

- ART
- VCT
- ABC+
- Positive living
- Nutritional therapy
- STIs
- OIs
- PMTCT
- Human Rights and HIV/AIDS
- Stigma and discrimination
- Sexual harassment

2.1.1.2 LCA will facilitate training of peer educators who will provide appropriate education related to HIV and AIDS within its workplace.

2.1.1.3 LCA shall ensure that the awareness and educational programmes should take place during paid working hours. Attendance should be considered as part of work obligation. This does not exclude out-of work hour's programmes.

2.2.2 Healthy and Safe Working Environment

2.1.2.1 LCA recognizes its obligations to provide a safe work environment and without HIV risk to health of its employees and clients. The Assembly will therefore take all reasonable and practical steps to ensure that:

(a) Appropriate education is provided to its staff on PEP, universal preventions and first aids procedures, so as deal with and reduce the risk of HIV infection in the workplace
(b) a representative number of employees from each directorate are trained to provide first aid

2.1.2.2 LCA shall take necessary actions following occupational exposure to HIV and other blood borne pathogens, which should include PEP.

2.1.3 Voluntary Counseling and Testing

2.1.3.1 LCA shall promote and facilite access to pre- and post HIV test counseling as well as ongoing counseling.

2.1.4 Safer Sexual Practice

2.1.4.1 LCA shall promote the ABC+ ethos for safe sexual practice among its employees.

2.1.4.2 LCA shall make condoms available to all employees, provided free of charge or at a nominal cost, and distributed in a polite manner within their workplace.

2.2. TREATMENT, CARE AND SUPPORT

2.2.1 Treatment

2.2.1.1 LCA recognizes that ART is a life-prolonging treatment; as such LCA shall facilitate access of ART to employees and their spouse and dependents through its partnerships.

2.2.1.2 LCA shall facilitate effective treatment of OIs and STIs.

2.2.2 Care and Support

2.2.2.1 LCA shall ensure all employees and their families, are given advice regarding relevant services and support available within their community such as PMTCT

2.2.2.2 LCA shall facilitate that its employees should establish self-help groups or the referral of workers whether affected or infected with HIV and AIDS to self-help groups and support organizations within the local community. This facilitation is kept confidential, whereby; it is open only to employees who are HIV positive.

2.2.2.3 In the event of death of an employee, dependants (widows, widowers, orphans) will be supported through provision of the usual benefits without discrimination, as stipulated in the conditions of services of LCA.

2.2.2.4 LCA shall consider integrating VCT, ART, STIs, OIs and PMTCT in all its existing health facilities at the workplace for the benefit of its employees and their families

2.2.3 Legal Information, Advice and Assistance

2.2.3.1 LCA shall encourage all of its employees to write wills disposing of their estates, including their pension and other terminal benefits payable from the LCA. The LCA shall use the legal aid services for advice and assistance.

2.2.4 Gender Equality

2.2.4.1 LCA acknowledges that HIV and AIDS impacts on male and female employees differently. This includes the recognition that women normally undertake the major part in caring for those with AIDS-related illnesses, and that pregnant women with HIV have additional special needs.

2.2.4.2 LCA shall ensure encourage and support men to be carers by designing interventions that address gender inequalities.

2.3 ORGANISATION AND HUMAN RESOURCE

2.3.1 HIV testing and Screening

2.3.1.1 LCA is an equal opportunity employer and will not use HIV testing as a pre-requisite for recruitment, access to training, or promotion for all LCA prospective and permanent employees.

2.3.1.2 In implementing the section below, it is recommended that parties take note of the position set out in item 2.3.1.1

2.3.1.3 LCA may provide testing to an employee who has requested a test in the following circumstances:

(i) In the event of an occupational accident carrying a risk of exposure to blood or other body fluids; and,
(ii) For the purposes of applying for compensation following an occupational accident involving a risk of exposure to blood or other body fluids.

Furthermore, such testing may only take place within the following defined conditions:

(i) At the initiative of an employee;
(ii) Within a health care worker and employee-patient relationship;
(iii) With informed consent and pre- and post-test counselling, as defined by the Ministry of Health's National Policy on Testing for HIV; and
(iv) With strict procedures relating to confidentiality of an employee's HIV status

2.3.1.4. All the above have to be done with employee's informed consent and in conditions of the strictest confidentiality.

2.3.2 Creating a non-discriminatory and caring environment

2.3.2.1 LCA shall ensure that all employees with HIV/AIDS are treated the same as employees without or with other comparable health/medical conditions.

2.3.2.2 LCA management and co-workers are expected to continue working relationships with any employees who is living with or potentially perceived to be living with HIV or AIDS. Management and co-workers who refuse to work with them, withhold service from, harass or otherwise discriminate against an employee living with or perceived to be living with HIV or AIDS will face disciplinary procedures.

2.3.2.3 In case, where there is adequate information that LCA's employee victimatised and discriminated against the client who is or perceived to be HIV positive or vice versa; LCA will see to it that necessary recourse are observed.

2.3.3 Confidentiality and Disclosure

2.3.3.1 LCA employees is under no obligation to inform his/her manager or other employees of his/her HIV status unless it is necessary to obtain benefits, request reasonable job accommodation, or in event of an emergency that necessitate such disclosure.

2.3.3.2 LCA shall encourage all employees and their families to be open about their HIV status and mechanisms shall be put in place that encourage openness, and acceptance and support of those employees who disclose their HIV status. Where an employee chooses to voluntarily disclose his/her HIV status to LCA or other employees, this information may not be disclosed to others without employee's written consent. Where written consent is not possible, steps must be taken to confirm the employee wishes to disclose his/her status.

2.3.3.3 LCA guarantees that any employee who has disclosed their HIV status will not be discriminated against or stigmatized.

2.3.3.4 LCA shall take careful precautions to protect confidentiality of any medical information relating to HIV status of the employees. In case of breach of confidentiality, LCA will ensure necessary disciplinary procedures are observed.

2.3.4 Shared confidentiality

2.3.4.1 Where an employee chooses to voluntary disclose his or her HIV status in order for them to benefit from stated LCA occupational benefit. The information disclosed shall be shared by all responsible and they will be obliged to terms of shared confidentiality.

2.3.5 Reasonable Accommodation

2.3.5.1 LCA shall ensure that HIV infected employees should continue to work under normal conditions in their current employment for as long as they are medically fit to do so. When on medical grounds they cannot continue with normal employment, LCA, where appropriate in consultation with the employee, shall redefine the job of an employee who is sick to reduce physical exertion or undue stress e.g. provision of light duties, flex time work, modified graduated sick leave etc without prejudice to their benefits.

2.3.5.2 LCA shall consider offering the employee a job swap or arrangements to job share where reasonable accommodation cannot apply.

2.3.5.3 If the employee is incapacitate and is no longer able to perform his/her duties, where certified by appropriate medical authorities, the LCA shall apply standard procedures for termination on medical grounds in accordance with the LCA conditions of service without discrimination.

2.3.6 Sick and Compassionate leave

2.3.6.1 Sick and compassionate leave shall be in line with the LCA's conditions of service or as per employee contract. If an employee continues to be ill for a long period the LCA shall encourage the employee to retire on medical grounds subject to the stated terms and conditions of services.

2.3.6.2 Employees who become ill with AIDS or employees affected by AIDS should be treated like any other employee suffering from or affected by a comparable life threatening illness with regard to access to employee benefits including sick leave and compassionate leave benefits.

2.3.6.3 LCA shall ensure that as far as possible the employee's right to confidentiality regarding his or her HIV status is maintained during any incapacity proceedings. An employee cannot be compelled to undergo an HIV test or to disclose his or her HIV status as part of such proceedings. Medical tests if any should be aimed at determining fitness for work like in the case of any other serious medical condition.

2.3.7 Dismissal

2.3.7.1 That employment should never be terminated solely on the basis of an individual's perceived or real HIV status or related family responsibilities, or should HIV status influence retrenchment decisions or employer initiated early retirement.

2.3.8 Staff Development Programme

2.3.8.1 LCA shall invest in training staff to ensure that they are multi-skilled so that they can easily multi-task in the event of one or more employees being off sick.

2.3.9 Compensation for Occupationally Acquired HIV

2.3.9.1 LCA shall deal with occupational exposures to HIV in accordance to the Workers Compensation Act and the Occupational Health and Safety Act.

2.3.10 Grievance and Disciplinary Measures

2.3.10.1 LCA shall ensure that the rights of employees with regard to HIV and AIDS and the remedies available to them in the event of breach of such rights become integrated into existing grievance procedures.

2.3.10.2 LCA shall ensure that employees with grievance related to HIV and AIDS shall present their complaints following the set grievance procedures on HIV.

2.3.10.3 LCA shall develop special measures to ensure the confidentiality of the complainant during such proceedings, including ensuring that such proceedings are held in private.

2.3.10.4 Personnel dealing with related HIV grievances shall protect the confidentiality of the employees medical information.

3.0 PARTNERSHIPS

3.1 LCA acknowledges that successful implementation of this policy and programmes require cooperation, trust and commitment of all its social partners: councilors, management, employees, and trade union and external partners.

4.0 POLICY CONSULTATION AND REVIEW

4.1 In view of the continuing spread of HIV, and changing scientific knowledge about behaviour, including treatment and the discovery of new drugs, LCA in consultation with its employees and relevant stakeholders will review its HIV/AIDS policy every year unless otherwise.

5.0 MANAGEMENT OF THE POLICY

Upon adoption of the policy by the LCA, this policy shall be managed as follows:

5.1 Custodian of the Policy

5.1.1 The management shall be the custodian of this policy.

5.1.2 The management shall ensure that the necessary structures, as and when necessary, are established in the LCA to ensure effective and proper furthering of the objects of this policy.

5.2 HIV and AIDS Workplace Committee

5.2.1 LCA shall establish HIV and AIDS Workplace Committee that shall serve for the following:

(i) Monitor the impact of the HIV and AIDS epidemic in the workplace
(ii) Monitor the effectiveness and impact of the HIV and AIDS workplace policy
(iii) Recommend amendments to the policy, as and when required
(iv) Manage the policy programme plan

(v) Develop an implementation plan based on the identified policy priority areas against the 2 per cent HIV and AIDS allocation in the annual LCA budget. Where the allocation may not suffice for the planned activity, the Committee will need to be creative.

(vi) At the end of every financial year, and where need be, the Committee shall present formal progress review report to all Management Meeting and Directorate meetings.

5.3 Composition of the Committee Membership

- The Chief Executive, shall be the Patron
- Designated member of senior management shall be the Coordinator and preside over all the meeting of the Committee
- Each Directorate shall have a representative
- Two trade union representative
- The Committee may, from time to time or in respect of specific matter, co-opt any person(s), provided that, although such person may take part in the discussions, he/she will not have a vote
- Membership of the Committee should also ensure gender representation

5.4 Responsibilities of an employee

- Take responsibility of own health
- Participate in the programmes
- Respect the rights, privacy and confidentiality of those living with HIV and AIDS
- Share the lessons learnt at the workplace with families and communities
- Encouraged to follow the ethos of ABC+

5.5 Responsibilities of Directors, Managers and Supervisors

- Ensure that all employees in their sections are aware and understand the policy
- Ensure a safe working environment through the promotion of the universal precautions
- Create a supportive and non-discriminatory environment for disclosure, gender equality
- Take responsibility of shared confidentiality
- Raise awareness concerning HIV and AIDS to their employees

5.6 Responsibilities of Human Resources Department

- To make the policy available and accessible to all employees
- To conduct formal orientation during induction for all new employees in regard to workplace policy
- To review existing human resource policies to align them with HIV and AIDS workplace policy
- To develop and implement policy procedures according to stipulated regulations and policies for people infected and affected with HIV and AIDS such as disclosure procedure

5.7 Responsibilities of People Living with HIV and AIDS

- Have a duty to protect and enforce their rights
- Have a duty to respect the rights, health and integrity of others
- Have a responsibility of enrolling with support groups
- Have a responsibility to access ART
- Have a responsibility of living positively both socially, emotionally and physically

5.8 Responsibilities of Trade Union

- Ensure involvement in HIV and AIDS programmes
- Ensure consultation in all processes
- Encourage employees to participate in the HIV and AIDS programmes
- Participate in collaborative partnerships

MZUZU CITY ASSEMBLY

HIV / AIDS SITUATION ANALYSIS

Consultancy Report

June 2006

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Summary of the findings

Mzuzu City Assembly with assistance from AMICAALL Project contracted Development Technical Assistance Services to conduct an HIV/AIDS situation analysis for Mzuzu City. The objectives of the situation analysis were to assess the scope, scale and trends of HIV/AIDS epidemic in the city, to develop city HIV/AIDS profiles, to develop a data base and profile for HIV/AIDS activities, to identify high and low risk population, to identify high areas of impact and high risk factors that fuel the HIV pandemic, to map the services being provided in the city, to identify gaps HIV/AIDS related service delivery and to identify best practices and means of application.

To achieve the expected output the consultant: conducted a review of existing literature on HIV/AIDS, held discussions with DACC members for Mzuzu City Assembly on various aspects related to HIV/AIDS programmes, contacted various HIV/AIDS and reproductive health service providers and collected information for mapping and developing a database for these service providers. Using a participatory appreciative approach the consultant examined the capacities of each organisation implementing programmes or providing HIV/AIDS services in the City.

HIV prevalence data were extracted from registers maintained by HIV testing sites. Both qualitative and quantitative data were collected in this study. The qualitative data were analyzed as summaries of resolutions made during the focus group discussions with various service providers. The quantitative data were analyzed using a Statistical Package for Social Scientists (SPSS). Projections of HIV prevalence in the future were made with assumptions that data collected were a random representation of the entire Mzuzu City populace and that there will be no change of HIV interventions.

This study has revealed that there are many service providers in HIV/AIDS related activities in Mzuzu City. The activities of the service are diverse including: VCT, PMTCT, support to the disadvantaged groups of people, control and treatment of STIs, peer education programs in schools, offering of community services, encouragement of youths to adopt various livelihood strategies, disseminations of information on HIV / AIDS through various methods and treatment of patients from various infections. There are a lot of overlaps in what different service providers do and where they offer the services. The positive attributes and areas which require improvement for better service delivery for each service provider are discussed. Many suggestions and recommendations have been made for better service delivery in mitigating the impacts of HIV / AIDS.

HIV prevalence rates in Mzuzu City vary according to several factors including: The reason for the test, HIV test centres, with time, gender, age and marital status. The findings on HIV prevalence tarry with those at national level. However, there were some shortfalls of to be born in mind when interpreting the data on HIV prevalence. Most sites have just started administering ARV drugs to HIV positive patients.

Future projections of HIV prevalence were made for two scenarios: The first scenario was based on MACRO data with the assumption that the data were less biased and the second was based on a combination of data for MACRO and other health institutions. HIV/AIDS projections based on interpretation of data from MACRO indicate that HIV prevalence would steadily decline up to the year 2011 when there would be no HIV positive individual.

Projection based on combined data for all the centres indicate that there would be an increase in HIV prevalence in Mzuzu city up to 2016 everybody would be infected with HIV. The projection trends for the two scenarios differ because of the variation of HIV prevalence amongst test sites. The shortfalls of the data for future predictions are discussed.

Monitoring indicators for HIV interventions in Mzuzu city have been developed based on the findings of the present study. Some suggestions have been made on the data collection methods for the indicators.

Several recommendations have been made for the future success of HIV interventions in Mzuzu City and most of them are linked to the need for proper coordination of the activities.

1. Introduction

1.1 Background

Mzuzu City Assembly with assistance from AMICAALL Project secured funding from UN Habitat to conduct HIV/AIDS situation analysis for the city of Mzuzu. The situation analysis would assist to establish trends, magnitudes and the impact of the epidemic and identify gaps for comprehensive HIV/AIDS interventions and HIV/AIDS impact mitigation strategies in the city.

Development Technical Assistance Services (DeTAS) was contracted to conduct the HIV/AIDS situation analysis for Mzuzu City Assembly.

1.1.1. Objectives of the consultancy

- To assess the scope, scale and trends of HIV/AIDS epidemic in the city
- To develop city HIV/AIDS profile
- To develop a data base and profile for HIV/AIDS activities
- To identify high and low risk population.
- To identify high areas of impact and high risk factors that fuel the HIV pandemic
- To identify and describe services being provided in the city, target groups, geographical coverage of the existing services and providers of services (mapping).
- To identify gaps in the service delivery in the city for HIV/AIDS related services.
- To identify best practices and means of application.

1.1.2. Expected outputs of the consultancy

- Provide city profile on HIV/AIDS
- Identify potential indicators for monitoring and evaluation of HIV/AIDS responses
- Provide statistics and future projections of HIV/AIDS in the city
- Provide a situation analysis report on HIV/AIDS in the city and recommendations.

1.1.3. Redirections on the terms of reference

The consultant noted that the development of an electronic retrievable and updatable database generating various reports was not possible within the available time frame for the

consultancy. Such a database would require a separate timeframe to provide ample time for design of data entry forms and reports to be generated and inputting of data into the database by an Information Technology specialist. However, within the available time frame it was practical for the consultant to produce a non-retrievable database that would be difficult to update.

2. Methodology for the consultancy

In order to achieve the required outputs for the consultancy the consultant employed a number of tasks. The major tasks included review of existing literature, discussions with DACC members, mapping of the service providers, analysis of the activities of service providers, and extraction of information from registers used by various service providers.

2.1 Review of existing literature.

The consultant reviewed available documentation on HIV (Annex 4) at Mzuzu City Assembly and other places. The documentation include: Draft Mzuzu City HIV and AIDS Strategic Plan 2005 – 2008; Malawi National HIV/AIDS ACTION framework (2005 – 2009) National Aids Commission; National Aids Commission and Reproductive Health Unit (April 2003), other correspondences on HIV / AIDS. Available documents for various service providers on HIV / AIDS within the boundaries of the city were also reviewed. The documents reviewed include service registers, institutional constitutions, mandates and progress reports. The literature review provided a preliminary situation analysis of HIV/AIDS issues in the City Assembly, the scope of the services being provided and the bulk of the quantitative data for the study.

2.2. Discussions with DACC members

The consultant met Mzuzu AIDS Coordination Committee (DACC) members to discuss HIV/AIDS monitoring and evaluation indicators with a view to examining the feasibility of measuring the indicators within the scope of the present HIV/AIDS situation analysis. An inventory of all the service providers and implementers of HIV/AIDS activities in Mzuzu City was also outlined during this meeting. This was useful as a planning guide for the subsequent meetings with other HIV/AIDS service providers. The discussions with DACC members also touched on the following subjects:

- the role of DACC members in HIV / AIDS,
- Stakeholders involved in HIV AIDS mitigation and control
- existing linkage mechanisms with other service providers
- What is working very well in relation to mitigation of HIV / AIDS impacts
- What needs to be improved for better services on mitigation of HIV / AIDS impacts

2.3. Mapping of the service providers and development of a data base

The consultant visited various service providers and collected the following information from each service provider:

- the name of the service provider,
- contact details,
- location of their offices,
- the goals and objectives for the service provider,

- description and numbers of the target group,
- geographical coverage of the services,
- Outline of activities and services for the service provider.

A database of the services on HIV/AIDS was developed in Microsoft Excel from the above information. The database has the following attributes:

- It indicates the name of each organization, contact details, location, geographical coverage area, target group, goals, objectives and key activities and services and staffing levels and areas of competencies.
- The database is designed in Microsoft Excel.

2.4. HIV prevalence

The consultant collected HIV prevalence information from specific service providers that conduct HIV test for various reasons including voluntary testing and counselling (VCT), ARV clinics, and reproductive health service providers (mostly focusing on PMCT, STI and condom use). The service providers involved were Milazi Clinic at St Jones Hospital, Mzuzu Central Hospital HIV testing centres (Pharmacy, TB Ward and Rainbow Clinic), Mzuzu Health Centre, MACRO and Banja La Mtsogolo (BLM).

The consultant examined the registers for HIV tests by various service providers and extracted the relevant information for the current study. Two enumerators were engaged in extraction of the relevant information that included: the date the clients were tested for HIV, number tested, sex, age, marital status, reason for HIV test, HIV prevalence and services offered to the client after the test. It was not possible to obtain all the required information from the service providers. For instance information on location clients came from, occupation of the client and education background is not recorded in the registers. Also the information bearing names of clients such as those on ARVs is very sensitive and could not be released to the consultant. For sensitive information the consultant was provided with summaries that lacked most of the required details.

The service providers that distribute condoms were asked to provide information on the reasons for condom distribution, number of condoms distributed and the target beneficiaries of condom distribution including age, sex and marital status of condom recipients.

2.5. Analysis of the service providers

The consultant, using a participatory appreciative approach, examined the capacities of each organisation implementing and providing HIV/AIDS services in the City. Two facilitators were involved in the discussions with various service providers and the assessment focused on the following:

- Description of services and approaches used by the organization
- Stakeholders or partners working with the service provider
- An assessment of the strengths and capacities of staffing and services
- An assessment of the things that are working very well and are contributing to the reduction of further spread of HIV infection in the City as well as helping to mitigate the impacts of HIV/AIDS in Mzuzu City.
- An assessment of things that the organization needs to improve if it has to effectively deliver its services

2.6. Data Analysis

Both qualitative and quantitative data were collected in this study. The qualitative data were analyzed as summaries of resolutions made during the focus group discussions with various service providers. The quantitative data were entered into and analyzed using a Statistical Package for social Scientists (SPSS). The outputs of these analyses include the prevalence of HIV by age group, sex, year and reason for test. Where possible the data have been presented in line with some of the national indicators on HIV outlined in the Malawi National HIV/AIDS Action framework (2005 – 2009).

Projections of HIV prevalence in the future were made through polynomial regressions of percentage HIV positive people on the annual trends from the time HIV prevalence data started being collected. The regressions were repetitively done on the same data by changing the order of regression from the lowest to the highest possible. A polynomial regression order output that gave the best and realistic fit to the data was chosen as the projection for the future. The assumptions for applying these regressions to project HIV prevalence in were as follows:

- People going for HIV test are a random representation of the entire Mzuzu City populace with each one of them having the same likelihood of being HIV positive.
- The trends of HIV prevalence in future will follow the current trends (for the years HIV prevalence data were collected) i.e. There will be no change of HIV interventions and human risk behaviour for HIV infection.

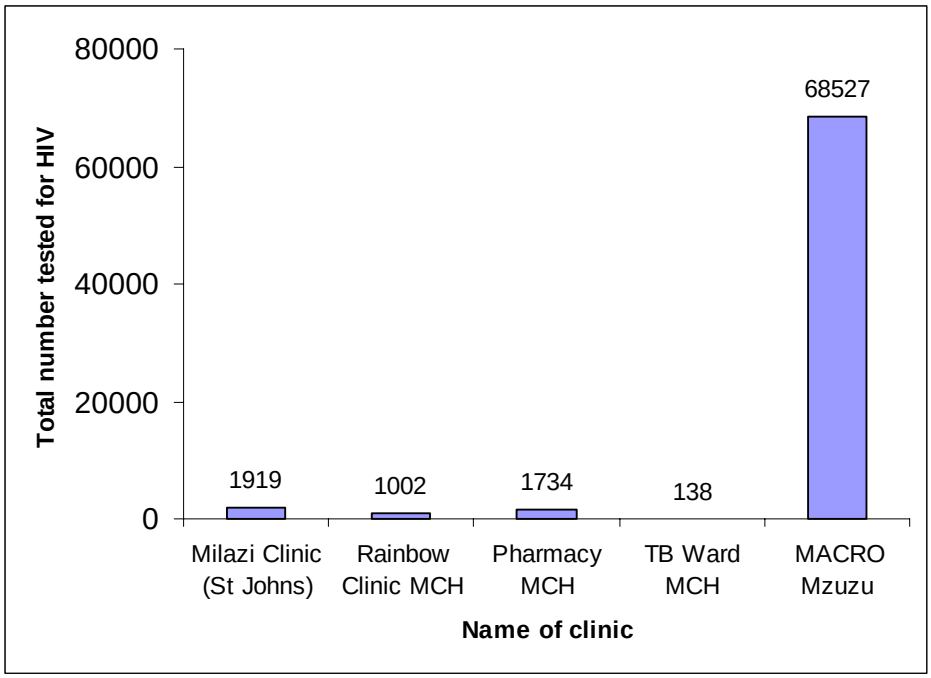
3. Findings of the consultancy

3.1. HIV Prevalence in Mzuzu City

3.1.1. HIV prevalence by VCT / ARV Centre and reason for HIV test

Three major centres offering services on HIV testing / counseling were visited. These are MACRO, Milazi Clinic based at St Jones Hospital, and Mzuzu Central Hospital that has three sub centres (Pharmacy, TB and Rainbow Clinic). Amongst these centres MACRO is the major service provider on tests for HIV (Figure 1).

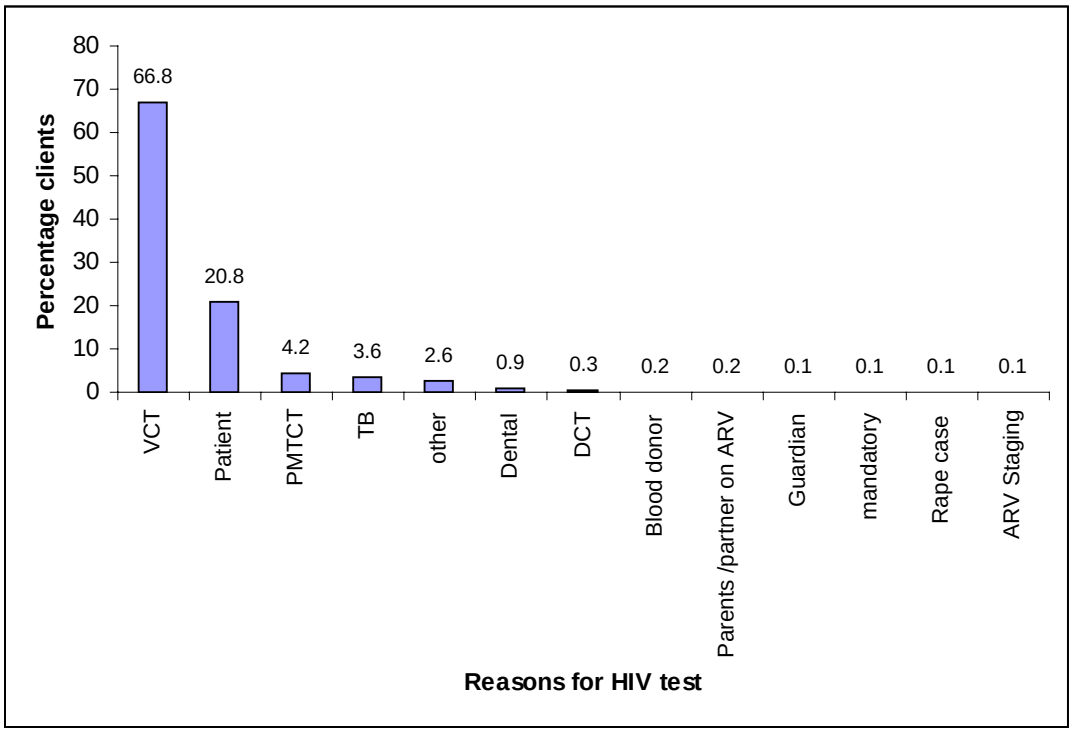
Figure 1. The number of clients that have been tested for HIV at the clinics visited in Mzuzu (from the time the clinics started operating to the time of the present study - early May 2006).



Note: MCH represents Mzuzu Central Hospital.

According to the registers accessed from Milazi Clinic and Mzuzu Central Hospital HIV tests are conducted for various reasons. The major reasons for testing are voluntary counseling and testing (VCT) (66.8%), diagnostic tests for patients (20.8%), PMTCT (4.2%) and test for TB patients (3.6%) (Figure 2). The data presented in Figure 2 excludes HIV tests conducted at MACRO because the consultant was provided with already summarized data without details of some variables. It can however, be assumed that most people go to MACRO for VCT such that the overall proportion going for VCT might be far much higher than 66.8%.

Figure 2. The percentage of clients by reason of going for an HIV test (based on registers for Milazi Clinic and Mzuzu Central Hospital HIV)



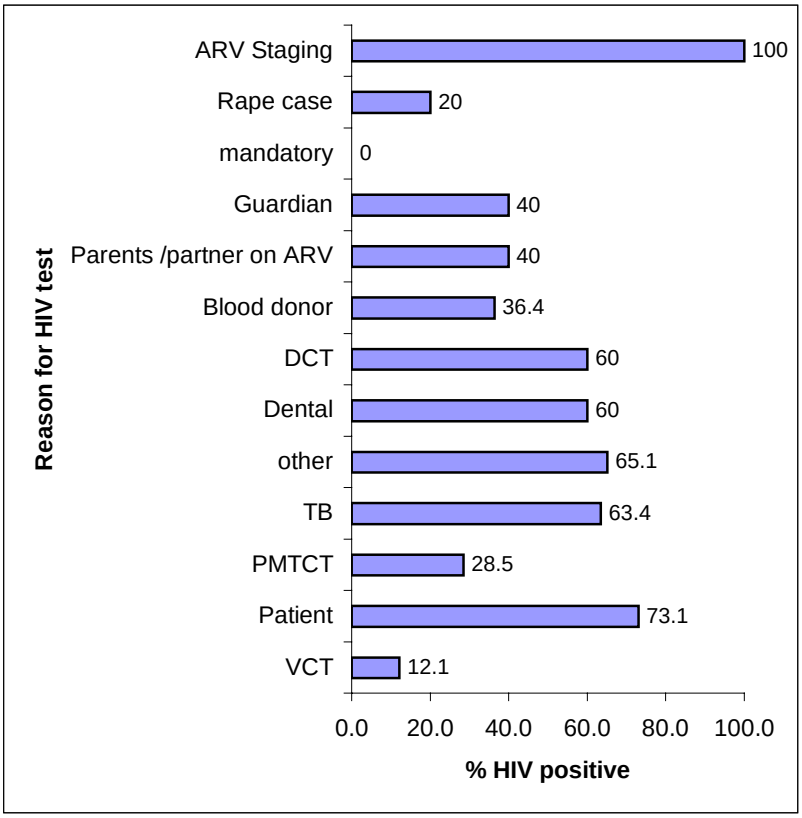
There was a considerable variation in the proportion of HIV positive individuals amongst various reasons of HIV test (Figure 3). All those that were being tested for ARV staging were HIV positive. The other reasons for testing that had higher HIV positive individuals are patients (73.1%), TB (63.4%), Dental (60%) and DCT (60%) (Figure 3). These data exclude those from MACRO and Mzuzu Health Centre.

There was also considerable variation in the percentage of HIV positive individuals amongst HIV test centres (Figure 4). The percentage of HIV positive individuals were 59.4 % for TB Ward Clinic, 56.5% for Pharmacy, and 55.2 % for Rainbow at Mzuzu Central hospital, 46.7% for Milazi clinic and 10.5% for MACRO. The overall percentage of HIV positive individuals for all the HIV test clinics visited (from the time they started operating to the time of this study) was 13.3%.

Most of those that test for HIV at Milazi Clinic and Mzuzu Central Hospital are sick people who have higher chances of being HIV positive. Those that go to MACRO do so on voluntary basis and most of them are healthy people with lower likelihood of being HIV positive.

More details of HIV prevalence by reasons for test at each site are provided in Annex 2.

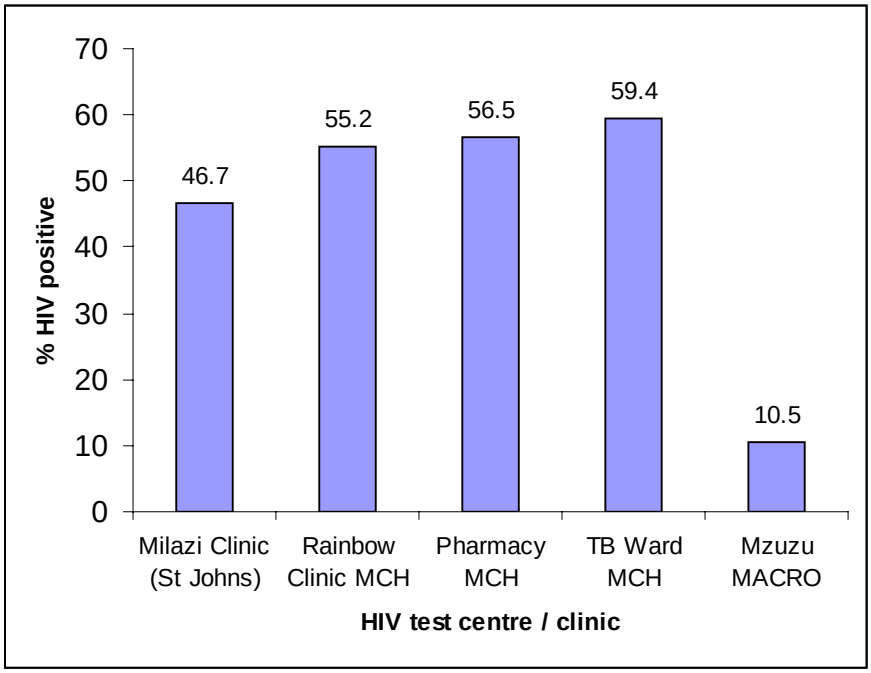
Figure 3: HIV prevalence according to reasons for test (based on registers for Milazi Clinic and Mzuzu Central Hospital HIV)



Noteworthy are some shortfalls the consultant realized on interpretation of these data:

- The registers where data on HIV prevalence results are recorded do not show the location where the clients come from. Consequently it was not possible to present the HIV prevalence data according to location of people in Mzuzu City as per the terms of reference for this study.
- The HIV prevalence outcomes based on hospital registers of HIV tests may not be a true reflection of the HIV situation in Mzuzu City because they include all referral cases of patients from different places within the region. Most referral cases have higher chances of being HIV reactive than healthy people within Mzuzu city hence could inflate the proportion of the reactive people in the city. The consultant thinks that the actual proportion of HIV positive people in Mzuzu City is slightly lower than the findings of the current study.

Figure 4. HIV prevalence by test centre /clinic



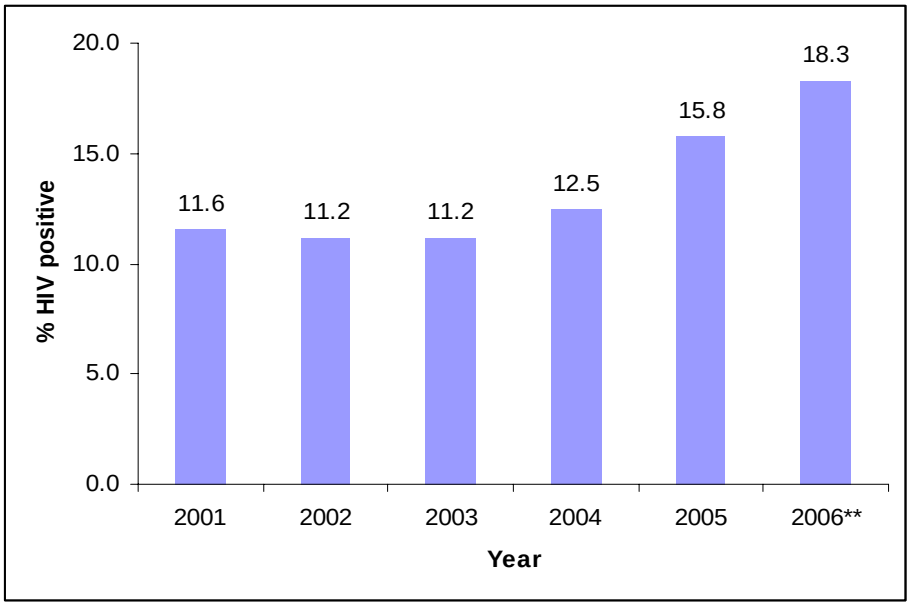
3.1.2. Temporal trends of HIV prevalence

Different HIV test centers started operating at different times. Figure 5 shows the temporal trends of HIV prevalence after bringing together data for all HIV test centres visited**.** The proportion of HIV positive people ranges from 11.2% in 2002 and 2003 to 18.3% in 2006. It decreased from 11.6 % in 2001 to 11.2% in 2002 and 2003 and then started increasing steadily to 12.5 % in 2004, 15.8 % in 2005 and 18.3% in 2006.

The proportion of HIV positive people of 12.5 % in 2004 is slightly higher than the national average during the same period of 12 % for Malawian adult age of 15 – 49 years being HIV positive (2004, MDHS).

The increase of HIV prevalence from 2004 to 2006 can be attributed to the increasing number of test centres in hospital which are mainly visited by patients most of whom are HIV positive. From 2001 to 2003 only MACRO was offering HIV test services and HIV prevelance was almost constant (Figures 5 and 6). In 2004 the coming in of Milazi Clinic at St Jones Hospital and Pharmacy Clinic at Mzuzu Central Hospital resulted into an increase in HIV prevalence. In 2005 and 2006 Rainbow and TB ward Clinics at Mzuzu Central Hospital meant more patients were being tested for HIV resulting to a further increase in the proportion of HIV positive people (Figures 5 and 6).

Figure 5. Temporal trends of HIV prevalence (based on data from all centres N = 74332)



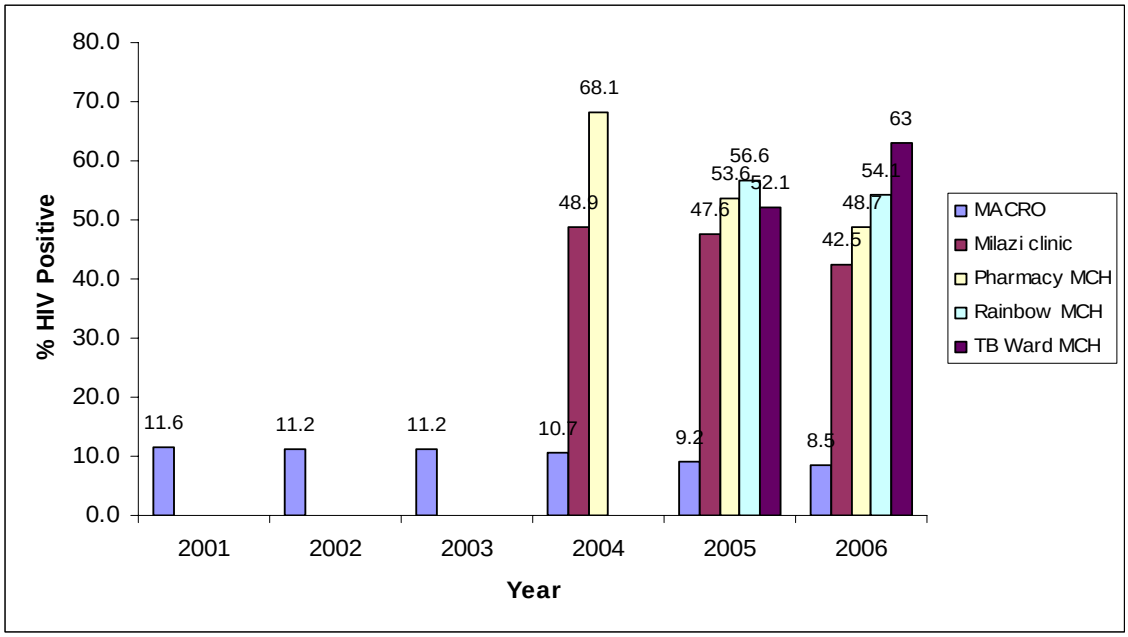
** Data covers months from January to early May

3.1.3. Temporal trends of HIV prevalence by VCT / ARV / HIV TEST CENTRE

According to MACRO data HIV prevalence has been declining with time. It was 11.6 % in 2001, 11.2% in 2002, 11.2 % in 2003, 10.7 % in 2004, 9.2 % in 2005 and 8.5 % in 2006. For Milazi Clinic the proportion of HIV positive people has been decreasing from 49.8 % in 2004 to 47.6 % in 2005 and 42.5 % in 2006. The Pharmacy Clinic at Mzuzu Central Hospital has also been registering a decreasing proportion of HIV positive people from 68.1% in 2004 to 53.6% in 2005 and 48.7 % in 2006. Rainbow Clinic indicated a decrease of HIV positive people from 56.6 % in 2005 to 54.1 % in 2006 while TB Ward Clinic showed an increase of HIV positive individuals from 52.1% in 2005 to 63 % in 2006 (Figure 6).

The data for the year 2006 were incomplete as they represented the months from January to April and a few days for the month of May. There is a possibility that HIV tests subsequent to the present study for the same year might change the HIV prevalence trends for the year.

Figure 6. Temporal trends of HIV prevalence by VCT / ARV / HIV CENTRE



Note for 2006 data are from 1st January 2006 to 9th May 2006

3.1.4. HIV prevalence by gender

HIV prevalence is higher for females than for males for all the years from 2001 to 2006 (Figure 7). This follows the same trend as at national level where HIV prevalence is higher among women than men in both urban and rural areas (2004, MHDS).

The overall percentage of HIV positive males was 9.2% and for females was 22.7 %. This translates into an overall proportional ratio of 100 HIV positive men to 244 HIV positive women. The temporal trends of the portions of HIV positive men and women are similar.

The annual proportions of HIV positive females range from 19.9 % in 2003 to 27.6% in 2006 (Figure 7). There were declining proportions of HIV positive women from 2001 to 2003 and an increasing trend from 2003 to 2006 when it reached 27.6%.

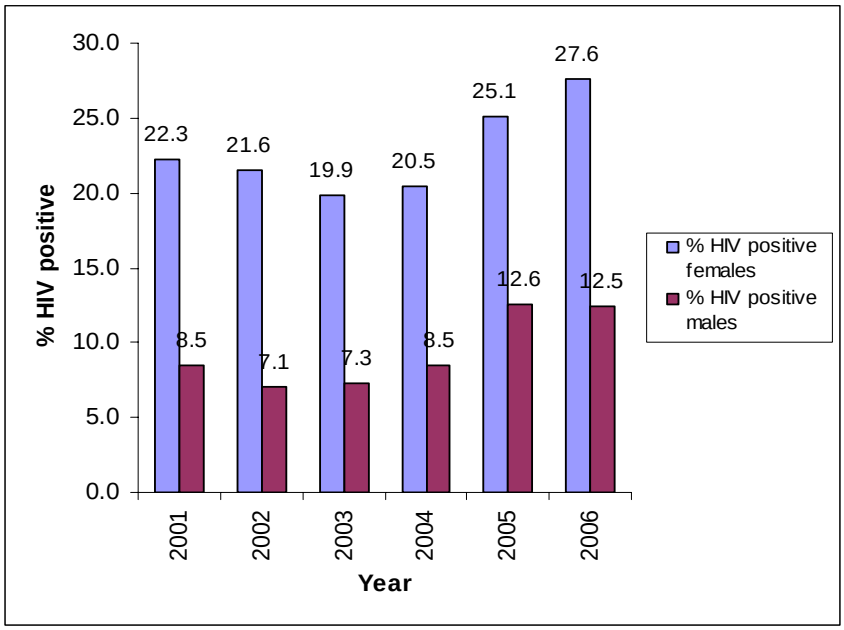
The proportion of HIV positive males ranges from 7.1% in 2002 to 12.6% in 2005. The trends in the proportion of HIV positive males show a decrease from 2001 to 2002, then an increase from 2002 to 2005 followed by a slight decrease from 2005 to 2006 (Figure 7).

One has to be cautious when looking at the trends in the proportion of HIV positive clients because the earlier years 2001 to 2003 are based on data from Mzuzu MACRO only while the years from 2004 and afterwards include data from other centres. Data presented in another section (Figure 4) show a big variation in the proportion of HIV positive clients between MACRO and other HIV test centres.

However, the fact that females are more prone to HIV infection is a legitimate concern. There might be several reasons for these trends. According to the discussions with WONECO

commercial sex workers have little control over the decision on the use of condoms for fear of male hostility. Sometimes males would take them to far places at night and threaten to leave them there if they refuse unprotected sex. The other reason for high HIV prevalence rates amongst women is the limited economic base. In their desperation for money they end up accepting to have unprotected sex in exchange for money.

Figure 7. Temporal trends of HIV prevalence by gender



3.1.5. HIV prevalence by age

The data for HIV prevalence by age were obtained from Mzuzu Central Hospital (TB Ward, Pharmacy and Rainbow Clinics) and Milazi Clinic (St Jones Hospital) only. The consultant did not access age data from MACRO. The summarized data accessed lacked the age details despite requesting for them.

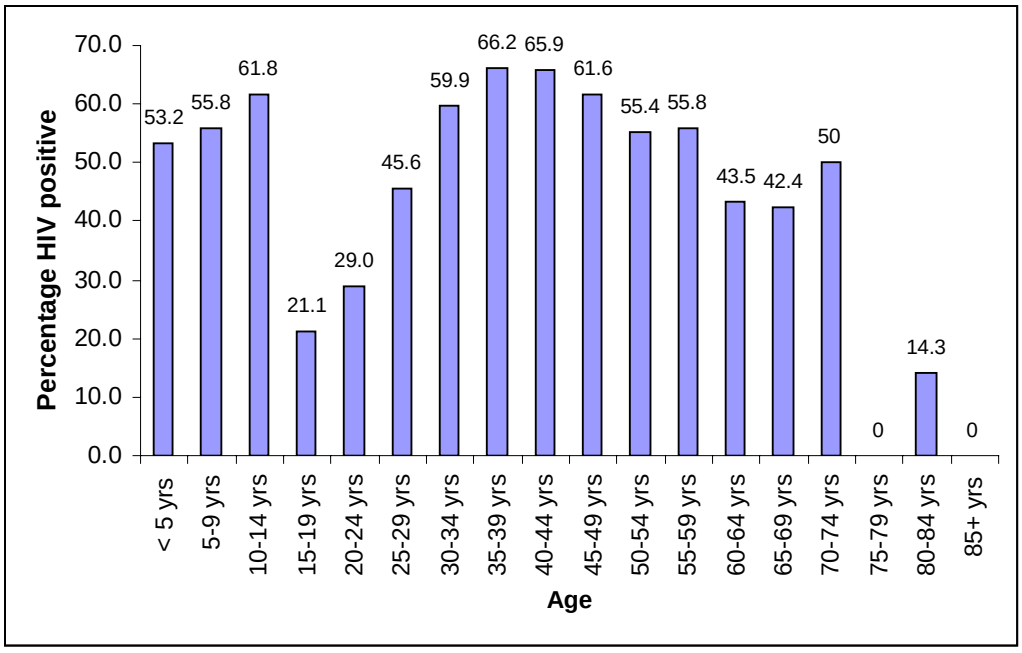
Age was categorized into five year age group ranges starting from less than five years to 85 years and above (Figure 8). Amongst these age groups HIV prevalence was highest for the 35-39 years age group (66.2 %) followed by the 40-44 years age group (65.9 %), 10-14 years (61.8 %), 45-49 years (61.6 %). Only two age categories 75-79 years and 85 years and above had no HIV positive individuals (Figure 8).

Two major modes (5 – 14 years and 30 - 49 years) of HIV prevalence can be discerned (Figure 8). The reasons for the HIV prevalence mode in the younger age group of 5 – 14 years could be due to transmission from parents particularly mothers to children while for the older age group of 30 – 49 years could be due to being sexually active.

More detail of HIV prevalence by age for different years based on pooled data for HIV test sites visited except MACRO are included in Annex 3.

The data presented in Figure 10 exaggerate HIV prevalence for the Mzuzu populace as they are only based on individuals who visited Mzuzu Central hospital and Milazi Clinics. These data are a reflection that most of the people who visit the hospital for various sicknesses and go for HIV test are HIV positive. A more realistic picture of the prevalence of HIV by age groups could have been obtained from MACRO where HIV tests are conducted mainly on voluntary basis including a majority of the health people. HIV tests of individuals of various age groups based on a random survey of the residents of Mzuzu City could give the best picture of HIV prevalence by age in the city.

Figure 8. HIV prevalence by age



3.1.6 HIV prevalence by Marital Status and Gender

The data on HIV prevalence by marital status are based on the accessed registers Milazi Clinic and Mzuzu Central Hospital (Pharmacy Ward, TB Ward and Rainbow clinics). MACRO data are not included because marital status information was not provided to the consultant.

Married females have higher rate of HIV infection (54.7 %) than married men (50 %). Single males had higher rate of HIV infection (36.4 %) than single females (27%). The divorced category showed higher rate of HIV infection for males (67.8 %) than for females (55 %). In the widowed category the HIV infection was higher for females (79.4 % than for males (76.1 %) (Figure 9). The trends for both males and females show that HIV infection rate is highest in widows followed by the divorced, married and singles had the least HIV infection rate. These findings tarry with those at national level for the year 2004 where the separated, divorced or widowed had higher rate of HIV infection with females having a higher rate than males (MDHS 2004).

Excluded in Figure 9 are children below marriage age (less than 15 for females and less than 18 for males). Amongst these children HIV infection rate was 57.9 % for girls and 54.1 % for boys.

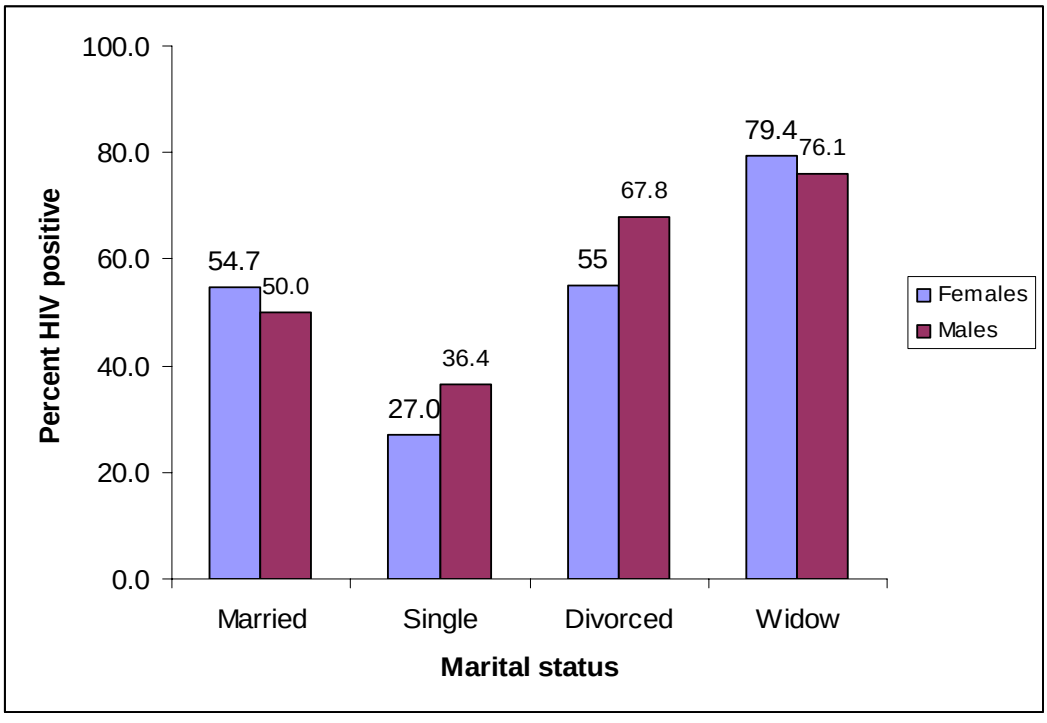
These data on HIV prevalence by marital status are not a true reflection for the whole Mzuzu City as they are based on tests at hospital centres with a high proportion of patients that have a higher likelihood of being HIV positive.

3.1.7. HIV prevalence amongst women tested for Prevention of Transmission from Mother to Child (PMTCT) services (pregnant and family planning)

The major service provider of PMTCT services in Mzuzu City is Mzuzu Health Centre (See section 3.2.1.3 of this report). All other hospitals and VCT centres refer women for PMTCT services to Mzuzu Health Centre such that Mzuzu Health Centre has comprehensive data of HIV prevalence for all women on PMTCT services within Mzuzu City. The data for HIV test for PMTCT was therefore obtained from the centre.

From a total of 5427 women tested for HIV in 2004 and 2005, 909 of them representing 16.7 % were HIV positive. The data for 2006 had not been compiled at the time of the present study. It should be noted that the 28.5 % (based on 95 HIV positive women from a total of 333 tested) of HIV positive PMTCT women for Milazi and Mzuzu Central hospital presented in Figure 3 above is included in the total number of 5427 of women from all HIV testing centres.

Figure 9. HIV Prevalence by Marital Status



HIV prevalence was 33.5 % and 16.4 % amongst women going for family planning and pregnant women respectively in 2004 and 11.2 % and 32.5 % respectively amongst the same groups in 2005. The percentage changes of HIV positive women in each category of women going for family planning show that women going for family planning and pregnant women categories can easily switch from one to the other such that family planning women of 2004 could become pregnant women of 2005 and vice versa.

3.1.8. Implications of the Current HIV Prevalence

The study has shown that HIV prevalence rates in Mzuzu City vary according to several factors.

Firstly HIV prevalence rate varies according to the reason for the test. ARV staging was associated with highest prevalence rate followed by diagnostic tests for patients suffering from various illnesses.

Secondly HIV prevalence rate varies according HIV test centres. The prevalence rates were high for Mzuzu Central hospital (TB Ward Clinic, Pharmacy and Rainbow clinic) and Milazi clinic but low for MACRO. The overall prevalence of HIV for all the HIV test sites visited (from the time they started operating to the time of this study) was 13.3%. HIV prevalence rate is high in health centre clinics because most t of those that test for HIV in these places are the sick that have higher chances of being HIV positive.

Thirdly there were temporal variations in HIV prevalence. The prevalence decreased from 2001 to 2002 and 2003 and then started increasing steadily from 2004 up to 2006.
The increase in HIV prevalence from 2004 to 2006 is attributable to increased HIV tests in health centres that test many patients who are HIV positive. The decrease of HIV prevalence from 2001 to 2003 was because only MACRO was offering HIV test services and MACRO tests register low prevalence rates. HIV prevalence for the year 2004 in this study is slightly higher than the national average for the same time for Malawian adult age of 15 – 49. The temporal variation of HIV prevalence was different amongst centres. At MACRO, Milazi Clinic, Pharmacy and Rainbow Clinic HIV prevalence has been declining with time. TB Ward Clinic showed an increase of HIV prevalence from 2005 to 2006.

Fourthly, HIV prevalence varied with gender. The prevalence is higher for females than males for all the years from 2001 to 2006. This is also the trend at national level (2004, MHDS). The temporal trends of HIV prevalence for men and women are similar. There were declining HIV prevalence rates from 2001 to 2003 and increasing trends from 2003 to 2006.

Fifthly the data for Mzuzu Central Hospital and Milazi Clinic HIV show that HIV prevalence varies according to age. The prevalence was highest for the 35-39 years age group followed by the 40-44 years age group, 10-14 years and 45-49 years.

Sixthly HIV prevalence varies according to marital status. The data for Milazi Clinic and Mzuzu Central Hospital show that HIV prevalence is highest in widows followed by the divorced, married and lowest for single people. These findings tarry with those at national level (MDHS 2004).

The shortfalls of various data on HIV prevalence have been discussed under their respective sections. These findings on HIV prevalence should therefore be noted with these shortfalls in the background.

Recommendation: There is need to either design a study to sample only Mzuzu city dwellers or to liaise with testing sites to include codes for localities of clients and other information required

3.2. Future projections of HIV in Mzuzu City

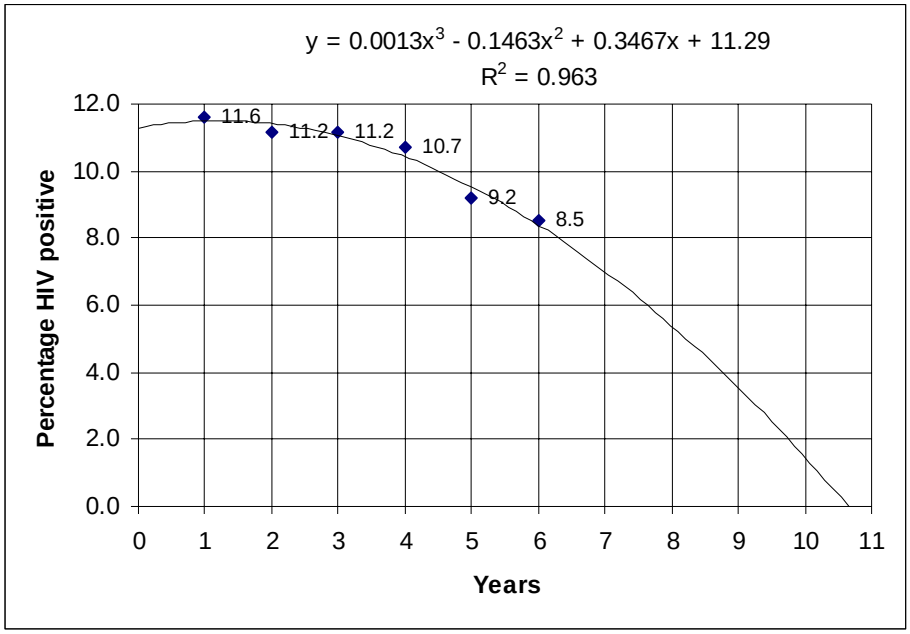
3.2.1 Projections on HIV Prevalence

Realising the disparity of HIV prevalence between data for Mzuzu MACRO and other centres, future projections of HIV were made for two scenarios. The first scenario was based on MACRO data alone while the second scenario was based on a combination of data for Mzuzu MACRO and other centres.

Scenario 1: Projections based on Mzuzu MACRO data

Since Mzuzu MACRO data showed declining temporal trends of HIV prevalence (Figure 6), the projections of HIV for the future for a combination of males and females show the same trends. HIV prevalence would steadily decline so that by the year 2011 there would be no HIV positive individual (Figure 10).

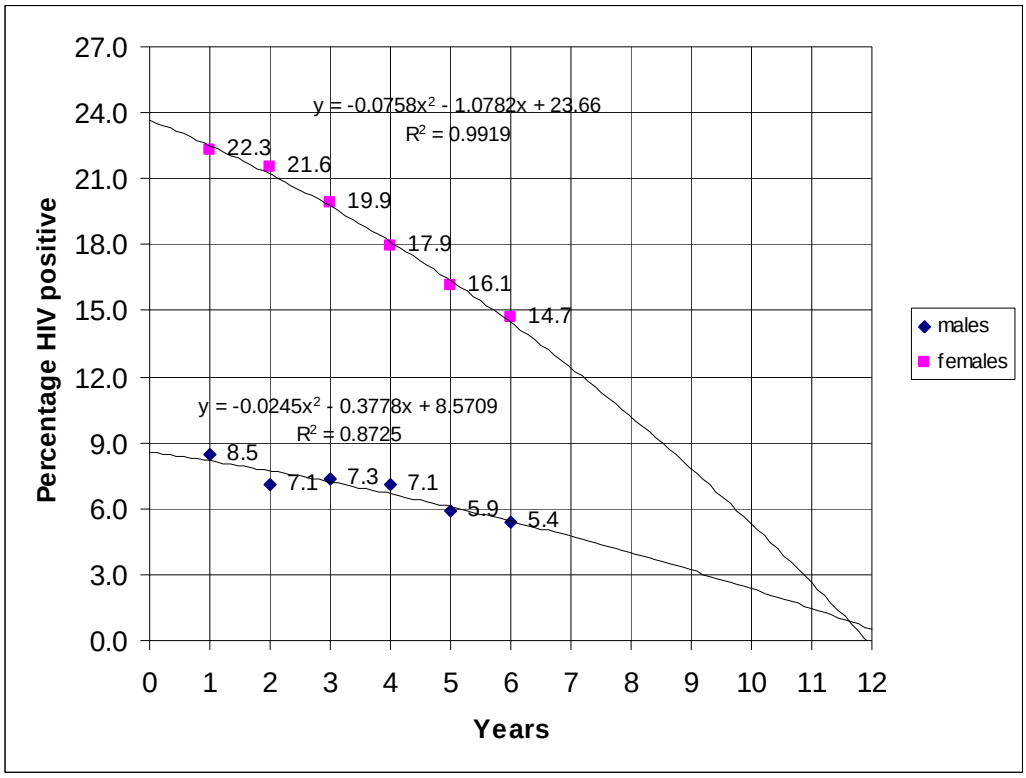
Figure 10. The future projections of HIV/AIDS prevalence in Mzuzu City for a combination of males and females based on Mzuzu MACRO HIV prevalence data from 2001 to 2006.



Note: Year 0 = 2000, Year 1 = 2001, - - - Year 11 = 2011

The declining trends of HIV prevalence applies to both males and females though at different rates. Females who have a higher infection rate for all the years show faster decline and the rates of the two sexes meet just before the year 2012. The projections suggest that there would be no HIV positive individual for both sexes by the year 2012 (Figure 11).

Figure 11. Projections of HIV AIDS in Mzuzu City by gender based on Mzuzu MACRO HIV prevalence data from 2001 to 2006.



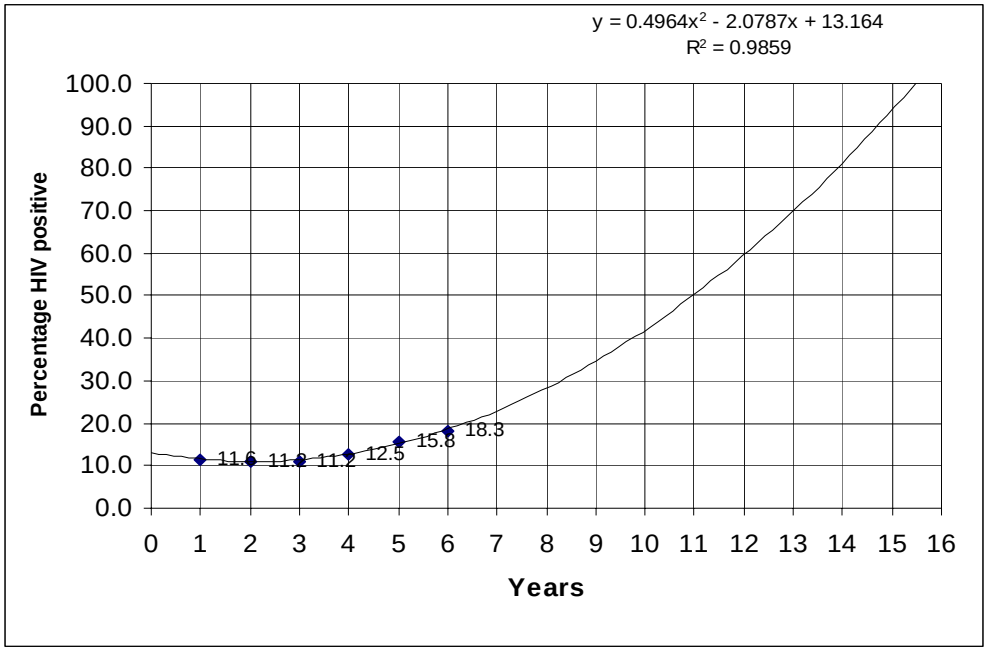
Note: Year 0 = 2000, Year 1 = 2001, - - - Year 12 = 2012

Scenario 2: HIV prevalence projections based on a combination of data for Mzuzu MACRO and other centres

The projections of HIV prevalence based on combined data for all the centres visited show a steady increase in HIV prevalence in Mzuzu city. For instance the infection rate would increase from 18.3% in 2006 to 35 % in 2009, 50 % in 2011, 60% in 2012, 70% in 2013 till the whole Mzuzu City populace is infected by 2016 (Figure 12).

These trends differ from the first scenario because of inclusion of data for Milazi Clinic and Mzuzu Centre Hospital (Pharmacy, TB and Rainbow) which show very high HIV prevalence rate (Figure 6).

Figure 12. Projections of HIV/AIDS in Mzuzu City based on HIV prevalence data for all HIV test centres visited.

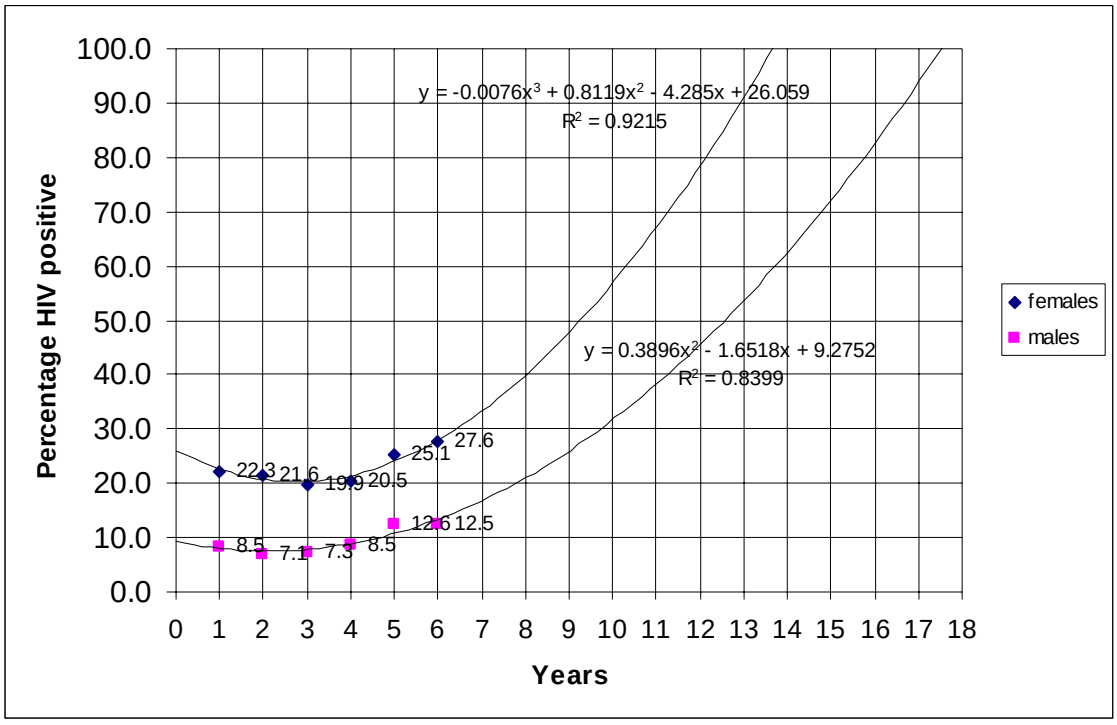


Note Year 0 = 2000, Year 1 = 2001, - - - - Year 16 = 2016

The HIV prevalence projections based on combined data show similar trends between males and females. For instance female HIV infection rate would increase from the rate of 27.6 % in 2006 to 33 % in 2007, 40 % in 2008, 56 % in 2010 and so forth till it reaches 100 % just before the year 2014. Male HIV infection rate would increase from 12.5 % in 2006 to 21 % in 2008, 45 % in 2012, 54 % in 2013 and continue till it reaches 100 % just before 2018 (Figure 13).

The accuracy of the HIV prevalence projections for the two scenarios is based on how close the data used for the predictions abide to the assumptions highlighted in section 2.5 of this report. The other factor to consider is that the data used were limited to a relatively short time period (the years HIV tests have been conducted in Mzuzu city). The regression models based on a short time period are very sensitive to HIV prevalence values for any single year such that a change in a single year can result to significant changes in predictions of future trends.

Figure 13. Projections of HIV AIDS by gender in Mzuzu City based on HIV prevalence data for all HIV test centres visited.



Note: Year 0 = 2000, Year 1 = 2001, - - - - Year 18 = 2018

3.2.2. Discussion on Future Projections of HIV Prevalence

Future projections of HIV prevalence were made based on assumptions depending on the information accessed by the consultant. Two scenarios were assumed: firstly projections based on MACRO data with the assumption that the data were less biased and secondly projections based on a combination of data for MACRO and other health institutions.

The projections of HIV prevalence for Mzuzu City in future based on MACRO data show that HIV prevalence would steadily decline up to the year 2011 when there would be no HIV positive individual.

On the other hand the projections of HIV prevalence based on combined data for all the centres showed a steady increase in HIV prevalence in Mzuzu city up to 2016 when the whole population of Mzuzu City would be infected with HIV. For both scenarios the prediction of HIV prevalence in future are very sensitive to HIV prevalence in any single year.

The projection trends for the two scenarios differ because of the variation of HIV prevalence amongst test sites. The HIV prevalence projections for both scenarios show similar trends between males and females.

Caution was made on interpretation of these data because of the questionability of the degree to which the people who go for HIV test at the sites represent a random sample of the entire Mzuzu City population.

Recommendation: There is need to have data for a longer time period to get better prediction trends of HIV prevalence.

3.3. ARV Situation

3.3.1. Number of people on ARVs

The consultant could not access most of the data for people on ARVs from most of the HIV test centres for two reasons. The first reason is that it was very sensitive for the service providers on ethical reasons to release the data because they bear names of ARV beneficiaries. The second reason was that the responsible staff who could have supplied the data (at Mzuzu Central Hospital and Mzuzu Health centre) were very busy attending to various patients. Consequently it was difficult for the consultant to meet them within the limited time frame of data collection.

The limited data collected showed that most centres have just started administering ARV drugs to HIV positive patients. Milazi Clinic started administering ARV drugs in June 2005 while MACRO started in March 2006. The total number of beneficiaries of ARV drugs for Milazi Clinic is 284 comprising of 130 males and 154 females. For MACRO which started administering the drugs less than two months before the study, the total number of ARV beneficiaries was 16 comprising of 10 males and 6 females (Table 2).

Table 1. The number of people on ARVs

ARV TEST CENTRE	Year	Number of people receiving ARVs	
		Males	Females
Milazi Clinic (St Johns)	June 2005 to 8th May 2006	130	154
MACRO	2006 (March to 9th May)	10	6

3.3.2. ARV administration

The consultant could not access most of the data for people on ARVs from most of the HIV test sites because of the sensitivity of the information and also the busy work schedules for those who could supply the information. It was however realized that most sites have just started administering ARV drugs to HIV positive patients.

Recommendation: There is need for various service providers on ARV administration to readily supply the information for ARV recipients without names for monitoring purpose at City Assembly level. For research purposes, other ARV administration registers can be opened with all other information included but names of people.

3.4. Service providers

There are quite a good number of service providers in HIV/AIDS related activities Three "loose" broad categories of service providers were identified that include the following: Service providers on health related activities, service providers on the disadvantaged groups of people such as orphans and youth organizations.

3.4.1. Activities of service providers

The activities of the service providers are quite diverse. The major ones include

- Voluntary counseling and testing services.
- Prevention of mother to child transmission of HIV / AIDS
- Various forms of support to the needy people – orphans, old people, sick people
- Control of sexually transmitted infections through condom distribution
- Peer education training in schools
- Community services
- Encouragement of youths to be self reliant through agriculture production and various IGAs
- Poultry keeping
- Disseminations of information about HIV / AIDS through various methods – drama, songs, workshops and others
- Treatment of patients from various infections

3.4.2. Analysis of what is working well for the various activities by service providers and are contributing to reduction of HIV / AIDS

Participatory discussions with various service providers revealed a number of positive attributes with respect to their activities. The major attributes include the following:

- The demand for services from some service providers is quite high showing an increasing realization of the general public about the importance of such services. Examples of such services include counseling at BLM, youth groups, MACRO.
- There are indications of reduced stigma for HIV positive people as a result of some of the services by NAPHAM.
- Some service providers enjoy good funding privilege from donors and well wishers and or / linkage with other organizations. Examples of such service providers include: Health Institutions such as Mzuzu Health centre, Mzuzu Central Hospital and Milazi Clinic; a few youth groups like Scorpion, YAAP and Mzuzu Young Voices.
- There are signs of reduction in some HIV risk behaviours amongst some targeted people as a result of the activities promoted by some service providers. A good example is that of switch from commercial sex to traditionally acceptable activities noted by WONECO amongst the commercial sex workers they have been working with.
- Peer education programs is proving to be a good strategy for education of the youths on various subjects of HIV/AIDS as youths are free to discuss with fellow youths. This was revealed by all the youth groups having this program.

- Some youth groups' activities are not only important for spreading HIV control messages but are also important forms of entertainment for the youths. Such type of activities includes drama, sporting activities and video shows. The activities keep the youths busy and promote good mental development of the youths.
- There is increasing awareness amongst girls and women about the importance of being self reliant. The realization has resulted to more women and girls venturing in various forms of livelihood strategies as noted by Malawi Girl Guide Association.
- Some service providers derive special pride from tangible positive results of their activities. Examples of such service providers are members of Women Development and information centre Orphan Care who are particularly happy to see orphan children excelling academically and spiritually; and youth groups (SIYA, Scorpion, YAAP) that reported to have been getting good feedback from the communities regarding their activities.
- Some service providers' activities are proving to be good training grounds for various skills useful to the society. This was noted by: Women Development and information Centre who teach various skills to girls, some youth groups (MAGA and Mzuzu Scout Network) that teach various skills to fellow youths.

3.4.3. Analysis of what needs improvement for various service providers to be more effective in their service delivery

- There is need for proper coordination of the activities done by various service providers listed in section 4.1. The consultant noted that almost all activities listed in section 4.1, are undertaken by many service providers. The exceptions to these are activities are those done by health institutions like VCTs, PMTCT, HIV tests, administration of ARVs and treatment of various infections. There are also a lot of overlaps with respect to the geographic areas of coverage for the various service providers. However, there is no mechanism for coordination of all these activities with respect to who does what and where. Furthermore, this has created a situation whereby the service providers are competing instead of complementing their efforts.
- There is need for even distribution of some services on HIV throughout Mzuzu City. This was noted mainly for services that target people in various localities. The geographic coverage by various service providers indicated that some localities (and schools) are reached by many service providers while others are not reached at all.
- Some service providers expressed the need for training in various aspects to enable them to improve their service delivery systems. The areas that require training include HIV / AIDS issues, leadership skills, financial management, reporting of the progress of activities to various service providers and coordination of HIV activities in Mzuzu City. Training in HIV / AIDS issues was demanded by WIDCOC, St Mark Anglican church women and some youth groups (Mzuzu Young Voices and Scouts). WONECO youth group expressed their training interest in leadership skill and financial management. DACC members indicated training interest in financial management and coordination role of activities done by different service providers. The scouts youth group showed interest for training in reporting mechanisms for the progress of their activities to various service providers. One observation made by various youth groups with respect to training was that there is no mechanism to ensure that trained members of various youth groups impart the knowledge gained to other members.

Recommendation: The service providers should be trained in the skills they require for better service delivery. The training should target members of the group who can impart the knowledge to others. Where possible the whole group should be trained in the required skills.

- Some service providers expressed the wish to expand their activities to cater for the demand arising from some groups of people. The example of such services is voluntary canceling and testing of HIV/AIDS at BLM and YAAP youth organization. It was reported that the people who demand these services would be freer to get them from such institutions than where they are offered at present.

Recommendation: There is need to upgrade the services of some service providers as demanded by their clients. The upgrading should be accompanied by training of members of such service providers in required skills for their additional roles and responsibilities.

- Some youth groups and other service providers revealed the need to get assistance for their activities to be advertised to a wider community. For example the Scorpion youth group is looking for assistance to have their HIV film shown on Television Malawi. Through talents organized by YAAP an album of songs on HIV / AIDS has been produced and it is on a CD with Foundation Malawi. The youth group is looking for assistance to have many copies of the album produced.

Recommendation: The youth groups should be assisted to have their activities promoted further particularly in situations where they make outstanding performance. This can encourage more youth groups to work hard in their activities.

- Despite undertaking a lot of activities most service providers indicated that they would need various material, infrastructure and financial support to enhance their service delivery. Examples relating to this are many. Almost all those who deal with orphans face the problem of acquiring enough resources (food, clothes money for school fess etc) to support orphans. Those involved in community outreach programs also mentioned of transport problems to enable them have flexible mobility. Those who are engaged in IGAs face the problem of raising enough capital for buying capital equipment such as sewing machines for tailoring. Other service providers like WIDCOC and most youth organizations face space / office problems. BLM lacks a computer for information storage.

Recommendation: The upcoming service providers should be assisted to establish links with funding organizations. The funding could be provided based on specific needs of the service providers. One option could be to assist the service providers (particularly youth groups) to write project proposals and channel them to donors for funding (through DACC).

- There is need for the activities of all youth groups to be recognized and linked to some specific sectors / government departments or ministries / or NGOs within Mzuzu City to provide them with mentoring services. The consultant noted that the youth groups enjoy being visited or affiliated to some bigger organizations that recognized their efforts and gave them encouragement. Some youth groups complained that their activities are not recognized and that even funding tends to go only to few privileged youth groups.

Recommendation: The youth groups should be linked to various organizations and government departments promoting similar services to those of the youth organizations.

- There is need for all service providers to institute a monitoring mechanism for their progress. Such a mechanism should be based on specific indicators for their goals (Section 4.3) and should ensure that the progress made is periodically reported at a specific forum that could be coordinated by DACC.

Recommendation: There is need for monitoring mechanism of HIV control activities by various service providers.

3.5. Monitoring Indicators for HIV/AIDS responses

All the activities done by various service providers are interrelated and they all aim at achieving a common goal of preventing the further spread and mitigating the impacts of HIV/AIDS for the infected and the affected. It is important to monitor the progress made on various activities in mitigating the impact of HIV/AIDS. This section presents possible indicators on HIV AIDS in Mzuzu City for monitoring the impacts of interventions and activities by various service providers. The indicators are based on the data collected and literature review. The indicators based on literature reviewed (Annex 4) were modified to suit the situation for Mzuzu City.

Some of the outlined indicators will require baseline information through the cooperation of Mzuzu city Assembly and specific service providers. For instance it will be important for some service providers to slightly modify the way their information is recorded to cater for the required information.

The impact / activity indicators have been classified according to specific outcomes of various interventions on HIV / AIDS.

3.5.1. Outcomes

3.5.1.1 Outcome 1: Reduced incidences of HIV

Impact indicators

- Percentage of HIV positive people by age group, gender, and marital status in Mzuzu city
- Percentage of people visiting health centres with STIs by age, gender and locality in Mzuzu City.
- Number and percentage of inmates at Mzuzu Prison with STIs
- Percentage of HIV positive PMTCT women by locality
- Percentage of HIV positive people by gender, age group accessing ARVs from various HIV testing centres in Mzuzu City
- Percentage of HIV infected infants born to HIV infected mothers

3.5.1.2 Outcome 2: Improved quality of life of those infected and affected by HIV / AIDS

Impact indicators

- Percentage of orphans and other vulnerable children accessing community support by gender, locality and residence.

3.5.1.3 Outcome 3: Reduced high risk sexual behaviours

Impact indicators

- Number of commercial sex workers in Mzuzu city
- Percentage of people consistently using condoms during sexual intercourse with a non regular sexual partner by gender, occupation, and age.

3.5.1.4 Outcome 4: Increased knowledge of HIV/AIDS prevention

Impact indicators

- Percentage of youths in schools and residential locations of Mzuzu City that correctly identify ways of preventing the sexual transmission of HIV / and reject major misconceptions about HIV transmission
- Percentage of people in Mzuzu City exposed to HIV / AIDS media campaign by gender, occupation and locality
- Number of cases of stigma and discrimination amongst Mzuzu City dwellers towards People Living With AIDS
- Percentage of Mzuzu City population with positive attitudes towards PLWH/As (by gender and education level)

3.5.1.5 Promotion of safer sex practices

Impact/activity indicators

- Number of youths exposed to life skills based on HIV AIDS education by gender, Mzuzu city location, and whether in school or out of school
- Number of condoms distributed to end users by clinics, health centres and other service providers in Mzuzu city (by Mzuzu City location / township, and institution)

3.5.1.6 Prevention of mother to child transmission

Activity indicators

- Percentage of HIV positive women in Mzuzu City receiving ARV prophylaxis to reduce the risk of mother to child transmission
- Percentage of pregnant women in Mzuzu City that have been counselled in PMTCT tested and received their serostatus results.
- Percentage of pregnant women in Mzuzu that have been tested who are HIV positive

- Percentage of HIV positive pregnant women offered PMTCT referred for care and support services

3.5.1.7 Voluntary counselling and testing

Impact/activity indicators

- Number of clients in Mzuzu city tested for HIV and receiving their serostatus results by VCT site, age and gender
- Percentage of clients who have been tested for HIV that are HIV positive by age, locality within the Mzuzu City and gender.
- Percentage of HIV positive VCT clients referred for care and support services

3.5.1.8 ARV therapy

Activity Indicator

- Number of people with advanced HIV infections receiving ARV therapy in Mzuzu City

3.5.1.9 Community and home based care support

Activity indicators

- Number of households receiving external assistance to care for adults who are chronically ill by location in Mzuzu City and type of help
- Number of persons in Mzuzu City enrolled at NAPHAM (and any other PLWA organization) by gender, age and location of Mzuzu city.
- Number of community home based care visits by Mzuzu City locality and type of visit (volunteer or health care worker).

3.5.1.10 Support for orphans and vulnerable children

Activity Indicators

- Number of orphans and other vulnerable children receiving care / support by support type (nutritional, psychological, financial), Mzuzu City locality and gender.
- Number of community organizations / iniatives receiving support to care for orphans in Mzuzu City

3.5.1.11 Mainstreaming of HIV / AIDS in the public and private sectors including civil society

Activity Indicador

- Number of companies and public institutions in Mzuzu City that have HIV / AIDS workplace policies and mainstreaming programs

3.5.1.12 Capacity building and partnership enhancement amongst stakeholders

Activity Indicator

- Number of trainees in HIV / AIDS interventions by type of service provider, gender and Mzuzu City locality.

3.5.2 Collection of information for the indicators

This study has shown that there are many service providers that are doing a number of activities aimed at mitigating the impacts of HIV /AIDS. It was also noted that DACC at Mzuzu City Assembly is supposed to play a coordinating role of all activities on HIV AIDS. It has also been recommended that there should be a forum where different service providers can meet to discuss their activities to ensure that there is synergy of implementation of activities. Through the same forum all service providers could periodically report (could be quarterly or bimonthly) the progress made with respect to specific impact / activity indicators as outlined in section 4.4 of this report. One format of reporting can be adopted for all service providers. A consolidated progress report capturing all indicators can be produced from these service providers' progress reports.

Mzuzu city Assembly can liaise with various service providers to include, in their reports, specific information as required by monitoring indicators. For instance this study has revealed that HIV registers at various HIV testing sites do not include information on locality of clients. It can be agreed with HIV testing service providers to include codes for the localities of their clients in the registers.

4. Recommendations

Several recommendations have been made in this study. For convenience they have been placed in specific sections of this report so that they can be easily linked to issues raised. This section of the report provides the list of recommendations made. For clarifications on specific recommendations in this list one should refer to the specific sections where the recommendations were made. The recommendations are as follows:

a) The service providers should be trained in their deficient skills. The training should target members of the group who can impart the knowledge to others. Where possible the whole group should be trained in the required skills.

b) There is need to upgrade some of the service providers to start offering more services that are demanded by their clients. The upgrading should be accompanied by training of staff of such service providers in required skills to enable them perform their additional roles and responsibilities.

c) The youth groups should be assisted to promote their activities particularly in situations where they make outstanding performance. This can encourage other youth groups to work hard in their activities.

d) The upcoming service providers should be assisted to establish links with funding organizations. The funding could be provided based on specific needs of the service providers. One option would be to assist the service providers (particularly youth groups) to write project proposals and channel them to donors for funding (through DACC).

e) The youth groups should be linked to various organizations and government departments promoting similar services to those of the youth organizations.

f) There is need for monitoring a mechanism of HIV control activities by various service providers.

g) To get a clear picture of HIV prevalence there is need to either design a study to sample only Mzuzu city dwellers or to liaise with testing sites to include codes for localities of clients and other information required.

h) There is need for various service providers on ARV administration to readily supply the information for ARV recipients without names for monitoring purpose at City Assembly level. For research purposes, other ARV administration registers can be opened with all other information but names of people.

i) There is need to have data for a longer time period to get better prediction trends of HIV prevalence.

Annexes

Annex 1: The consultant's schedule of activities

Date	Activity	Location
Wednesday, 3rd May 2006	The Consultancy team travel to Mzuzu	Lilongwe to Mzuzu
Thursday, 4th May 2006	Briefing on background information and collection of relevant literature from Mzuzu City Assembly, Booking of meetings with DACC members	Mzuzu
Friday, 5th May 2006	Meeting with: DACC members, staff at St Jones Hospital, Summarizing of HIV data for Milazi Clinic at St Johns.	Mzuzu
Saturday, 6th May 2006	Meeting with: Mzuzu Scout Network youth group, Mzuzu Young Voices Youth group, Summarizing of HIV prevalence data for Milazi Clinic at St Johns.	Mzuzu
Sunday, 7th May 2006	Meetings with: WIDCOC (St Peters church), Scorpion Youth group, SIYA. Summarizing of HIV prevalence data for Milazi Clinic at St Johns	Mzuzu
Monday, 8th May 2006	Meeting with: YAAP, Director of Mzuzu MACRO, Mzuzu Central Hospital Staff, Summarizing of HIV prevalence data for Mzuzu Central Hospital, Data entry template development	Mzuzu
Tuesday, 9th May 2006	Meeting with NAPHAM, staff at Mzuzu Central hospital, Summarizing of HIV prevalence data for Mzuzu Central Hospital, Data entry into computer, Summarizing of focus group discussions	Mzuzu
Wednesday, 10th May 2006	Meeting with MAGA, WONECO, Summarizing of HIV prevalence data from registers of Mzuzu Central Hospital, Summarizing of focus group discussions data, Development of data entry template	Mzuzu
Thursday, 11th May 2006	The Consultancy team travel to Lilongwe	Mzuzu Lilongwe
Friday, 12th May 2006	Quantitative data entry into the computer and summarizing of focus group discussions data	Lilongwe
Saturday, 13th May 2006	Quantitative data entry into the computer and summarizing of focus group discussions data	Lilongwe
Sunday 14th May 2006	Quantitative data entry into the computer	Lilongwe
Monday, 15th May 2006	Quantitative data entry into the computer	Lilongwe
Tuesday, 16th May 2006	Quantitative data entry into the computer	Lilongwe
Wednesday, 17th May 2006	Quantitative data entry into the computer	Lilongwe
18th to 23rd May 2006	Data analysis and report writing	Lilongwe
	Presentation of draft report	Mzuzu

Annex 2. HIV prevalence by testing centre / clinic and reason for the test.

VCT ARV CENTRE	Reason for HIV test	HIV Status			
		Number HIV Positive	Number HIV Negative	Total number tested	% Positive
Milazi Clinic (St Johns)	VCT	470	832	1302	36.1
	Patient	330	118	448	73.7
	PMTCT	29	46	75	38.7
	TB	55	17	72	76.4
	other	5	2	7	71.4
	Blood donor	4	7	11	36.4
	Parents /partner on ARV	0	1	1	0
	ARV Staging	3		3	100
	Sub Total	**896**	**1023**	**1919**	46.7
Rainbow Clinic Mzuzu Central Hospital	VCT	374	361	735	50.9
	Patient	149	65	214	69.6
	TB		1	1	0
	other	23	11	34	67.6
	Dental	3	4	7	42.9
	Parents /partner on ARV	3	5	8	37.5
	Rape case	1	2	3	33.3
	Sub Total	**553**	**449**	**1002**	55.2
Pharmacy Mzuzu Central Hospital	VCT	634	595	1229	51.6
	Patient	234	86	320	73.1
	TB	33	24	57	57.9
	other	53	29	82	64.6
	Dental	24	14	38	63.2
	mandatory	0	5	5	0
	Rape case	0	2	2	0
	ARV Staging	1		1	100
	Sub Total	**979**	**755**	**1734**	56.5
TB Ward Mzuzu Central Hospital	VCT	13	17	30	43.3
	Patient	31	5	36	86.1
	TB	23	22	45	51.1
	other	3	3	6	50
	DCT	9	6	15	60
	Parents /partner on ARV	1		1	100
	Guardian	2	3	5	40
	Sub Total	82	56	138	59.4
Mzuzu MACRO	****	**7208**	**59419**	**68527**	10.5

**** Reason cannot be presented because the consultant was provided with already summarized data that lacked information on some variables.

Annex 3. HIV prevalence by age and year pooled for all HIV test sites except MACRO (N=4903).

Age category (years)	HIV Status for 2004			HIV Status for 2005			HIV status for 2006		
	No. HIV +ve	Total No. tested	**% HIV Positive**	No. HIV +ve	Total No. tested	**% HIV Positive**	No. HIV +ve	Total No. tested	**% HIV Positive**
< 5	10	15	**66.7**	58	114	**50.9**	53	96	**55.2**
5-9	8	9	**88.9**	46	80	**57.5**	28	55	**50.9**
10-14	10	14	**71.4**	27	48	**56.3**	26	39	**66.7**
15-19	8	35	**22.9**	28	144	**19.4**	17	68	**25**
20-24	30	93	**32.3**	104	346	**30.1**	49	185	**26.5**
25-29	47	88	**53.4**	226	516	**43.8**	120	264	**45.5**
30-34	74	122	**60.7**	304	498	**61.0**	115	198	**58.1**
35-39	52	74	**70.3**	258	376	**68.6**	94	158	**59.5**
40-44	45	63	**71.4**	188	284	**66.2**	87	140	**62.1**
45-49	23	36	**63.9**	92	160	**57.5**	41	60	**68.3**
50-54	13	18	**72.2**	69	127	**54.3**	24	46	**52.2**
55-59	6	8	**75**	26	52	**50**	16	26	**61.5**
60-64	7	10	**70**	17	43	**39.5**	5	14	**35.7**
65-69	1	4	**25**	6	17	**35.3**	7	12	**58.3**
70-74	3	3	**100**	3	5	**60**	3	10	**30**
75-79	0	1	**0**	0	5	**0**		1	**0**
80-84	0	1	**0**	0	3	**0**	1	3	**33.3**
> 84				0	1	**0**			

Note: The data from MACRO are not included in this Table because age information was not provided to the consultant

Annex 4. Existing Service providers.

a4.1. Role of DACC

In a meeting with DACC members a number of issues were learned. The DACC members gave description of DACC membership and their roles. The existing service providers on HIV AIDS were also listed. The consultant used this knowledge for planning meetings with various service providers on HIV / AIDS.

DACC has just been incorporated in the City Assembly structure less than four months (before 5th May 2006). DACC members meet regularly on monthly basis. It has technical sub-committees. DACC members said would require some orientation on their terms of reference. DACC is supposed to coordinate all interventions on HIV / AIDS by various sectors within Mzuzu City Assembly but it is not yet clear how this should be done.

At the time of this consultancy Mzuzu city Assembly had just finished developing its HIV / AIDS Strategic Plan for the period 2005 – 2008. In this Strategic Plan a number of activity are outlined but the impact indicators are not clear.

What works well for DACC structure

- There is potential for collaboration and interaction amongst service providers. With the current arrangement there is potential for DACC members to know who does what through proper reporting and sharing of notes from various sectors.
- Funding has been forth coming to DACC. National aids commission funds DACC activities through Malawi Local Government Association (MALGA)

What needs to be improved

- There is need for guidelines on roles of DACC, DACC sub committees and various sectors working in the Mzuzu City Assembly.
- There is need to institute a monitoring mechanism for all activities coordinated by DACC.
- Some DACC members noted the need for a very transparent system on the use of DACC funding which is controlled from Mzuzu City Assembly. This could enable them to properly plan for their activities.
- DACC members raised the need for orientation workshop on reporting of various activities and financial management. Relating to reporting it is important that representatives from all sectors adopt one format. Currently information on HIV / AIDS activities is not forth coming to the Secretariat. Concerning financial management was the question as to whether DACC should maintain its own account with a Secretariat and City assembly as signatories or maintain the current state of affairs where funds are controlled by the city assembly with DACC operating as any committee under the City Assembly.

There is need for DACC to incorporate some impact indicators for their various activities. The National HIV/AIDS Action Framework (NAF) for Malawi 2005 – 2009 contains several impact indicators most of which can be modified and adopted to fit the anticipated outcomes from HIV AIDS activities for Mzuzu City Assembly.

There are a number of service providers that are responding to the HIV/AIDS pandemic in Mzuzu city. These service providers have clearly defined roles that are complementary. The service providers consulted in this study have for convenience been categorised into three groups including:

- Health service institutions: Banja La Mtsogolo (BLM), St. Johns Hospital, Mzuzu Central Hospital, Mzuzu Health Centre, MACRO, National Association of People with HIV/AIDS in Malawi (NAPHAM)
- Orphan care groups
- Youth organisations

a.4.2 Health service institutions

a4.2.1. Banja La Mtsogolo.(BLM)

BLM has several programs that directly respond to HIV/AIDS pandemic in the city besides treating several diseases affecting Mzuzu city residents such as malaria. The programs include:

- Provision of Sexually Transmitted Infection treatments to Mzuzu city residents including prisoners at Mzuzu Prison. A total of 6514 patients comprising of 3012 females and 2794 males have been treated of STIs from January 2005 to April 2006 (Table 1). In addition to these 63 inmates with STI problems have also been treated.
- Provision of HIV/AIDS counselling to the Mzuzu City residents and prisoners
- Distribution and retail selling of condoms. A total of 77400 condoms have been distributed by Mzuzu BLM between January 2005 and April 2006 (Table 1).
- Provision of HIV/AIDS work place prevention in collaboration with interested organisation.
- Provision of emergency contraception services to women.

Discussion with BLM nurses revealed that BLM is the leading clinic in the city of Mzuzu in STI treatments. Some of the reasons that were mentioned that make people prefer this clinic include:

- Fast delivery of services to its clients.
- Availability of laboratory services at the clinic for precise diagnosis.
- Clients are able to access STI treatments like any other disease without stigma or suspicion.
- Availability of credit facilities to a number of companies.

*What is working well***.**

- BLM services are of high quality and are probably the most preferred. A random survey BLM conducted revealed that most people prefer BLM clinics for STI treatments than other clinics or hospitals. This is evident from the large numbers of people accessing the services.
- BLM offers its services to people of all age categories and income levels without discrimination though it is a private institution. The youths (under 25 years) who come for STI treatments usually access the treatments for free and are given a package of condoms for safer sex.
- Clients coming for medical treatments without sufficient money access the services by paying 40% of the total medical bills.
- BLM is also actively involved in the provision of medical services including STI treatment to prisoners in Mzuzu prison. It was noted that STI problems in the prisons are on the increase apparently because of homosexuality in the prisons.

What needs to be improved

There are a few things that need to be improved to enhance service delivery. These include

- There is need for establishment of VCT centre at the clinic. The demand for VCT services at BLM Mzuzu clinic is high as most people prefer BLM to other clinics for most services. Currently BLM is referring a number of people seeking such services to other VCT centres and clinics.
- There is need for computer facilities at the clinic for data storage. BLM collects a lot of data on clients treated for STI infections as well condom distribution but the data storage system at the clinic is not computerised. The system is manual and data sheets for every year are filed and temporally kept in a storage room. Within few years after sending reports to headquarters the data are archived resulting in accessibility problems when needed.

Table 2. Number of patients treated for sexually transmitted infections and condom distributed.

Month and year	Female patients	Male patients	Total patients	Condoms distributed
January 2005	148	183	331	1220
February 2005	248	216	464	4996
March 2005	168	169	337	1360
April 2005	-	-	464	-
May 2005	140	164	304	2728
June 2005	277	146	423	1894
July 2005	-	-	541	-
August 2005	241	210	451	12074
September 2005	120	102	222	7436
October 2005	260	189	449	9234
November 2005	223	141	364	5156
December 2005	278	115	393	8992
January 2006	256	175	431	3384
February 2006	264	261	525	3478
March 2006	232	245	477	10952
April 2006	157	181	338	4496

a4.2.2 National Association for People with HIV/AIDS in Malawi (NAPHAM).

NAPHAM regional office located in Masasa Township was also consulted in this HIV/AIDS situational analysis study. The consultant held discussion with the regional coordinator for the centre about the activities of the association. The association has over 430 members that are actively volunteering in the association activities.

Activities undertaken by NAPHAM.

- Outreach programmes on HIV/AIDS prevention
- Provision of library services to the residents of Mzuzu city
- Distribution of free condoms to people
- Nutrition programmes to its members
- NAPHAM members are raising broilers as an income generating activity to support their other activities.

What is working well

- Many association members volunteer to go out in locations and other places to organise HIV/AIDS campaign meetings and sensitise people on the dangers of HIV/AIDS.

- The stigma that was usually accompanied with HIV / AIDS has been reduced resulting to more association members participating in this programme. The reduction of stigmatisation is also evident from the increase of people joining the association.
- The library facility set up within NAPHAM offices is contributing to the effective delivery of the services. It is equally accessible to both members and non members of NAPHAM and it has a lot of material (booklets, pamphlets, books) on HIV/AIDS accessible to the people visiting the centre. Patronage to the library is very high with the reduced HIV stigma among the people.
- HAPHAM Regional Centre has a TV set that people use to watch various movies including those on HIV/AIDS.
- NAPHAM members distribute free condoms when they go for HIV/AIDS campaign meetings. Other people access these condoms at the association offices when they come to the library.
- The nutritional status of NAPHAM members was said to be good. NAPHAM has a nutritional program that ensures members with deteriorating nutritional status are given assistance by the association. There is a mechanism for monitoring the health status of its association members to ensure that they are free from opportunistic infections and that their nutritional status does not deteriorate to make their bodies prone to opportunistic infections.
- The broilers project is positively contributing the effective delivery of services not only to NAPHAM members but also the community at large through the association outreach programs.
- There is good coordination and linkages between NAPHAM and Mzuzu City Assembly. The association has a representation in The District AIDS coordinating committee (DACC). This ensures that the association gets an appraisal of the activities the assembly wants to embark on. The linkage also facilitates some of the association activities.

What needs to be improved

- There is need for more sensitisation of the communities about NAPHAM to completely wipe out the pockets of stigmatisation that could be left out in other places. This could also result in to more people joining the association thereby enhancing its activities.
- There is need for proper structures in the villages. It was noted that previously the ward councillors used to play a very big role in mobilising people in the villages. If such structures could be restored or similar structures be put in place the delivery of the services could be enhanced.
- The nutrition program run by the association needs more support. The association members mentioned that ARVs intake tends to increase the appetite for food. The association thus realises that its members who are currently on ARVs need support for them to acquire more food which is a very important component NAPHAM service delivery.

a4.2.3 Mzuzu Health centre

Mzuzu health centre has a number of activities and programmes are directly relating to HIV/AIDS pandemic in the city. The health centre offers the following services:

- Medical services to general illnesses
- Treats sexually transmitted infections,

- Distributes condoms to individuals, institutions, organisations such Mzuzu University, Moyale Barracks, Nkhorongo dispensary
- Prevention from mother to child transmission of HIV (pregnant women, family planning baby deliveries, NVP administration).

Mzuzu Health Centre distributes condoms to other dispensaries such as Nkholongo, youth organisations such as WONECO, institutions such as Mzuzu University and Moyale Barracks and other sections of the Health Centre including STI, Family Planning and VCT. The aim is to curb STI and HIV/AIDS transmission. According to the condom distribution stores register maintained at Mzuzu Health Centre a total of 11733 boxes of condoms have been distributed between July 2003 and 10th March 2006. The health centre was initially issued with 10,000 boxes of condoms on 29th July 2003 and it periodically receives condom consignments to replenish the stocks. 2636 boxes of condoms were left in stock at the time of the present study. The information on the number of condoms in a box was not provided.

The health centre with the support of Medicine San Frontier also offers prevention of mother to child transmission of HIV/AIDS services. Other hospitals and VCT centres refer women for PMTCT services (pregnant, family planning, baby deliveries and NVP administration) to Mzuzu Health Centre. All the data for women receiving PMTCT services from the year 2004 are kept at Mzuzu Health centre. The data do not specify the localities from which the women came from.

Besides HIV prevalence data the consultant could not conduct participatory analysis with health centre staff about their general experiences because the staff were very busy assisting patients.

a4.2.4. Milazi Clinic St Jones Hospital

Milazi Clinic adjacent to St Jones Hospital has been offering HIV tests from the year 2004 to date. A total of 1931 clients had been tested for HIV from the 2004 to the time of the present study (early May 2006). The major reasons for HIV tests include voluntary counselling and testing (VCT), diagnostic test for patients from St Jones Hospital and PMTCT tests for women visiting St Jones Hospital. The centre also started administering ARVS to HIV positive patients in June 2005.

The registers of people on ARVs at this Clinic were not accessed because they bear names of people that are supposed to be confidential. Consequently the consultant collected very limited information relating to people on ARVS (from the summaries provided by the staff). The details of HIV prevalence tests are presented in section 3.3 of this report.

Participatory analysis with health centre staff about their general experiences was not conducted because it was not possible for the hospital staff to be brought together leaving their jobs unattended to.

a4.2.5. Mzuzu Central Hospital

Besides treating patients for various illnesses, there are three clinics at Mzuzu Central Hospital that conduct HIV tests. They started carrying out HIV tests in the year 2004. . The major reasons for HIV tests are VCT, diagnostic tests for patients suffering from various illnesses and other unspecified reasons. The hospital also administers ARVS to HIV positive

patients. The data for patients on ARVs were not accesses because the people concerned could not be found as they were always busy with patients. The numbers of clients that have undergone HIV tests at the three clinics of Mzuzu Central hospital from the year 2004 to 8th May 2006 are 1871 for the Pharmacy HIV test Clinic, 1004 for Rainbow Clinic and 138 for TB ward Clinic. The findings of serostatus tests are presented in section 3.3 of this report.

Mzuzu Central Hospital does not offer PMTCT services but refers clients in need of such services to Mzuzu Health centre. All data on HIV tests for women that require PMTCT services are sent to Mzuzu Health Centre.

The participatory analysis with health centre staff about their general experiences was not conducted because it was not possible for the hospital staff to be brought together as each one of them were very busy to spare time for the discussions.

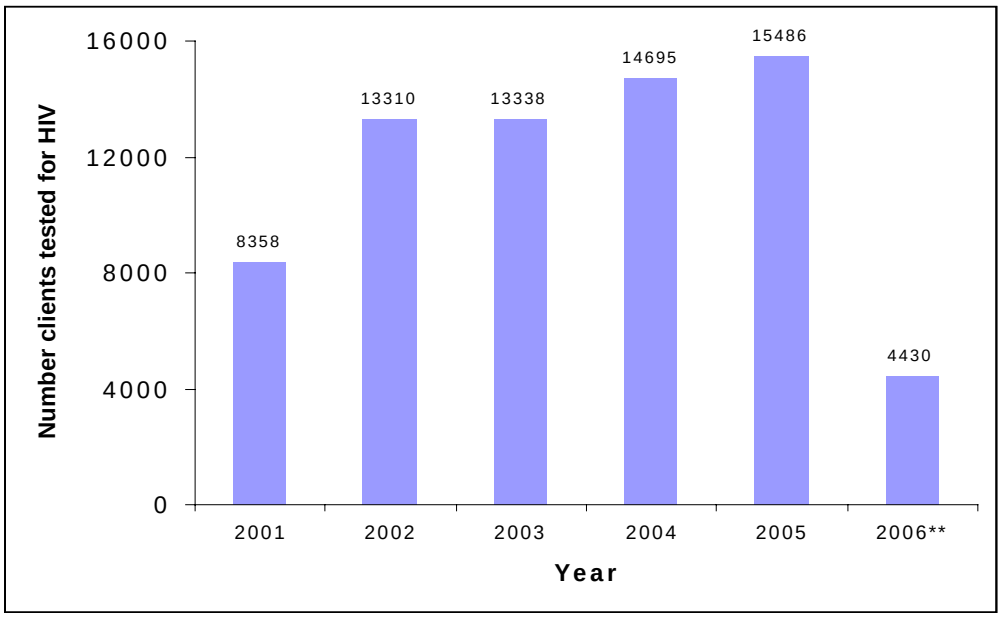
a4.2.6. Mzuzu MACRO

MACRO is the oldest service provider for HIV tests in Mzuzu with information dating back to 2001. A total of 69617 clients had been tested from 2001 to the time of this study (6th May 2006). The number of clients tested for HIV at Mzuzu MACRO has been increasing annually (Figure 1). Note that data for the year 2006 were incomplete for it only covered data for a few months of the year at the time of the study (3rd to 11th May 2006). The number of clients going for HIV test at MACRO by far outnumbers the sum for those going to the three other centres (Mzuzu Central Hospital test centres, Mzuzu Health Centre and Milazi clinic).

The consultant did not have access to MACRO registers for HIV prevalence as in other centres. MACRO provided summaries of data that were not as detailed as the registers would have shown.

Mzuzu MACRO does not provide ARTs to prevent HIV transmission to new babies. Pregnant mothers tested and counselled (Table 8) are referred to Mzuzu Health Centre for ARTs. A centre for ARV has just been opened (in March 2006) supporting a total number of 16 clients (6 males and 10 females) so far (Table 7).

Figure 14. The temporal trends of the number of clients that have been tested for HIV at Mzuzu MACRO



** Data covered only a few months of the year before May.

a4.3. Orphan care projects

a4.3.1 Women Development and information centre – orphan care (WDICOC)

This is a group of 8 (initially 15) active women based at St Peters Catholic Church in Mzuzu working with orphans, widows, old people, widows, disabled and the needy. Their major activity of is support of orphans. It comprises of retired women, teachers, secretaries and housewives. The group started in 1998 with Medical Missionaries of Mary sisters, the owners of St Jones Hospital who rendered various forms assistance to the needy including paying school fees, provisions of food, building houses and others. The handing over of St Jones Hospital to the Diocese by the Medical missionaries of Mary Sisters resulted to the establishment of WDICOC that started operating in 2002.

The goal of WDICOC is to improve the social life to economically empower the orphans. Their mission statement reads "*We are a group of women who have a common vision and commitment to share skills and knowledge and contribute to a process of development, peace and Justice in the spirit of the Gospel Message*".

The geographic area of coverage includes the following: Ching'ambo, Zolozolo, Masasa, Chibavi, Chiputula, Katawa, Mzilawaingwe, Kavuzi and Sonda (next to Mchengautuwa).

Support rendered to the needy:

The orphans are identified from various locations by CADECOM of St Peters, guardians and the Parish. The target age group of orphans is 4 to 15 years of age. Well wishers and Medical missionaries of Mary Sisters operating from their home countries provide some assistance to the same orphans. One family donated a sewing machine to help the organisation for their fundraising activities. At present WDICOC assists 70 orphans 60 of who are at primary school and 10 at secondary school. A teacher in Scotland provides support for the ten orphans at secondary school. WDICOC meets all orphans every week between 2.00 pm and 4.00 pm. Nine of those at primary school are fully supported for all their needs while others are provided with partial support. One of those at primary school was picked at a very tender age and is now at SOS Vocational Training Centre. WDICOC follows up the progress of the orphans at school and is in constant touch with the school authorities.

The services offered to orphans and their guardians are payment of school fees, sourcing of funds to buy clothes and food, support in sporting activities and social and spiritual counselling. WDICOC also offers other services like academic support in form of glooming the children in various academic subjects, teaching girls how to cook and training orphans in tailoring. After finishing school WDICOC further assists orphans to secure jobs. WDICOC has a library for children. At their meetings children are also given food which is sometimes shared with their guardians. Whenever the clothes are in stock they are shared to the children.

To accomplish their objectives WDICOC is engaged in income generating activities such as a tailoring shop and has employed a widow with 7 children to run its affairs. Members also contribute money to buy some resources.

At Kavuzi one household has a father who was incapacitated in a bus accident. WDICOC has empowered the man to weave mats (mphasa) and he is also a big farmer. At Sonda three families are being assisted.

What has worked well:

- The women are proud to have supported some children to secondary school level.
- Most of the orphans at primary and secondary schools are doing very well academically, spiritually and behaviourally. Those at junior primary school are able to cite poems and many Bible verses.
- Members of WDICOC have gathered experience and learned a lot of ways of dealing with various people like the needy and orphans.

What needs to be improved to make WDICOC achieve even better outcomes for their goals

- There is need to increase space for the orphans. Currently space for orphans is so limited that those between standard 1 and 5 learn outside and only those between standard 6 and 8 can fit in the available room.
- There are limited resources to fully provide the needs of all the orphans. WDICOC members also have to fight for their survival such that they compromise between their home needs and orphanage needs.
- There is need for the orphanage centre to be formally recognised as an important unit of the Diocese.
- There is need for more cooking equipment to suffice the number of girls at the orphanage
- There orphanage would like to have more tailoring equipment to broaden its financial base.

- The women running the orphanage require training in some skills such HIV issues.
- The orphanage needs to link with other service providers like the City Assembly and social Welfare Department.

a4.3.2. St. MARK ANGLICAN CHURCH WOMEN

This is a splinter group of WDICOC based at Mzuzu St. Mark Anglican Church engaged in the same activities as their mother organization. The consultant failed to meet the group for detailed focus group discussion on the scheduled day because they were busy with their church activities. However, from the short chat with members of this group a few things were learned.

The organisation does several activities aimed at mitigating the effects of HIV/AIDS on the orphans. The activities include: cookery, knitting, tailoring and counselling of the youths. The activities are for both church affiliates and non- affiliates.

What is working well

- Their activities are positively contributing to the welfare of the disadvantaged children. More children have been trained in various skills. The institution has facilities such as sewing machines that are used to train the children.

What needs to be improved

- There is need for proper linkage with other support organisations such as the Mzuzu City Assembly, other Faith Based organisations and youth organisations. Such linkages can enable sharing of experiences and ensure that there is synergy of activities by various organizations instead of duplicating them.
- The women expressed the wish to access funding for implementation of some of their activities. Some activities are not properly implemented because of lack of funds.

a4.4. Youth organizations

Several youth organisations were also consulted in this study. All the youth groups fall under the umbrella of the Mzuzu Youth Association that links all youth programs in Mzuzu City. These youth organisations are working with youth and the elderly in several programs. These programs include:

- HIV/AIDS awareness and behavioural change campaigns
- Girls empowerment
- Environmental conservation
- Protection of children from abuse and violation of their rights
- Assisting the old and the sick
- Training in technical skills
- Entertainment and sports
- Sexual reproductive health education
- Free condom distribution
- Distribution of HIV/AIDS reading materials to people
- Computer training

In this study a total of 7 (seven) individual youth groups were visited and discussions were held at length with members. The groups visited are:

- Wovwiri Networking Community Based Organisation (WONECO)
- Scorpion
- Mzuzu Young Voices
- Malawi Girls Guide Association (MAGA)
- Youth Against HIV/AIDS Pandemic (YAAP)
- Mzuzu Scout Network
- Society For The Improvement of The Youth Affairs (SIYA)

a4.4.1 Wovwiri Networking Community Based Organisation (WONECO)

WONECO is a youth organisation that has its focus on the commercial sex workers in the city of Mzuzu. It also has a small component on the issues of child rights and controlling the influx of street children in the city.

Goals of the organisation

The following are the goals of the organisation:

- To provide adequate and high quality care and support services to people living with HIV/AIDS, youths, affected families and communities.
- To assess and mitigate the impact of HIV/AIDS on the national economy

Objectives of the organisation

- Reduce HIV/AIDS prevalence in the city and the peripheral areas.
- Control the influx of street children in the city of Mzuzu and transform them into self reliant citizens
- Reduce the number of commercial sex workers and promote safer sex practices in the city of Mzuzu to reduce the spread of HIV/AIDS.

Activities

- Distribution of condoms to commercial sex workers
- HIV/AIDS awareness campaigns
- Distribution of information materials on HIV/AIDS to commercial sex workers

What is working well

- The free condom distribution program is working very and positively contributing to promotion of safe sex among the commercial sex workers. The commercial sex workers find this very helpful as previously they were engaging in unprotected sex because of lack of money to buy condoms.
- Many commercial sex workers have abandoned the profession and switched to more acceptable activities in the society such as resuming school and running small scale businesses such as selling kaunjika, tomatoes and other household items. This development has resulted to a drop in the number of commercial sex workers supported by WONECO from 650 in 2004 to 450 in 2005.

What needs to be improved for WONECO to effectively deliver its services.

- There is need for linkage between WONECO and other support providing institutions such as Mzuzu city assembly, MANASO, NAPHAM, Mzuzu Health Centre and BLM. WONECO gets its condoms for free distribution from several organisations such as NAPHAM, MANASO, Mzuzu health centre and sometimes BLM. However, usually condoms accessed from BLM are paid for. For effective linkage with other service providers WONECO needs to have proper structures both within and outside Mzuzu. This can also enable WONECO access funding for implementation of their useful services on HIV/AIDS in Mzuzu City.
- There is need to educate commercial sex workers to take their stand against male hostility. Discussions with WONECO indicated that quite often commercial sex workers face men who refuse to use condoms. This makes the women vulnerable to contracting HIV / AIDS virus.
- There is need free increased supply of free condoms to commercial sex workers. The discussions with WONECO revealed that condom sharing amongst commercial sex workers is problematic because very few of them can afford to buy them. This is compounded by the fact that there is low money circulation within the Mzuzu City translating into low charge rates for the services of commercial sex workers. Any money earned from their services is used for their necessities and they have nothing to spare for buying condoms.

a4.4.2. Mzuzu Young Voices

Mzuzu Young Voices is a youth organisation that focuses its activities on the youth aged between 10 – 26 years.

Objectives of the organisation

- HIV/AIDS prevention campaigns
- Girl empowerment
- Child rights protection
- Environmental conservation

Activities of the organisation

- Sports competitions such football and netball
- Quiz competitions
- Debate competitions
- HIV/AIDS awareness campaigns
- Girl empowerment activities

What is working well

- The sports competitions the organisation organises are contributing to reduction in the spread of STIs and HIV/AIDS. These competitions are played for a long period which prevents the youths from engaging in destructive and risky behaviours.
- Besides patronising the sporting activities, the people are also sensitized on the dangers of HIV/AIDS through addresses made to players and spectators by the president before games kick off and distribution of various materials on HIV/AIDS.
- The organisation has also managed to establish branches in various primary schools and secondary school in Mzuzu city and beyond. Examples of such schools are: Katoto primary school, Viphya secondary school, Mary mount secondary school,

Mzuzu CCAP primary school, Mzuzu Government secondary school, Nkhata Bay secondary school

- Mzuzu Young Voices Organization is well linked to other support institutions such as the Regional Youth Office (N), Land 'O' Lakes and Southern Bottlers. Regional Youth Office (N) sometimes provides transport to the Mzuzu Young Voices to ease their mobility challenges. Land 'O' Lakes and Southern Bottlers have also supported their activities in the past.
- Activities aimed at empowering girls are positively contributing to reduction of STIs and HIV/AIDS. Girls are trained in various skills such as computer, tailoring and knitting. These activities are bringing useful skills to girls.

What needs to be improved

- The organisation expressed the wish to have an office and equipment such as computers and phones to enhance their operations. The organisation is operating within the Regional Youth Centre premises which are quite congested. Phones could for communication and sharing of information with branches in other districts such as Dedza and Blantyre.
- The organisation needs to develop good structures to ably link it with other support institutions. Currently the organisation has limited links with organisations that support a few activities. The majority of the activities are not supported. Strong linkages could facilitate large scale support of activities such as competitions that are organised with the aim of keeping youth busy thereby contributing more to effective delivery of services established.
- There is need for training and capacity building of more members of Young Voices organisation in their activities so that they have adequate information on the subject matter. Currently very few members have attended a workshop and been trained in HIV/AIDS prevention. One of such conferences was organised by MACRO while the other was organised by the National AIDS Commission (NAC) in collaboration with the Youth Council and Bridge Project. The other required training areas are in leadership and financial management to enable members effectively run the organisation.

a4.4.3. The Scorpion

This is a small youth organization launched on 6th July 2002 at Msongwe Area in Mzuzu. It works in Mzuzu city and Senior Chief Kabunduli in Nkhata Bay District. Some of its projects target the whole northern Region of Malawi. The youth organization has its office in Bazaar Building, second Floor. The World Bank and Action Aid have funded the organization and it has its account with the Bank.

The youth organization works in the following areas:

- HIV and AIDS prevention and mitigation through the following activities:
  - Drama: The dramas are on HIV AIDS related subjects.
  - Video production: The production is done through a program known as Watch and Learn funded by Action Aid. The youth organization has produced a film that is shown in secondary schools in the Northern Region of Malawi. Questions and discussions follow the presentation of the film on the subject of AIDS in schools.

- Peer educators program: In this program the youth organization visits fellow youths in their homes to spread the message on HIV control and mitigation. They offer some precounselling information and encourage other youths to go for VCT.
- Walls of hope Project (at Kabunduli): The youth organization builds pillars on which they paint pictures and messages through Participatory Approaches Towards Addressing Challenges of Aids (PATACA) meetings. The World Bank and Action Aid funded this Project (2.5 million kwacha).
- Child rights. The youth organization pays visits to homes of orphan children. They educate the guardians of the orphans on the rights of the orphan children regarding child labour, defilement and other malpractices that affect the lives of orphans.

- Computer training: The National Youth Council of Malawi through the UK Youth Connect Mission "Each youth to know a computer by 2010-2020" trained 3 youths as trainers of trainees in Computer. The UK Youth Connect provided the computers to the youth organization through the National Youth Council of Malawi. The youth organization train fellow youths in 5 computer packages icluding: Microsoft Word, Microsoft Excel, Microsoft Power Point Presentation, Microsoft Access and Internet Exploration. The trainees pay K500 / week for maintenance of the computers and payment of electricity bills.
- Sports: The youths play girls football and Flizebel (Plate) sponsored by Stephen Dotto from Canada.

What is working well for the Scorpion youth Organization?

- The video production aroused the donor's interest to fund the organization.
- The youth organization has gained international recognition. The Director of the organization went to Lusaka in Zambia to represent Malawi in the World Bank Project "Develop Market Place" for the three countries Zambia, Zimbabwe and Malawi. The Project "Wall of hope" was won through the same trip to Zambia where the project proposal was presented. The director also presented the proposal in Washington DC in an Annual General Meeting.

What needs to be improved

- There is need for the youth organization to cover the whole country. Currently the organization is only operating in the Northern Region of Maawi.
- The youth organization would like to feature some of their films on Television Malawi so that a greater majority can learn from them. However, the organization does not have financial muscle to have their film featured on TVM.
- The organization would like some of their services such as mobile VCTs, and computer training to be extended to the villages. Currently villages are not reached.
- The youth organization expressed the need for funding to open sporting trophies in rural areas.

a4.4.4. Malawi Girl Guide Association (MAGA)

This is an organization dealing with girls and young women between the ages of 6 and 40 years that started in Malawi in the year 1997. The work of the organization is on voluntary basis and its gets funding from contributions of individuals and well wishers from Norway.

MAGA has seven sites of operation within Mzuzu City including Zolozolo, Katawa, Masasa, Sonda, Chibavi, Nkholongo, and Lupaso. The activities of MAGA are as follows:

- Disseminating messages on sexually reproductive health incorporating aspects of sexuality, HIV/AIDS, gender, planning for the future and development of life skills. They also provide some counseling services to fellow girls. In each of the seven sites of operation are two peer educators and seven committee members who work with peer educators. The peer educators and committee members have one supervisor from MAGA.
- Conducting meetings in schools: Each site of MAGA operation has its own schools where girls are taught to be self reliant by training them in technical skills like knitting, cooking, household management and counseling. They also do sporting activities.
- Providing assistance to the old, orphans and the sick in the hospitals such as:
  - Cleaning houses and washing clothes of the old people
  - Contributing money to buy basic needs for the orphans and the sick
- Encouragement of fellow girls to be self reliant through various income generating activities such as cooking mandasi and knitting. Through role plays and teaching MAGA encourages girls to properly plan for their futures to control problems of pregnancies while at school or being enticed to go into commercial sex.

What works well

- MAGA has been providing 9 orphans with some assistance (5 of them are in Zolozolo and 4 in Katawa).
- The messages disseminated are accepted by their peers in the community.
- Sporting activities attract many girls where they also share quite a number of ideas.
- Women are realizing the importance of being self reliant.

What needs to be improved for MAGA to deliver better services than at present

- MAGA members realize the need for assistance with some resources to achieve their goal. Since they work on voluntary basis most members face the problem of raising money for transport to do various activities. They also provide limited assistance to the orphans because of resource limitations.
- There is need for proper coordination and cooperation amongst youth groups targeting the same communities with similar messages.
- MAGA members also expressed the need for proper linkage with the city assembly and other service providers so that their activities are recognized at Mzuzu City level.

a4.4.5. Mzuzu Scout Network

The Youth Scout network originates from the involvement of children to assist soldiers in the 1920s. In Malawi the group started some time but stopped in 1964 it was replaced by the Malawi Young Pioneer. It was later reintroduced in 1999 by Lutheran Church.

The Mzuzu Scout Network is part of the Northern Region Scout Network. The goal of Mzuzu Scout Network is to contribute to development of young people to become self reliant and responsible.

The scouts are divided into four categories including: cups (6 – 10.5 years), Junior scouts 10.5 – 14 years), senior scouts (14 – 18 years) and rovers (> 18 years). The younger scouts

are gradually introduced to services till they reach 18 years when they fully perform the prescribed services.

As a pilot phase the scout group started working at Katawa, Mzilawaingwe, Chiputula, Chiwavi, Mchengautuwa, Masasa and Lupaso.

Activities undertaken by the Mzuzu Scout Network

HIV / AIDS activities:
These include:

- Dissemination of information on HIV / AIDS mitigation through drama in schools and communities in nearby areas like Masasa and Lupaso..
- The distribution of condoms (for male and female).
- Counseling. Two scouts have been trained in HIV AIDS counseling. They go to health centres to counsel fellow youths with the assistance of UNICEF Program.
- The Scouts Red Ribbon. This comprises a card containing HIV / AIDS messages on knowledge, skills and attitude that are taught to primary school children. The children are given tests and those who pass the test are given a red ribbon badge as an incentive for others to learn the messages on HIV/AIDS contained in the book. Failures of the tests are guided to learn what they fail. This program has reached six primary schools.

Keeping of Black austrolops chickens:
This program is supported through the OVOP Program. Chickens were initially distributed to a few members so that others can benefit through pass on mechanism.

Camping outdoor using tents
In these camps the youths are taught first aid, hiking using a campus and good hygiene. They also undertake outreach programs on various subjects. The outreach programs are through drama and songs during the day and campfire in the evening. The camp fire is made with the communities where they spread the messages of scouting, HIV AIDS, food security and they engage in dialogue with the old people. Four camps are planned per year.

Holding guest speaker fora
Two fora are organized per year where experts in various areas like agriculture, HIV AIDS address the youths.

Community services
The Youth Scout Organization undertake various community services including bridge construction and assisting the needy such as HIV / AIDS victims, old people, prisoners, orphans and the sick at the hospital.

What working well and is contributing to the success of the Youth Scout Organizationl

- The youth recognize the camp as a good training college for scouting where various skills are taught.
- The scouts enjoy HIV / AIDS school outreach programs through drama as they also act as part of entertainment for schools.
- The award of red ribbon badge encourages all children to work hard to learn information on HIV/AIDS.

- Young children feel comfortable to be counselled by fellow youths who refer them to medical staff for their problems.

What needs to be improved to have even better services

- There is need to train more scouts in HIV AIDS issues and drama particularly for shy youths.
- There is need to strengthen partnerships with other youth groups and stakeholders like DACC, Social welfare, Youth Department and Youth Association. The scouts noted that currently there are poor linkage mechanisms between the youth organization and other stakeholders. Furthermore, the scouts were concerned that DACC recognized their presence only when representatives from National Aids Commission visited Mzuzu City Assembly to see what was happening but for other programs at DACC level they are not approached. The youth representatives to various stakeholders' fora do not also give feedback to their respective youth groups.
- The youth organizations should learn to effectively share information and that those involved in training youth group representatives in various aspects should institute a follow up mechanism to ensure that the knowledge gained from training is imparted to others. The scouts noted that the youth groups in Mzuzu City are not open to one another in what they do.
- The scouts noted that the Youth Association need to be strengthened so that is can properly link all youth groups.
- The scouts noted the need for a proper reporting mechanism of the youth activities to the other service providers.

a4.4.6. Mzuzu Society for the improvement of Youth Affairs (SIYA) Youth club

Mzuzu SIYA Youth Club is part of SIYA organization that has three branches including Board of Trustees, Executive and Youth Groups. It has a constitution and membership agreement. It is a non-profit making organization based on voluntary work.

The main aim of Mzuzu SIYA Youth Club is to improve living standards of youths amongst themselves in view of the challenges they face such as HIV / AIDS pandemic, poverty and unemployment. Its objectives are:

- to deliver services and information for prevention and of spread of HIV / AIDS pandemic
- To encourage youth to venture into agricultural production
- To support orphans and elderly people
- To create and environment that promotes friendship between boys and girls.

Target areas and groups of people

The target areas of Mzuzu SIYA Youth Group are Masasa, Msongwe, Mchengautuwa and Lusangazi. The target groups of people are people living with AIDS, elderly people, orphans, youths and disabled people.

Activities

- HIV / AIDS prevention: They conduct outreach programs with youths in villages on HIV prevention and encourage youths to go for VCTs and counselling. These activities are accentuated by drama and dancing.
- Encourage youth to indulge in agriculture: This program is promoted with assistance of Plan International. SIYA Youth have a dimba garden where they grow cabbage, sugarcanes as a way of encouraging youths to have their own gardens.
- Support of orphans and elderly people: SIYA youth undertake the following activities
  - Identify orphans that they refer to the Village Development Committee who refer them to service providers that are ready to offer support such as SOS Vocational Training.
  - Visit orphans in specific areas to entertain them through sports
  - Use money realized from dimba sells for assisting the needy.
  - Have recently made plans to make money contributions for assisting the orphans.

What has worked well

- SIYA youth club members are appreciating the importance of agriculture through their dimba garden
- The activities of the youth are recognized by St John of God
- The impact of outreach programs are noted from the good feed back obtained.
- There is good networking with local leaders who appreciate the services of SIYA Youth Group.

What needs to be improved

- There is need for outreach programs to have a balanced target group. Currently the programs mainly target men and local leaders.
- There is need for DACC members to recognize the activities of SIYA youth groups. It was alleged that DACC only recognizes the Youth Centre but not specific youth groups. It was also stated that DACC members should show interest in and recognize the activities of the youth group at all the times not only on World Aids Day.
- SIYA youth group would like to be assisted with transport for their outreach programs especially when going to distant places. The group now depends on contributions from working class members for their transport means.
- SIYA Youth Group considered the need for external funding to enable it acquire stationery, uniform and football, make brochures for their activities and perform secretarial services.
- SIYA Youth Group expressed the wish to have an office. The group is using Mzuzu Youth Centre which they said gets congested sometimes.

a4.4.7. Youth Against HIV / AIDS Pandemic (YAAP)

This youth organization is located at Chibavi Township. The membership comprises of any interested youth older than 13 but less than 30 years of age. An entry membership fee of K30 and an annual subscription fee of K100 are paid. YAAP's aim is to increase young people's participation in the control of spread of HIV / AIDS and other sexually transmitted diseases. The sources of funding for this youth organization are: donors, donations from well wishers, subscription fees, income generating activities such as drama, shows, discussions and tournament trophies and business ventures. The donors for this youth organization include

National Aids Commission (through Plan International), the Dutch Initiative, Foundation Malawi Aid, Malawi Aids Networking Organization (MANASO) and Connect Youth UK (through National Youth Council of Malawi).

YAAP has employed staff and also works with 15 volunteers. The Youth Organization has a bank account where money from donors for paying its staff is kept.

Activities

The following are activities of YAAP:

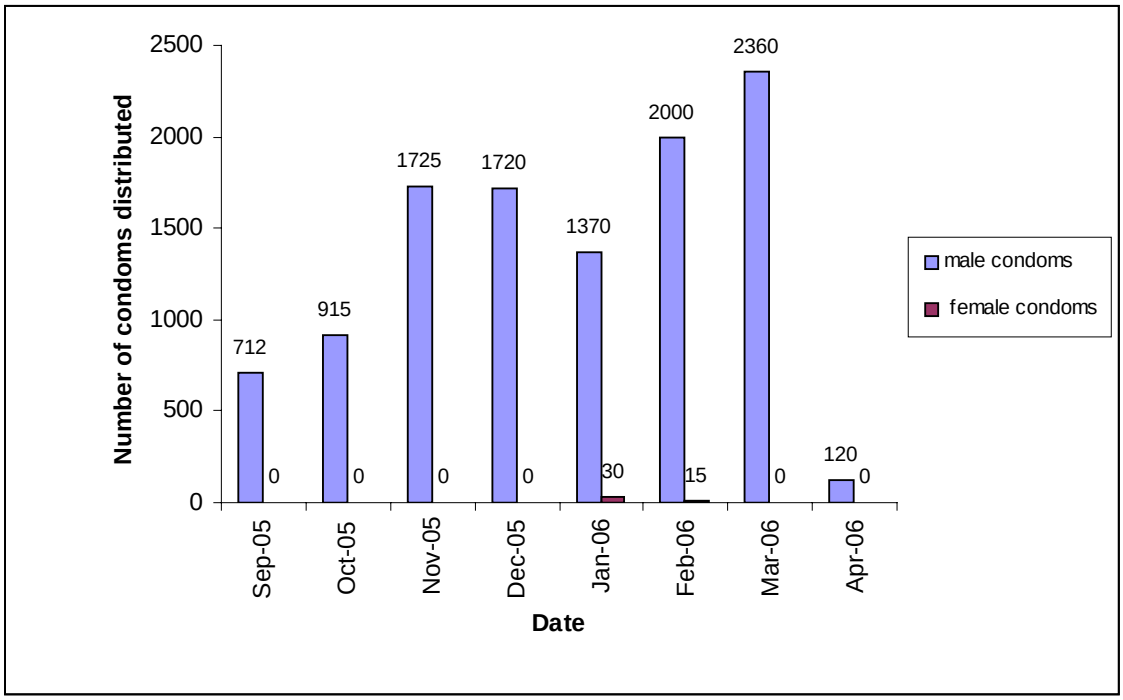
HIV / AIDS and Sexual Education
Related to HIV AIDS the following are done:

- Peer education training in secondary schools. Six secondary schools have been covered reaching a total of 400 secondary school youths.
- Public awareness through meetings involving community leaders
- Pre-counselling services to fellow youths and behaviour change intervention. The youth organization works in collaboration with Banja La Mtsogolo. An average of 8 youths (3 female and 5 males) is counselled per day. After precounselling youths with problems such as STIs are refereed to Banja La Mtsogolo using referral cards BLM gives to the youth organization.
- Condom distribution: The condoms are purchased from BLM with funding from Foundation Malawi Aid. Condoms have been distributed to youths both within and outside YAAP Catchment areas. Data on number of condoms distributed from September 2005 are presented in Figure 2.
- IEC – pamphlets, leaflets and library which attracts many youths
- Hope Kit Project: This is a project supported by Bridge Malawi where youths are trained to teach others about HIV AIDS spread using various tools.

Vocational skills training: The skills include:

- Tailoring: The Dutch bought the tailoring machine as a support for this activity. The technical expertise for the training was supported by MANASO by inviting trainees to workshops. Six youths comprising three girls and three young men have been trained so far.
- Computer skills: A total of 42 youths have been taught in computer skills.
- Carpentry: This was about to be introduced at the time of this study (8th May 2006)

Figure 15. The number of condoms distributed by YAAP



Sports and entertainment: Including the following

- Talent shows promotion that is done every Saturday. The examples of talents shown are composing songs on HIV / AIDS. One album has been produced by the youths and it is on CD with Foundation Malawi just awaiting the making of copies. Approximately 1500 youths come for talent shows every Saturday.
- Sporting games like football, volleyball, netball and table tennis

What has worked well

- Saturday talent shows attract so many youths that benefit from the messages conveyed and the participation of girls is quite high.
- Most youths prefer fellow youths to other service providers like MACRO when it comes to precounselling services. This happens despite the fact that VCT services are not offered by YAAP.
- Peer education training is proving to be effective in creation of youth awareness on issues of HIV AIDS.
- There is increasing demand of condoms by fellow youths (Table 2). Parents that have been reached by YAAP freely talk about condoms with youths.

What needs to be improved

- The youths would like YAAP to be offering VTC services. The fact that youths are freer to approach fellow youths for VCT is a testimony to this.

- There is need for YAAP Youth Organization to have more income generating activities. The Youth organization sometimes runs out of money to meet running costs like purchase of stationery.
- YAAP wished there were flexibility on the activities the organization undertakes with the funds from donors. It was stated that sometimes there are very pressing issues on the ground which would require YAAP taking some action but nothing happens because of specification of the donor on how the money should be used.

Annex 5. Literature Cited

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MZUZU CITY ASSEMBLY
MALAWI

HIV/AIDS & STI

WORKPLACE
POLICY GUIDELINES

June 2006

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ACKNOWLEDGEMENT

The Mzuzu City Assembly Internal Mainstreaming (Workplace) Policy Guidelines have been developed with assistance from UN-HABITAT through MALGA/AMICAALL. The technical assistance of the preparation and development of this Policy document was rendered by the tireless efforts of a consultant (Mrs P. S. Chabinga) to whom the Mzuzu City Assembly is indebted to.

Special recognition with due respect goes to the entire Management Team and staff for their leadership and valuable contribution, in very difficult circumstances, during the data collection exercise. The same specifically goes to Mr Namakhuwa (the City's HIV/AIDS Coordinator, for his personal commitment in seeing to it that this document is truly a product of the Mzuzu City Assembly Staff. With this empowering tool now, let us unite together even more strongly to create an AIDS free Mzuzu City Assembly workplace.

Mr. Chikwapulo
Director Department of Health

DEDICATION

To the management and the entire workforce of Mzuzu City Assembly, for having suffered Silently for a long time, and now For having said it with feeling.

May these policy guidelines empower you to live positively regardless of your HIV status.

APPLICATION OF THE POLICY

The Mzuzu City Assembly Workplace Policy shall be applied and interpreted in accordance with the National HIV/AIDS Policy, Public Service HIV/AIDS Policy and the Local Authorities Service Conditions.

This Policy, therefore applies to <u>all</u> categories of Mzuzu City Assembly employees, their immediate family members and primary dependants of below 21 years old, from the highest to the lowest form of rank, including temporal or seasonal workers.

ACRONYMS

AIDS - Acquired Immunodeficiency Syndrome
AMICAALL – Alliance of Mayors Initiative for Community Action on HIV/AIDS at Local Level
ART - Anti-Retroviral Treatment
ARV - Anti-Retroviral drugs
HIV - Human Immune Virus
MALGA - Malawi Local Government Association
NAC - National HIV/AIDS Commission
PEP - Post Exposure Prophylaxis
STIs - Sexually Transmitted Infections
VCT - Voluntary Counselling and Testing

INTRODUCTION

According to the Sentinel Surveillance Technical Report of January 2004, the estimated HIV/AIDS prevalence rate in adults between the age of 15-49 is 14.4%. The report further estimates that between 750,000 and one million people in this age group are currently living with the virus. It is also indicated that 80,000 die each year of AIDS and as many as 110,000 new infections occur in the same period of time. The estimates have been worked out on the targeted age group of 15-49 due to the following reasons:

- It is a reproductive age group, therefore, if living with the virus, can pass it on to their unborn babies during pregnancy.
- This is the most sexually active age group and thus at high risk of contracting the virus if not practicing safer sex.
- It is the most dependable productive age group that, with the current HIV prevalence rate can severely affect the socio-economic development of Malawi.

Specific data on the Assembly employees HIV/AIDS/STIs situation is not readily available but the City's HIV/AIDS Coordinating Committee strategic plan (2005-2008) states that the age group of 15-49 is the most infected and affected in Mzuzu. The strategic plan cites inaccessibility of condoms, inadequate positive behavioural change strategies and high prevalence rate of sexually transmitted infections as some of the contributing factors. As a result there has been evident low productivity due to loss of skilled man power, illness and absenteeism, increased institutional costs due to ever escalating demands on medical care fees, funeral costs and early terminal benefits. Incidentally, Mzuzu City Assembly has the majority of its employees in this age group. This indicates that the majority of the City Assembly staff, by nature of their age group, are at high risk of being affected or contracting or infecting their sexual partners with HIV or STIs. The staff vulnerability situation is made worse because most of the HIV infected people in Mzuzu do not know their HIV status.

Although there has been no systematic study, conducted on the impact of HIV/AIDS in Mzuzu City Assembly since the advent of the epidemic, there is general acknowledgement that, the effects of HIV/AIDS in its workplace are considerable. Mzuzu City Assembly like any other local government sector is struggling with different emotions and fears such as: anger and outrage, the sense of helplessness and hopelessness, loss, absenteeism and worse still the misery of financial crisis.

Generally, not until now, there has been no much evidence of staff involvement in form of the City Assembly internal HIV/AIDS mainstreaming. Like in most decentralisation steering institutions, workplace programmes have been non functional. Lack of workplace policy and operational guidelines at Mzuzu City Assembly shows that the assembly leadership and staff were not yet aware of the possible benefits they can get in terms of target specific IEC materials, Psychosocial Counselling, HIV/STIs testing, treatment, including care and support. At Mzuzu City Assembly there are great uncertainties, seen but not normally acknowledged, surrounding human resource and HIV/AIDS. For example, despite worries about physical safety, economic livelihoods, emotional and Psychological stress, many operative level staff display enormous dedication and fortitude to the assembly programmes regardless of such severe hardships. Meanwhile, the unprecedented HIV/AIDS epidemic exposes most front line staff to infectious hazards and social stigma, it decimates the workforce and posses new severe stresses on the already fragile assembly human resource base.

In the past assembly management may not have captured well the rapidly changing human resource situations such as high morbidity, absenteeism rate, the need for a more supportive working environment and comprehensive care and support strategies for the assembly staff. Therefore the development of a workplace policy will enable management and staff to formulate, in their comparative advantage, a strategic framework that will address their institutional needs arising from unprecedented HIV/AIDS epidemic.

GOAL

The internal mainstreaming at Mzuzu City Assembly aims at halting and reversing staff vulnerability to HIV, AIDS and STIs infection rate, so that those that are HIV positive can live positively and the HIV negative remain negative, by ensuring that all staff regardless of their HIV status, are maintained healthy and productive until retirement and beyond. Those with STIs have early diagnosis, appropriate treatment and psychosocial couple counselling.

OBJECTIVES

Mzuzu City Assembly staff display enormous dedication and fortitude to the assembly programmes regardless of such severe hardships arising from HIV, AIDS and STIs. There is evident great uncertainties, seen but not normally acknowledged, such as problems with physical safety, economic livelihoods, emotional and Psychological stress arising from the HIV, AIDS and STI's.

Currently this situation is the source of worry as it greatly affects the performance of the Assembly employees. In view of this, these internal mainstreaming policy guidelines once implemented shall help the staff to:

1. Prevent and minimise HIV, AIDS and STI's infection through the provision of educational programmes, psychosocial counselling, voluntary counselling and testing and condom distribution campaigns.
2. Enhance Management proactive involvement and support for HIV, AIDS and STI's staff targeted Programmes.
3. Promote a non-discriminating and stigmatising City Assembly workplace environment and encourage openness about HIV, AIDS and STI's.
4. Ensure equity in the application of rules and regulations to all City Assembly staff regardless of their HIV status.
5. Initiate and establish the City Assembly Workplace HIV, AIDS and STI's staff targeted Programmes.
6. Conduct workplace research and establish an inhouse HIV, AIDS and STI's Data Bank.
7. Establish local and national Collaboration and Networking linkages with partners, stakeholders, clients and the Assembly beneficiaries to enhance mainstreaming of the workplace programmes.
8. Establish a workplace monitoring and evaluation mechanism that will ensure that the set strategic framework is on course and yielding the intended staff oriented benefits.

GUIDING PRINCIPLES

At Mzuzu City Assembly, in operationalising these policy guidelines, there shall be

- High levels of management commitment illustrated by providing proactive workplace HIV, AIDS and STIs leadership.
- High levels of in-house staff consultations and worker empowerment on workplace HIV, AIDS and STIs issues.
- Great consideration of general human rights particularly, that of confidentiality, access to treatment, care and sick leave.
- Special consideration of staff HIV,AIDS and STIs related gender prejudices at the workplace.
- Evidence based workplace interventions that improves staff's human dignity, health and productivity.
- Acceptable standards of workplace programme governance, transparency and accountability.

MZUZU CITY ASSEMBLY STAFF CODE OF PRACTICE

1. MANAGEMENT STAFF:

The Mzuzu City Assembly management staff by virtue of their Terms of Reference shall:

- Become personally committed to inspire and mobilise other City Assembly workers to own and generate effective internal mainstreaming of HIV, AIDS and STIs activities.
- Recognise HIV, AIDS and STIs as part of the core business of the Assembly.
- Ensure that they get adequately capacitated and well vested in HIV, AIDS and STIs issues, particularly how they affect them, their immediate families, the City Assembly mandate and its employees.
- Through proactive leadership with a consultative approach with assembly employees, initiate the formulation of the internal mainstreaming strategic framework and integrate it into the overall annual City Assembly work plan.
- Mobilise and allocate resources specifically for internal mainstreaming.
- Advocate for the internal mainstreaming strategic framework by creating opportunities for co-operation with complementary services from stakeholders and partners.
- Through proactive leadership, initiate and lead in regular staff general medical checkups including VCT, to establish staff HIV status as well as rule out possible occupational health problems that can cause Opportunistic Infections (O.Is), for institutional planning purposes.
- Create and provide a more supportive working environment with reduced forms of stigma, discrimination, stress and occupational hazards.
- Through proactive leadership, control, coordinate monitor and evaluate the effectiveness and efficiency of the internal mainstreaming programmes.
- Strongly recommend to Ministry of Local Government and Rural Development, to urgently review the Local Government Act and the Local Authorities Service Staff Regulations so that they incorporated Local Authorities work place HIV, AIDS and STIs issues.
- Initiate future reviews of these policy guidelines in order to keep abreast with the changes taking place with the national response of the HIV, AIDS and STIs epidemic.
- Ensure that newly recruited employees have HIV, AIDS and STIs issues and the workplace policy modules in their induction courses.

- Provide appropriate professional protective clothing at workplace.
- Cultivate a spirit of voluntarism and self-giving to operationalise a successful workplace programme.
- Clarify and distribute the final copies of the workplace policy document to all employees.
- With proactive leadership initiate workplace research and maintenance of evidence based in-house data bank.

2. GENERAL STAFF

The employees of Mzuzu City Assembly shall:

- Collectively own and become personally committed to the City Assembly workplace HIV, AIDS and STIs programme.
- Collectively or individually ensure that they get adequately capacitated and well vested in HIV, AIDS and STIs issues, particularly how they affect them, their immediate families, and the City Assembly mandate.
- Collectively and individually cooperate and participate in the formulation of the internal mainstreaming strategic framework and integrate it into the overall annual City Assembly work plan.
- Use and maintain appropriate professional protective clothing at workplace.
- Collectively and individually take own responsibility to abreast them selves and share with their immediate families and primary dependants on the final copy of the workplace policy document.
- Collectively or individually participate in generating and conducting workplace research and maintenance of evidence based in-houese data bank.
- Treat the body fluid of any employee or his immediate family member or primary dependant, who has died of any known AIDS Related Complexes as potentially infectious **regardless** of whether the deceased was on Anti Retroviral treatment or not. In view of this, the last respect or any funeral rights of the deceased person's body should be dealt with caution using appropriate protective clothing.
- Not deliberately use or manipulate the HIV status to gain special favours or commit any misconduct or in-disciplinary behaviour at work. Employees with HIV status shall adhere to the service regulations currently prevailing at the workplace, unless management discretionary considers otherwise.
- Not regard themselves, because of HIV status as though they are crippled or wear any guilty or inferiority complex. But shall be assertive and forthcoming to prove their professional, psychosocial and economic potential.
- Adapt a positive living approach with their immediate families and primary dependants.
- Support and maintain a supportive, non-stigmatising, non-discriminatory and occupational hazard free working environment at all times.
- Take it upon themselves to use and practice prevention and control methods against HIV, AIDS and STIs with their immediate families and primary dependants as evidence of behavioural change.
- Comply and take part in regular general medical check ups and VCT so that they can have early access to treatment, care and support.
- Reserve the right to receive adequate psychosocial counselling services before VCT.

OPERATIONAL STRUCTURE

Management of Mzuzu City Assembly is mandated by the National AIDS Polic, and the Public Service HIV/AIDS Workplace Policy to constitute institutionalised working committees and groups to spear head the internal mainstreaming programme. In view of this, management shall operationalise the workplace strategic framework by setting up the following structure:

1. The internal mainstreaming "**Steering Committee**" which will directly report to management on the workplace programme. Its responsibilities shall include the following:
    - Leading in workplace policy development and amendment processes
    - Demonstrate personal proactive commitment in spearheading the operationalisation of the policy and its strategic framewrok.
    - Provide policy guidance on HIV, AIDS and STIs mainstreaming.
    - Advocate, lobby and mobilise financial support for the running of the workplace programmes.
    - Approving workplace HIV, AIDS and STIs proposed plans and budgets compiled by the Mainstreaming Coordinator.
    - Initiating in-house research and documentation of findings.
    - Collaborate and Network with other local or national stakeholders on internal mainstreaming.
    - Attend and participate in all stipulated local and national and international HIV and AIDS Commemoration days, workshops, conferences and other such forums.
    - Monitor and evaluate workplace programmes.
    - Make available teaching aids, home based care kits and counselling designated in-house places.
    - Perform any other workplace related assignments delegated by management.

2. The "Workplace HIV, AIDS and STIs **Coordinator,** reporting to the "Steering Committee" shall perform the following duties:
    - Participate in planning and budgeting of all workplace programmes.
    - Conduct on site monitoring of the workplace activities.
    - Produce regular progress reports to the Steering Committee.
    - Mobilise employees for the workplace strategising, budgeting and implementation of activities.
    - Facilitate the setting up of peer educators, peer counsellors and home based care working groups.
    - Identify training needs and determine support needs of the working groups.
    - Participate in programming activities, conducting in-house research and directly supervise the working groups' activities.
    - Collaborate and Network with other local or national stakeholders on internal mainstreaming.
    - Attend and participate in all stipulated local and national and international HIV and AIDS Commemoration days, workshops, conferences and other such forums.
    - Perform any other assignment as delegated by the Steering Committee.

3. The internal mainstreaming **working groups** shall be constituted by the steering committee and the coordinator using a criteria approved by management. There shall

be not more than the three stipulated working groups for programme easy monitoring, efficiency, effectiveness and cost effectiveness.

3.1 The "**PEER EDUCATORS**" working group shall:

- Be trained and knowledgeable employees responsible for conducting educational activities to fellow staff in Prevention and control, Treatment, Care and Support as well as in Impact Mitigation of the HIV, AIDS and STIs epidemic.
- Develop and disseminate workplace specific IEC materials and messages.
- Report directly to the workplace coordinator.
- Collaborate and cooperate together with the other working groups.
- Participate in identifying educational needs assessment of other employees, their immediate families and primary dependants.
- Conduct periodic staff behavioural change surveys to measure whether the information and knowledge provided has any influence to their attitudes and practice on prevention and control of HIV, AIDS and STIs.
- Perform any other related assignments as delegated by the workplace Coordinator.

3.2 The "**PEER COUNSELLORS**" working group shall;

- Be trained employees and knowledgeable to conduct and provide general psychosocial counselling.
- Relate general psychosocial counselling to HIV, AIDS and STIs.
- Create an interactive relationship with other employees and help them identify, clarify, explore feelings or fears about psychosocial, physical, spiritual or economic HIV related impacts and become empowered to make informed decisions or resolve own problems created by HIV, AIDS and STIs.
- Be conversant with the Positive Living Concept to empower other employees live positively; the power of positive thinking may aid healing.
- Be of good counselling qualities to deal with, preventive, crisis, problem solving and decision making skills.
- Perform any other related assignments as delegated by the workplace Coordinator.
- Collaborate and network with other working groups to form a multidisciplinary team approach where necessary.
- Conduct periodic staff surveys to check whether counselling is influencing positive behavioural change towards HIV, AIDS and STIs.

3.3 The "**Home Based Care Providers**" working group shall partly be developed from the existing Social Welfare Committee therefore their expanded roles shall include:

- Provision of outreach preventive, care and support services to employees and their families and primary dependant suffering from prolonged illnesses in their homes.
- Conducting home visits and assessments of the sick persons home environment and report to the coordinator for planning and decision making.
- Use the standardised home based care kits during home care assignments.
- Identifying clinical support systems for the purpose of referral and professional support.

- Identifying community support systems for continuity of home support.
- Training in Home Based Care and First Aid skills.
- Provide regular reports to the Coordinator on the progress of the client.
- Collaborate and network with other working groups to form a multidisciplinary team approach where necessary.
- Conduct regular staff home based care surveys to establish the effectiveness and benefits of the service.
- Perform any other related assignment assigned by the Coordinator.

ORGANOGRAM OF THE OPERATIONAL STRUCTURE

Mzuzu City Assembly Management

⇧

HIV, AIDS and STIs Steering Committee

⇧

Workplace HIV, AIDS and STIs Coordinator

⇧

Working Groups
(Peer Educators, Counsellors, Home Care Providers).

GUIDELINES FOR STRATEGIC PLANNING

CHECKLIST FOR HIV, AIDS AND STIs WORKPLACE MAINSTREAMING SHALL INCLUDE SOME OR ALL OF THE FOLLOWING:

Stages	Key Questions to Ask?
Identifying Internal Mainstreaming Needs	1. What are the impacts of HIV, AIDS and STIs on the staff and City Assembly workplace? 2. What are the existing traditional coping strategies used by the City Assembly as an institution and the employees? 3. What are the capacities available in the Assembly as an institution and in the employees? 4. Which additional capacities need to be built? 5. What human and material resources are available that could help integrate HIV, AIDS and STIs into the daily routine of the Assembly? 6. What additional human and material resources are required for the workplace programme? 7. What are the partners and stakeholders available in the City and their focus on HIV, AIDS and STIs mainstreaming? 8. How to involve employees, partners and

Stages	Key Questions to Ask?
	stakeholders who have experience, knowledge, or resources with HIV, AIDS and STIs issues? 9. How can assembly staff, regardless of their HIV status get involved intentionally in the planning processes of the workplace programme?
Building Staff Capacity	10. What can be done to enhance the capacity of Management, the steering committee, the workplace programme coordinator and the entire work force to identify, internalise, integrate and address HIV, AIDS and STIs related issues in planning and implementation in the assembly? 11. What can be done to enhance the capacity of the City Assembly staff immediate families and their primary dependants in order to participate fully in the workplace programme?
Implementation of activities at the workplace	12. Using the City Assembly's institutional **comparative advantage** how can management, the steering committee and working groups operationalise the set workplace activities?
Monitoring and evaluating internal mainstreaming activities.	13. How can the devised internal mainstreaming M/E tool be incorporated into the existing institutional M/E framework. 14. How often shall the workplace programmes M/E be conducted and documented in the set local data bank. 15. How often shall the HIV, AIDS and STIs M/E reports be reviewed for the purpose of re- planning

GENERAL SERVICE GUIDELINES

There shall be a budgetary allocation for HIV, AIDS and STI's workplace activities in the City Assembly annual budget. The mainstreaming expenses and activities shall be subject to internal and external auditing.

RECRUITMENT

The Mzuzu City Assembly shall exercise an equal employment opportunity to all prospective applicants.

- Applicants shall be recruited on merit and fitness to work regardless of their HIV status.
- No HIV testing shall be conducted privately without consent of the applicant.
- Medical examinations and VCT be used for planning purposes only.
- Employees and new applicants shall not be forced to disclose their HIV status.
- New employees shall receive information about HIV, AIDS and STI's workplace policy and activities on induction.

- Applicants shall be required to conform to Local Government Service recruitment conditions.

EDUCATION AND TRAINING

The Mzuzu City assembly shall promote and ensure equal opportunities in professional enhancement through education and training for its employees regardless of their status.

- HIV screening as a pre-selection condition for education and training shall apply only if it is a pre-requisite of a foreign learning institution or country where the staff will study or train.
- Employees known to be HIV positive shall not be discriminated against on opportunities for education and training.

AT THE WORKPLACE:

The Mzuzu City Assembly shall promote and ensure the best and safe standards of practice, high standards of infection control and commitment to behavioural change at the workplace.

- Employees known to be HIV positive shall not be discriminated against opportunities for promotion, loans, social facilities and amenities. They shall have the same rights and duties as other officers except where a doctor advises otherwise.
- In cases where an employee is discriminated against, the staff shall seek redress from the staff union and the workplace executive committee.
- Employees may decide to make their HIV status known. In such cases staff need to make their intentions known to their superiors or subordinates so that they can be given the necessary guidance, psychosocial counselling and support through their work place HIV, AIDS and STI's structures.
- HIV status must not be used by employees for their non performance at their work place.
- Owing to the pervasive nature of the problem, all employees should be involved in psychosocial counselling, distribution of condoms and dissemination of HIV, AIDS and STI's information to employees, their immediate families and primary dependants.
- Management and the executive committee shall ensure the provision of HIV, AIDS and STI's information and distribution of condoms to employees.
- The workplace position, grade or ranking system shall not be a barrier to psychosocial counselling and support.
- All employees shall be protected against occupational hazards that may expose them to HIV infection or induce progression from just being HIV positive to AIDS. Protective clothing shall be provided according to employees professional needs at work.
- The Management and the workplace steering committee shall ensure that universal precautionary measures, including Post Exposure Prophylaxis (PEP) to prevent HIV infection are adhered to at the workplace.
- Employees shall be provided with annual general medical checkups for early detection of occupational health problems, general diseases, VCT and sexually transmitted infections (STI's) and thus have early access to treatment, care and support.
- Management and the workplace steering committee shall ensure provision of gender sensitive HIV, AIDS and STI's work place programmes.

- Pregnant employees **and their spouses** shall be given time and have access to prevention of mother to child transmission of HIV (PMTCT) information, facilities and programmes.
- Management and the workplace steering committee shall promote and ensure provision of **adequate work place, psychosocial counselling before** Voluntary Counselling and Testing services to all employees.
- Employees, **regardless of gender status**, looking after their sick immediate family members or primary dependants with AIDS shall be given time off work accordingly to allow them provide the much needed home-based care service.
- Employees, **regardless of their gender status**, looking after their immediate family members or primary dependants with AIDS should not be stigmatised or discriminated against at the workplace.
- Management shall appoint a senior level HIV, AIDS and STIs workplace steering committee with representatives from all departments, the union and social welfare. Identify and train workplace HIV, AIDS and STIs coordinator and trainers at various levels of the City Assembly staff ranking.
- Employees operating out of station on tour or attending workshops shall be given HIV, AIDS and STIs prevention and control briefing before departure to such assignments.

EMPLOYEES LIVING WITH HIV

- Upon learning the HIV status of an employee, the supervisor shall deal with the infected staff with compassion, concern and without being judgemental.
- The supervisor shall ensure that medical and supportive care services are accessible and affordable to all employees living with HIV.
- The supervisor shall ensure confidentiality of all information and records of the employee found to be HIV positive.
- Employees shall be encouraged to undergo HIV counselling and testing or to disclose their test result in order to access services.
- The supervisors shall ensure that staff known to be HIV positive, are encouraged to attend supportive counselling, peer support groups and other socio-medical requirements during official working hours.
- The supervisors shall encourage and lead in the **safe motherhood/parenthood** and **positive living** campaigns and practice.
- Employees living with HIV shall undergo frequent medical assessments to determine appropriately those that may require ARV treatment promptly and plan for them.
- In cases where the HIV status of a staff is, known to the supervisor, advice from the medical Practitioners shall be sought on how to maintain them on duty.

EMPLOYEES WITH AIDS AND STIs

- Management and the workplace steering committee shall ensure that institutional and home-based, medical and supportive care services are available, accessible and affordable to all employees or their immediate families and primary dependants with AIDS.
- On the advice of a medical practitioner, employees with AIDS shall be encouraged to attend supportive Counselling, treatment, Peer support groups and other socio-medical requirements, including home-based care, safe parenthood and positive living campaigns where necessary.

- The department of health shall deal staff with AIDS just like any other employee with life-threatening illness.
- In cases where the AIDS and STIs status of a staff is, known to the supervisor, advice from the medical Practitioners shall be sought on how to maintain them on duty.
- The supervisor shall through the staff's consent recommend for medical assessment, advice and psychosocial counselling if the employee's HIV status is not known and his/her illness is affecting work performance.

STAFF TERMINATION OF EMPLOYMENT

When an employee fails to perform his or her normal duties due to ill health related to AIDS, a medical opinion shall be sought by the supervisor through the Chief Executive, in form of a medical board appropriately recommending for the retirement of the staff to the City Assembly. The medical board shall recommend an the employee to retire:

- On grounds of very poor incapacitating health.
- Due to staff's own willingness to stop work because of chronic ill health.
- Due to staff's death due to AIDS disease and the City Assembly shall ensure that terminal benefits are processed quickly and facilitate quick repatriation and settling of surviving spouses and orphans. (and all conditions stipulated by the Local Authorities service conditions regarding death of a staff shall apply).

HIV, AIDS AND STIs PROGRAMMES

Management and the steering committee through the process of consultations with the entire Assembly's work force shall:

- Identify their comparative advantage in the multicultural response against scourge of HIV, AIDS and STIs.
- Include all components of Prevention and Control, Treatment, Care and Support as well as Impact Mitigation of HIV, AIDS and STIs as stipulated by the National Action Framework.
- Develop HIV, AIDS and STI's workplace strategic work plans and ensure their effective implementation.
- The HIV, AIDS and STI's workplace strategic work plans shall be integrated in the City Assembly annual work plans.
- Assess and document the effectiveness of HIV, AIDS and STI's work place programmes on regular intervals through appropriate monitoring and evaluation mechanisms.
- Devise an HIV, AIDS and STIs monitoring and evaluation tool for HIV, AIDS and STIs that should be integrated into the City Assembly's existing general monitoring and evaluation strategy (as stipulated by the National Action Plan 2005- 2009)
- Ensure establishment, implementation and sustainability of HIV, AIDS and STI's activities in all departments of the Assembly.
- Define the standard process and impact indicators to assess the magnitude of HIV, AIDS and STI's at the assembly workplace programme.

COLLABORATION AND NETWORKING

Management and the steering committee shall collaborate and network with partners, clients, beneficiaries and other stakeholders in the City in order to share information, experience and maximise the utilisation of resources. In this way the City's workplace programme shall:

- Establish and strengthen local and national multisectoral linkages and partnerships in HIV, AIDS and STIs mitigation.
- Maintain and expand an effective referral system with organisations that have expert services in dealing with HIV, AIDS and STIs at the workplace.
- Lobby and advocate for syndromic management, sourcing and procuremment of affordable anti-retroviral drugs for staff with AIDS and STIs.
- Ensure the roles of the workplace steering committee and the internal mainstreaming coordinator are strengthened and appropriate resources are sourced and channelled for the effective implementation of HIV, AIDS and STIs activities.

INTERNAL MAINSTREAMING RESEARCH

In accordance with the National Research Strategy (NAC) the city assembly management and the workplace steering committee through consultancy services shall:

- Equip the internal mainstreaming coordinator and supervisors with research and information management skills.
- Conduct HIV, AIDS and STIs in-house prevalence (epidemiological) surveys.
- Conduct HIV, AIDS and STIs impact studies on employees and their immediate families and primary dependants.
- Establish and update at regular intervals a City Assembly internal mainstreaming HIV, AIDS and STIs in-house data bank.
- Utilise the results of the research activities for re-planning and implementation purposes.
- Report study findings to appropriate institutions as additional local data.

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USEFUL TERMINOLOGIES AND THEIR DEFINITIONS IN HIV/AIDS RESPONSE.

It has been observed (Health Research for Action, 2005) that there is generally lack of a common understanding of the concept of mainstreaming and also the differences between internal and external mainstreaming. Definitions of these key terms are thus provided to help with a much clearer understanding of what HIV/AIDS mainstreaming is all about.

HIV/AIDS work: This is work directly focused on HIV/AIDS prevention, treatment, care and support for those infected. Work is distinct and implemented separately from other existing development work. For example, organisations or programmes that have HIV/AIDS prevention and education or care and support for those with AIDS or orphans, as a separate community service from their mandate, are implementing them as AIDS WORK. Staff in these AIDS work activities, are usually oriented to it as separate or additional assignment focused at attaining specific work related outputs.

Integrated HIV/AIDS work: This is also thematic AIDS work which is implemented as a service to clients along with, or as part of development work. The focus is still on direct prevention, treatment or care and support except that, the work is conducted in conjunction with and linked to other projects or within wider programmes. For example, HIV prevention and control alone as part of the broader health-promotion activities or treatment as part of wider health care services.

Internal HIV/AIDS mainstreaming: Changing organisational or workplace policy and practice in order to reduce that organisation's susceptibility to HIV infection, the development and devastating effects of AIDS. The focus is internally, within (HIV/AIDS and) the organisation or workplace. This also applies to informal social settings like families. The organisational approach has two elements: HIV/AIDS work with staff, such as HIV prevention, control and treatment as well as modifying the ways in which the organisation functions in relation to work plans, workforce planning and budgeting.

External HIV/AIDS mainstreaming: Taking into account and adapting as its core function of the organisation's susceptibility to HIV infection, the development devastating impacts of AIDS. The emphasis is that the organisation plans and effects its core programmes (such as service delivery or capacity building) with the view that the targeted clients, partners or communities are vulnerable to multiple challenges among which HIV/AIDS plays an immediate and long term role that should be addressed.

ZOMBA MUNICIPALITY
HIV/AIDS SITUATION ANALYSIS REPORT

HIV/AIDS KILLS
THERE IS NO CURE FOR AIDS
THERE IS NO VACCINE AGAINST HIV

BUT THERE IS HOPE
ZOMBA MUNICIPALITY
HIV/AIDS SITUATION ANALYSIS

MAY, 2006

The purpose of the situation analysis was to assess and establish the impact of the HIV/ AIDS epidemic and identify the gaps and needs for HIV/AIDS impact mitigation strategies in the Municipality

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FOREWORD

This situation analysis is a historic achievement and demonstrates Zomba Municipal Assembly's commitment to address HIV/AIDS prevention, treatment and care and support interventions aimed at meeting the goals of the HIV/AIDS Policy and the National AIDS Framework. As the war against the HIV/AIDS epidemic continues to rage on, the disease remains the single greatest challenge and has severely crippled families, health care delivery services and the core businesses of nearly all institutions including Zomba Municipality.

The scope, scale and trends of the HIV/AIDS epidemic in Zomba Municipality calls for concerted efforts in order to respond to the levels of infection, care and support and impact mitigation. However, hope is just beginning to emerge because with increased efforts there is possibility of reversing the trend especially through reducing new infections and mitigating against the resultant impacts.

According to the National HIV/AIDS Policy, there is need to carry out an HIV/AIDS research aimed at addressing the gaps in existing knowledge, policy, practices and HIV/AIDS related interventions. It is an open secret that without proper analysis of the actual situation of the epidemic, the Zomba Municipal Assembly may find it difficult to remain focused, priority areas may be ignored and efforts may be duplicated leading to considerable wastage of the scarcest resources. Already, the disease has exerted undue pressure on the Municipality's resources including the productive labour sector, health care services and is threatening the livelihood systems and the very survival of its residents and clients.

It is important that the findings of the situation analysis of HIV/AIDS in Zomba Municipality should be disseminated widely and timely for the benefit of all at policy and community level. Identifying relevant AIDS related projects that are reflective of people's needs and priorities, let alone prioritizing and coordinating their implementation, would have limited impact without the ownership of the people themselves.

Apart from the various initiatives the Assembly is currently undertaking, there is need to intensify the efforts in genuinely mainstreaming the HIV/AIDS activities. In addition there is also need to speed up the process of developing a workplace policy and indeed advocating for the same in the other local institutions

While the information presented here will not be sufficient in itself, future policies must be developed in a fundamental understanding of the condition of gravity of HIV/AIDS in Zomba Municipality and this report contributes to that understanding.

Although the efforts are mainly geared towards the objective of contributing towards establishing the impact of the epidemic, the factors involved are many and wide ranging, requiring the analysis of the underlying factors and processes extending beyond the 14 day exercise.

HIV/AIDS will be there for a long time and until there is a cure the Municipality will have to focus on what works best.

J.N. Magwira
Chief Executive

ACKNOWLEDGEMENTS

Mbangala Development Consultants would like to acknowledge the efforts of a number of organisations and individuals who contributed immensely to the success and conduct of this HIV/AIDS situation analysis.

First we acknowledge the financial assistance from the AMICAALL Programme with funding from UN Habitat and the institutions that provided the technical support in carrying out the study

We further thank the Chief Executive of Zomba Municipal Assembly, Mr. J. N. Magwira for his assistance in accessing the respondents for this study and the general fulfillment of the situation analysis. In particular we are grateful to the Assembly staff that gave their time.

We also wish to thank a lot of people for working tirelessly, to make data the collection exercise and the compilation of this report possible.

Information on HIV/AIDS City Profile was the responsibility of Mr. F. Nankuyu the Director of Planning and Development (DPD). We thank him for his assistance and providing guidance in the use of the information and for his important contribution to the study for which we are grateful. Specifically, let us recognise the role of Mr. O.B. Ching`oma; the Director of Public Health and Environment (DOPHE) and Mrs M. Mchombo the District AIDS Coordinator (DAC) respectively, for their support.

We are greatly indebted to the various respondents and local HIV/AIDS support groups that generously gave their time to provide the information, which form the basis of this report. All others who contributed in one way or another to the success of this study deserve our appreciation.

ACRONYNMS

AIDS	Acquired Immuno Deficiency Syndrome
AMICAAL	Alliance of Mayors` Initiative For Community Action on HIV/AIDS at the Local Level
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASO	AIDS Support Organisation
BLM	Banja La Mtsogolo
CADECOM	Catholic Development Commission in Malawi
CBO	Community Based Organisation
CDC	Community Development Committee
CDSS	Community Day Secondary School
CRECOM	Creative Centre for Community Mobilisation
CSW	Commercial Sex Workers
DAC	District AIDS Coordinator
DACC	District AIDS Coordinating Committee
DHO	District Health Officer
DOPHE	Director Of Public Health & Environment
DPD	Director Of Planning & Development
DSWO	District Social Welfare Officer
FBO	Faith Based Organisation
FGD	Focus Group Discussion
GOM	Government Of Malawi
HBC	Home Based Care
HH	Household
HIV	Human Immuno Deficiency Virus
IEC	Information, Education & Communication
IGA	Income Generating Activity
LGA	Local Government ACT
MACRO	Malawi AIDS Counseling & Resource Organisation
MASAF	Malawi Social Action Fund
MDHS	Malawi Demographic Health Survey
MSE	Medium and Small Enterprise
NAC	National AIDS Commission
NGO	Non- Governmental Organisation
NSO	National Statistical Office
OI	Opportunistic Infection
OVC	Orphans and Other Vulnerable Children
PLWA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PRC	Project Review Committee
PRSP	Poverty Reduction Strategy
PTC	Peoples Trading Centre
SWOT	Strength, Weaknesses, Opportunities and Threats

SSI	Semi- Structured Interview
STI	Sexually Transmitted Infection
TB	Tuberculosis
UDP	Urban Development Plan
UNDP	United Nations Development Programme
VCT	Voluntary Counseling & Testing
YODEP	Youth Development Programme
YONECO	Youth Net & Counseling
ZMA	Zomba Municipal Assembly

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EXECUTIVE SUMMARY

BACKGROUND AND INTRODUCTION

This report contains the HIV/AIDS situation analysis and is perhaps the first of its kind. The report d forms a monitoring and evaluation tool designed to track the trends, scope and scale of the epidemic in Zomba Municipality. It was conducted following consultations with the client and it reminds us of the importance of the Municipal Assembly's role to the HIV/AIDS cause.

The situation analysis provides information at the localised level focusing on how the HIV/AIDS is impacting on the residents, the extent of its spread, gaps and needs for HIV/AIDS impact mitigation strategies in the Municipality.

With the broad scope of the impact of the epidemic, the amount of information may be limited nevertheless, as we hope most readers will agree, it does provide important insight to guide the Municipality's efforts to handle impact mitigation.

It is expected that the report will yield evidence and provide indicators on policy and programme impact, highlight persistent problem areas, identify priority groups, identify specific behavior in need of change particularly considering that HIV transmission is exclusively through heterosexual sex. The report should also function as a policy and advocacy tool in supplying comparative data concerning risk behavior and to provide data for formulating programmes and adapting existing ones.

OVERVIEW OF HIV/AIDS IN THE MUNICIPALITY

The municipality's projected population for the year 2010 is 131,628. About 40% of the population in Zomba Municipality in 1998 was aged 14 and below and 56% were adult aged 15-49 while only 4% were aged 50 and above and about 48% of the total population were female. About 25% of the population was aged 15-24 in which 13% were female and 12% were male. Almost 66% of the population was 24 years and below implying that the population was mainly youthful.

If other factors remain constant the number of infected people in Zomba Urban in 2006 is estimated at 19,000 including 13000 women .The Zomba DHO projected estimates for 2005 was 15,313 for Zomba urban and rural. However, statistics from local VCT clinics and other publications indicate that the number of infected people in the urban area was likely to be higher than the national urban prevalence (in the range of 20 - 33%). The Malawi Demographic and Household Survey estimates that the prevalence rate for Zomba District was 18% placed fifth in the country the first being Blantyre (22.3%) followed by Thyolo (21%) then Mangochi (20%) and Mulanje (19.8%).

Among the five highest districts, HIV prevalence for women was highest in Zomba (25%) while Mulanje was at 23% and Blantyre at 22.5%. For men the highest was Blantyre (22.1%) followed by Mangochi (19.9%) and then Thyolo (18.6%). In Zomba, men are at 10.5% which means women have twice as much chances of being infected as their male counterparts.

About 721 women and 340 men in the urban area would be infected annually implying that if HIV prevalence stabilizes, 1061 residents would be dying from AIDS related illnesses annually and between the year 2004 and 2010 the Municipality would register close to 6000 such deaths majority in their productive age (15-49). At Police College in 2004, about 20% of the tested clients were positive while in 2005 about 31% tested positive.

Support institutions registered a minimum of 308 PLWAs in Zomba Municipality and if the conditions remained, between 422 and 515 would be registered by the year 2010.

About 48% of those who attended VCT clinics in Zomba urban were female and it was encouraging to find that 60% of them were aged 24 years and below. It is estimated that VCT clinics will test about 16,000 clients by the year 2010 and with a projected population of 131,628 this would only represent 12% response rate.

There were 3 ART clinics in Zomba Urban, which included Zomba Central Hospital, Police College Hospital and Cobbe Barracks and about 95% of the clients receiving ARVs at these clinics were aged 25 and above and at Cobbe the number of clients almost doubled in 2005. Only about 9% of those who tested positive in the 2 years were receiving ARV therapy including 50% female. Overall the clients receiving ARV at Police College and Cobbe Barracks ART clinics increased 8 fold within the 2 years.

The estimated minimum number of orphans in the urban area up to 18 years in 2006 was 5409 and this figure was expected to rise further in the year 2010 to about 15,000.

WHY THE HIV/AIDS SITUATION ANALYSIS?

The overall goal of the National HIV/AIDS Framework for 2005-2009 was to prevent HIV infection among Malawians, provide access to treatment for PLWAs and mitigate the health, socioeconomic and psychosocial impacts of the pandemic on individuals, families, communities and the nation.

The purpose of the situation analysis was to assess and establish the impact of the HIV/ AIDS epidemic and identify the gaps and needs for HIV/AIDS impact mitigation strategies in the municipality. It expected to provide evidence and reflect on the core impact areas, integrity and effectiveness of the Municipality's and other stakeholders` efforts in relation to the goals, objectives and values. It expected to provide credible information useful for advocacy and for formulating new programmes and adapt existing ones.

The objectives of this study were: to assess the scope, scale and trend of HIV/AIDS in the Municipality; to develop city HIV/AIDS profile; to develop a database and profile for HIV/AIDS activities; to identify high and low risk population; to identify high areas of impact and high risk factors; to identify and describe services being provided in the Municipality, target groups, geographical coverage of the existing services and providers of the services (mapping); to identify gaps in the service delivery in the Municipality for HIV/AIDS related services and to identify best practices and means of application

TARGET

The intended audience for this study includes the Zomba Municipal Assembly and all those engaged in policy making for addressing the HIV/AIDS related challenges. It is our desire

however that all residents will recognise their own role and it is our hope that this document will be widely distributed so that all stakeholders should have as much information as possible as they continue to debate on the possible strategies for combating the epidemic.

PROCEDURES/ APPROACH TO THE STUDY

The study took place between 24th April 2006 and 12th May 2006 i.e. 14 working days including meetings with the data collectors, communication and contacts, policy analysis, document review, questionnaire design, preliminary identification of target groups, data collection, triangulation, data analysis and draft as well as preparing the final report.

The overall process was guided by a steering committee of the HIV/AIDS situation analysis comprising the DPD, DOPHE and the DAC and the consultant led the team.

Sampled target respondents/groups included stakeholders implementing the HIV/AIDS local response as listed in appendix 18 and also included both high and low risk subpopulations including those with the greatest risk of contracting or transmitting HIV such as commercial sex workers (CSWs).

The information collection process involved both qualitative methods and structured questionnaire. Before conducting the data collection, participatory preparation of the questionnaires was done during steering committee preparatory sessions in order to have mutual understanding of the study, identify key target respondents and set stepwise activity plan, timing and logistics.

The terms of reference for the HIV/AIDS situation analysis determined the creation of the hypothetical /research areas also capturing on how the Municipality and its stakeholders are carrying out HIV/AIDS issues and in order to assess the contribution they were making toward the mitigation strategies. The data collection process also involved review of literature in Malawi including analysing the objectives of the Malawi National AIDS Policy, the National AIDS Framework (2005-2009) as per attached bibliography and the external and internal factors and specific hypotheses on the problem. Primary data was obtained from respondents along with secondary data that included office records, publication and informal interviews. Survey instruments were mainly structured and semi-structured questionnaires using the Kenda Matrix.

Several site visits were made to meet various respondents including CBOs, CSWs, etc and NGOs and focus group discussions were conducted with the CSWs, women Assembly staff, CBOs, HIV/AIDS Assembly steering committee using both structured and semi- structured questionnaires.

Assembly staff was involved in the entire exercise from design, data collection, data analysis and report writing. Mrs. M. Mchombo (DAC) provided specialized knowledge of the HIV/AIDS situation in the Municipality and the understanding of current constraints and support programmes. After the first draft report, dissemination meetings involving the key stakeholders were conducted and the final report submitted to the Chief Executive.

LIMITATIONS

- Conducting the situation analysis within 14 days was an enormous challenge. The duration meant that we could not reach a larger sample size, as we would have desired. A true analysis would require a more longitudinal study and therefore time was the main limiting factor.
- Not all questionnaires were returned and in time so that data may not have been sufficient enough to allow determination of the actual impact.
- The majority including some respondent organisations that were operating in both urban and rural areas failed to disaggregate data based on locality and gender.
- Quality of response was affected by some of the structured questionnaires that involved many thematic areas that in turn affected the data interpretation .The questionnaires were not pre-tested.
- Office bureaucracy meant that some institutions could not provide response through structured questionnaires in time let alone others who never returned at all, a situation that might have an effect on the outcome of this report.
- The HIV/AIDS situation analysis was limited in generating information on households.

1. FINDINGS

RELEVANCE OF THE HIV/AIDS SITUATION ANALYSIS AND CHANGE IN PROGRAM INTERVENTION CONTEXT

Zomba District (Zomba Municipality inclusive) has the fifth highest HIV prevalence rate in Malawi (18%) with Blantyre being the first at 22% followed by Thyolo at 21% then Mangochi at 20.8% and Mulanje at 19.8%.

This situation analysis summarises the information about HIV/AIDS in Zomba Municipality that is relevant for its future planning. It is a *status quo* of the real situation of the epidemic that should enable the authorities, other institutions and organisations and the people to make proper decisions in their planning and implementation of HIV/AIDS related program activities including on HIV/AIDS.

It is noted that in line with the government's policy on decentralized planning, increased data needs have been emerging at the local level. In reaction to these data needs the Assembly was justified and the benefits accruing from this study need not be overemphasized. The process not only will also provide useful information for the development of the Urban Development Plan (UDP) which among other objectives ensures that there is adequate provision and suitable social services and facilities to meet the present and future needs and minimize the social costs associated with uncontrolled growth.

The Urban Development Plan is geared to the goal of empowering the Municipality in identifying its own HIV/AIDS related problems, finding ways and solutions to these problems, implementing the solutions and evaluating the progress and impact. It is envisaged that this situation analysis will be useful for providing a better information base upon which to make effective decisions that can help to reduce uncertainties about the pandemic.

Since the AIDS epidemic appeared on the scene in Malawi in 1985, a number of efforts and interventions have been carried out and over the time new issues have been emerging including the new emphasis on behavioral change, the need for new approaches towards orphans and other vulnerable children, the need for nutrition support for the needy PLWAs. Some of these have been highlighted in section 1.8 under Best Practices in Zomba Municipality.

STRATEGIC POSITIONING OF ZOMBA MUNICIPALITY IN VIEW OF THE HIV/AIDS EPIDEMIC

Zomba Municipal Civic Offices
Plate 3

SWOT ANALYSIS FOR COORDINATING HIV/AIDS LOCAL RESPONSE

Zomba Municipal Assembly has the overall responsibility of coordinating HIV/AIDS response at the local level and within the area of its control the assembly is able to tap skills and resources from the various stakeholders and cooperating partners. The Malawi Decentralisation Policy sections 3(d) and 6(d) empowers the Municipality to have the legal status for mobilising resources within and outside it and mobilising the local masses for socio economic development at the local level.

The Municipality also makes by-laws conferred to it by section 103 of the Local Government Act (LGA) 1998 and the Malawi Decentralisation Policy section 6(f). As part of the decentralisation process the Municipality conducts all development plans as stipulated in section 146(2) of the Malawi Constitution and section 21 of the second schedule of the (LGA) 1998. External support was to be channeled directly to or through the Assembly. This means that at the local level, the Assembly is in a unique position to make a difference in facing the HIV/AIDS epidemic.

The study notes that the Assembly is however not the registering authority for community based organisations (CBOs), non- governmental organisatios (NGOs), faith based organisation (FBOs) and other support groups, currently done by the Social Welfare Office. This situation makes it difficult to monitor the data on these structures. In addition the Assembly has no control on some of the matters such as macro-economic conditions that exacerbate the poverty situation and hence fueling the impact of the HIV/AIDS pandemic. Some of the residents may also be engaging in social-cultural practices outside the Municipality that may increase the risks of contracting HIV.

The Municipality registered overwhelming community support as evidenced by the emergence of CBOs, FBOs and other HIV/AIDS support groups. Councilors and traditional leaders were most helpful at mobilizing community response through formation of these structures. The challenge is that the geographical distribution of service delivery is not equitable.

Zomba Municipal Assembly was also getting considerable support from the National Aids Commission (NAC). However, the external financial resources are generally inadequate and not timely which makes it difficult for the Assembly to carry out its planned activities

It is noted that there are also institutions of higher learning such as Chancellor College and various HIV/AIDS related supportive infrastructure that includes health centres, hospitals, voluntary counseling and testing clinics (VCTs) as well as facilities offering Antiretroviral Therapy (ART).

However, in the past year Zomba Municipal Assembly was frustrated by the HIV/AIDS umbrella organization (Action Aid) and continued to face resource constraints including that of reliable vehicles, which often made it difficult to visit other support institutions regularly. There was also inadequate training on HIV/AIDS related matters, so far, for its staff as well as limited information to reach out to the community-based organisations and the wider community. Staffing was seen to be inadequate as evidenced by use of a nurse who is doubling as the AIDS Coordinator.

SUSTAINABILITY OF HIV/AIDS PROGRAMS IN THE MUNICIPALITY

Locally based community structures such as CBOs, FBOs and AIDS support groups (Appendix 2), have been created. Committees created include Workplace Intervention Committees, City AIDS Coordinating Committee at ward level, Proposal Review Committee (PRC), District AIDS Coordinating Committee (DACC), Community Development Committee (CDC) and Staff Social Welfare Committee.

On resource mobilization the Assembly almost entirely relies on external assistance especially from MASAF, NAC and the Education Sector Package although internally, there is hidden resource mobilisation since the Assembly provides material resources such as stationery and vehicles and responds to issues as they come.

Management and coordinating committees were separately trained by the Alliance of Mayors` Initiative for Community Action on HIV/AIDS at the Local Level (AMICAALL) on mainstreaming HIV/AIDS in local institutions and Action Aid trained the PRC but there has been no training conducted locally for the other Assembly staff.

MANAGEMENT, HIV/AIDS PROGRAM STEERING AND LOCAL CAPACITY TO IMPLEMENT AND MONITOR HIV/AIDS INTERVENTIONS

It is noted that the only activity plan available on HIV/AIDS is the Integrated Annual Work Plan 2005/06 in which plans from the other stakeholders were taken on board. Unfortunately the plan was barely implemented but the assembly was in the process of preparing another for the year 2006/07.

All support groups and CBOs submit their reports, to the Assembly who in turn sends these to the umbrella organization who forwards them to NAC. However, on organizations reporting per month per district NAC acknowledged very few from Zomba Municipality (HIV/AIDS Quarterly Service Coverage Report Vol.4 April to June 2005, NAC). On feedback, NAC responds to the Assembly otherwise there is no other feedback except when the Assembly reports about the status of the proposals back to the CBOs.

On linkages with other stakeholders there were planned quarterly meetings with all CBOs but this was only done once due to lack of resources. Only in special circumstances do meetings with NGOs take place. The Assembly revised its composition of the DACC through including institutions such as Chancellor College, Army and Prison after it realized these stakeholders were being sidelined. However, information sharing among the various stakeholders in the Municipality was barely adequate.

It was noted that CBOs and other support groups considered the receiving of NAC calendars and occasional allowances during meetings as incentives while the Assembly would want to use its operational system by among other measures making efforts to improve the remuneration package in order to reduce income inequality for its staff. The District AIDS Coordinator (DAC) was however facing serious problems in carrying out HIV/AIDS related activities due lack of a vehicle or motorcycles which complicated the monitoring of the CBOs and support groups.

There are no readily available monitoring indicators set for the Assembly to be able to measure both progress and success in the implementation of HIV/AIDS related activities. The Assembly continued to rely on the Social Welfare Office (for information on orphans etc.) and other institutions for the rest of the information. Records available on HIV/AIDS activities were about the World AIDS Day, condom distribution, awareness activities in hot spots such as rest houses and market centres. Regular meetings and follow-ups did not take place.

Human resources are not adequate in most areas and the Assembly does not have its own VCT clinics. In addition there are no qualified medical doctors or trained personnel to manage the VCT service.

IMPACT ON THE MUNICIPALITY`S CORE BUSINESS

The study noted that although the Municipality's core business is that of service delivery to its residents, some of its own commercial undertakings such as rest houses and entertainment joints including Mulunguzi Cottage were suspected to be promoting HIV acquisition and transmission. Some of the privately owned rest houses from which the Assembly collects revenue were being used as brothels while some male revenue collectors are said to have been conniving with female market vendors to dodge fees payment in exchange of sexual favours.

Frequent illnesses morbidity and deaths have affected the Assembly mainly through absenteeism from work and as people attend funerals of staff dying from HIV/AIDS related illnesses a situation that has led to loss of institutional cohesiveness. Besides, the Assembly has been experiencing reduced on-the-job productivity, loss of intellectual capital, increased recruitment and training costs, loss of the productive work force- who could have contributed to the development of the Municipality. The Assembly is also experiencing drain on the net

income through loss of some of its ratepayers and there is pressure exerted on the limited resources including use of vehicles.

Meanwhile the mission learnt that the Assembly was seeking to buy extra land for a cemetery. In addition emerging concerns includes the establishment of more VCT clinics even though their patronage is yet to be determined. There is also need to increase access to ARVs to residents who may need them. The increasing number of orphans and other vulnerable children (OVCs) means that support for this vulnerable group is becoming more inevitable and there is need to regularly screen the CBOs to assess resource utilisation.

HIV/AIDS MAINSTREAMING AND GENDER IMPLICATIONS

The study learnt that data to show the profile and extent of the HIV/AIDS severity was not documented. Although practical employee programs designed for care and to prevent workers from contracting the disease as well as reducing the impact were not documented at least the assembly has established a workplace intervention committee whose current role is to promote awareness and behavioral change.

In the Integrated plan the Assembly intended to increase workplace HIVAIDS related interventions. However, other routine activity plans were not readily available. The Assembly is also currently advocating for the promotion of voluntary testing, increased VCT clinics and more care regimes.

Stigma prevailed at the civic offices although the Assembly tried to include de-stigmatisation messages during awareness sessions. Otherwise there were no formal programs and this scenario makes it difficult for the assembly to know the actual number of its staff who are or may be HIV positive and as are result no one has already directly benefited from the 2% mandatory budget allocation meant to assist HIV/AIDS related activities including assistance for the infected and their families. This situation has led the Assembly to do fire fighting through responding to rising cases of demand for loans and emergency advances for medical care services resulting in partly affecting the management time and effort to respond to the impact.

The Assembly did not have its own referral system for HIV/AIDS related testing, counseling, treatment and care for vulnerable families otherwise at its clinics clients are referred to other service providers. The facilities offering nutrition supplements included Kachere that was providing Likuni Phala fortnightly, Hope for Life who provided food for the sick monthly and Zomba Action Project who conducted an under 5 child-feeding program. The readily available assistance was during funerals and that within the wider community sometimes well-wishers were assisting orphans with school fees and provision of nutrition.

The mission noted that Information, Education and Communication (IEC) materials were mostly given to CBOs and support groups who display them in their areas of coverage. Some brochures, pamphlets, were distributed directly to the employees while others were posted on the notice boards, assembly clinics, schools, and market. Sometimes IEC materials are displayed during open days such as the one the assembly conducted at Chikanda Location widely considered as a densely populated and slum area.

In the 2006/07 integrated plans the assembly intended that its own health workers should have adequate information about the HIV/AIDS besides other trainings that have been lined

up. For HIV protective interventions specially designed for the young people all primary schools within the Municipality had AIDS TOTO clubs while secondary schools and tertiary institutions such as Chancellor College had HIV/AIDS clubs. There were also promotional measures for condom distribution, sporting activities and entertainment centres.

Overall, while the Municipality took some action on management, coordination, implementation of plans through establishment of steering and technical committees, appointment of a coordinator, and the carrying out preventive measures and institution of clinic and home based care; there was still room for improvement in the areas of leadership support and commitment, policy and legislation and procedure; and participatory planning (Appendix 12). For instance in participatory planning, gender-disaggregated database was not yet developed and gender situation analysis was not yet conducted. The mission noted that out of a workforce of about 450 the Municipal Assembly had only about 50 female employees and there was no woman in the decision-making directorates i.e. no female director.

THE SCOPE, SCALE AND TRENDS OF HIV/AIDS EPIDEMIC IN THE MUNICIPALITY

OVERVIEW ON DEMOGRAPHIC CHARACTERISTICS AND IMPACT OF THE EPIDEMIC

Table 1: Population Characteristics Overview[1]

	14 yrs & below	Adult (15-49)	50yrs +	Total
Female	13754	17010	1089	31853
Male	12801	19626	1635	34062
Total	26555	36636	2724	65915
%	40	56	4	
	24yrs & below	25yrs & above		
Female	22309	9544		
Male	20931	13131		
Total	43240	22675		
%	66	34		

Aged 15-24	%
8555	13
8130	12
16685	25

Table 1 presents population characteristics of Zomba Municipality as at 1998. About 40% of the population was aged 14 and below and 56% were adult aged 15-49 while only 4% were aged 50 and above and about 48% of the total population were female. About 25% of the population was aged 15-24 in which 13% of the population was female and 12% of the

[1] Source: Malawi Housing & Population Census (NSO), 1998

population was male. Almost 66% of the population was aged 24 years and below implying that the population was mainly youthful and even the population in Malawi continued to get younger as people were expected to live up to 40 years (UNDP, 2001a) mainly to the HIV/AIDS epidemic. The Municipality's projected population is presented in table 8.

The Municipality had a population of 43,250 in 1987 while the 1998 Population and Housing Census (NSO) showed the population was 65,915 representing a 52% increase and an intercensal growth rate of 3.6% per annum. In 1998 the national population increase and intercensal growth rate were 24% and 2.0% respectively.
The Municipality registered a crude birth rate of 50 per 1000 in 1998 showing a decline from 52 per 1000 in 1987.

The population density for the Municipality was about 1644 persons per sq. km in 1998 while the Zomba District rural district it was 209. Most of the population was concentrated in Mtiya, Chinamwali and Likangala Wards and in all these areas, squatting is problem.

HIV/AIDS Situation Overview

Table 2: National HIV/AIDS Situation[2]

Urban Areas HIV prevalence 2001	22.5%
Urban adult prevalence 2003	23%
HIV prevalence among adults (15-49) 2004	12.7%
Rural adult HIV prevalence 2003	12.4%
Urban HIV prevalence 2004	17.1%
Urban Women HIV prevalence 2004	18%
Rural Women HIV prevalence 2004	13%
Urban men HIV prevalence 2004	16%
Rural men HIV prevalence 2004	9%
Number of infected adults (15-49) 2003	760,000
HIV prevalence among adults (15-49) 2003*	14.4%
HIV prevalence among adults (15-49) 2004	12%
HIV prevalence among women (15-49) 2004	14.4%
HIV prevalence among men (15-49) 2004	10.8%
HIV prevalence among men (15-19) 2004	4%
HIV prevalence among women (15-19) 2004	9%
HIV prevalence among women (15-24) 2004	4%
HIV prevalence among men (15-24) 2004	2%
HIV prevalence among urban women (15-24) 2004	13%
HIV prevalence among urban men (15-24) 2004	0.3%*
HIV prevalence among urban (men and women 15-24) 2004	7.2%
HIV prevalence among rural women (15-24) 2004	8.2%
HIV prevalence among rural men (15-24) 2004	2.5%
HIV prevalence among rural (men and women) 2004	5.8%
Number of infected adult women (15-49) 2003	440,000
Number AIDS related deaths 2001	80,000
Number of orphans 2001	937,000

[2] Source: Malawi Demographic & Health Survey (NSO) & Various

Zomba District Estimates

HIV prevalence women 2004	25%
HIV prevalence men 2004	11%
HIV prevalence women and men 2004	18%

Other highly Infected District Estimates

Blantyre

HIV prevalence women 2004	22.5%
HIV prevalence men 2004	22.1%
HIV prevalence women and men 2004	22.3%

Mangochi

HIV prevalence women 2004	21.4%
HIV prevalence men 2004	19.9%
HIV prevalence women and men 2004	20.8%

Mulanje

HIV prevalence women 2004	23.3%
HIV prevalence men 2004	15%
HIV prevalence women and men 2004	20%

Thyolo

HIV prevalence women 2004	23.1%
HIV prevalence men 2004	18.6%
HIV prevalence women and men 2004	21%

Municipality Estimates

Total number infected 2006	19000
Number of infected women 2004	12000
Number of infected women 2010	16000
Number of infected men 2004	5447
Number of infected men 2010	7484
Youth infected (15-24) 2004	1724
Youth infected (15-24) 2010	2369
Number of new infections (annual)	1000
Number of new infections (daily)	10
Number of deaths annually	1000
Number of orphans 2006	5409
Number of orphans 2010	15000
Annual rate of increase of registered orphans	30%
Present hectare of cemetery area	5 ha
Additional Area required	2 ha
Police College number tested for HIV 2004	375
Police College number tested positive for HIV 2004	20%
Police College number tested for HIV 2005	590
Police College number tested positive for HIV 2005	31%
Police College total number tested positive 2004 and 2005	81men and 185 women

The 2003 estimates (HIV & AIDS in Malawi, NAC 2004) showed that HIV prevalence in urban areas was 23% with a 19% low and 28% high compared to the rural at 10.8% but the situation appeared to have stabilised since the Malawi Demographic and Household Survey (MDHS, National Statistical Office 2004) put the urban prevalence at 17.1% with 18% of urban women being HIV positive compared to the rural women with 13%. HIV prevalence for urban men at 16% was about twice as much as rural men (9%.)

If other factors remain constant and based on the Zomba estimates, the minimum number of infected people in Zomba Urban in 2006 is estimated at 19,000 including 13,000 women. The MDHS, 2004 estimates the HIV prevalence rate for Zomba District (Zomba Municipality inclusive) in 2004 at 18% and placed fifth in the country in which the first is Blantyre at 22.3% and then Thyolo at 21% followed by Mangochi at 20.8% and then Mulanje at 20%.

About 721 women and 340 men in the urban area would be infected annually implying that if the HIV prevalence continues to stabilise, 1061 residents would be dying from AIDS related illnesses annually and between the year 2004 and 2010 the Municipality would register close to 6000 such deaths with the majority in their prime age (15-49). In 2003 about 87,000 people were expected to die from AIDS in Malawi (HIV/AIDS in Malawi, 2003 Estimates and Implications, NAC).

At Police College in 2004 about 20% of the tested clients were positive while in 2005 about 31% tested positive. Support institutions registered a minimum of 308 PLWAs in Zomba Municipality and if the conditions remained, between 422 and 515 would be registered by the year 2010. About 48% of those who attended VCT clinics in Zomba urban were female and it was encouraging to find that 60% were aged below 24 years (table 5). It is estimated that VCT clinics will test about 16,000 clients by the year 2010 and with a projected population of 131,628 this would only represent 12% response rate.

There were 3 ART clinics in Zomba urban, which included Zomba Central Hospital, Police College Hospital and Cobbe Barracks and about 95% of the clients receiving ARVs at these clinics were aged above 25 (table 6) and at Cobbe the number of clients almost doubled in 2005. Only about 9% of those who tested positive in the 2 years were receiving ARV therapy including 50% female. Overall the clients receiving ARV at Police College and Cobbe Barracks ART clinics increased 8 fold within the 2 years.

The estimated minimum number of orphans in the urban area up to 18 years was 5409 in 2006 and this figure was expected to rise further in the year 2010 to about 15,000.

THE MUNICIPALITY`S INFECTION AND HIV PREVALENCE RATE

For the first time in the history of the Municipality, HIV/AIDS became the single greatest challenge and a health issue that was emerging to the top of the Assembly's agenda. It has taken about 19,000 (projected) people living with the virus in 2006 and annual 1000 (about 10 daily) deaths to demonstrate that it requires the involvement of all the residents in life giving responses to the epidemic. As a result, urban life expectancy would continue to fall, family incomes destroyed and service delivery would decline.

Table 3[3]

POPULATION PROJECTIONS AND GENDER DISTRIBUTION FOR ZOMBA MUNICIPALITY

Year	Mid year Population	Women (49%)	Men (51%)
1998	65915	31843	34072
2000	74915	36191	38724
2002	85016	41071	43946
2004	95797	46729	49518
2006	107195	51785	55410
2008	119150	57560	61590
2010	131628	63588	68040

Table 3 presents Zomba Municipality's mid-year projected populations in which it is estimated that the population could reach as high as 131,628 by the year 2010 and the infection estimates in figure 1 are based on the above presented projected populations.

The Municipality HIV Infection Estimates & Trends

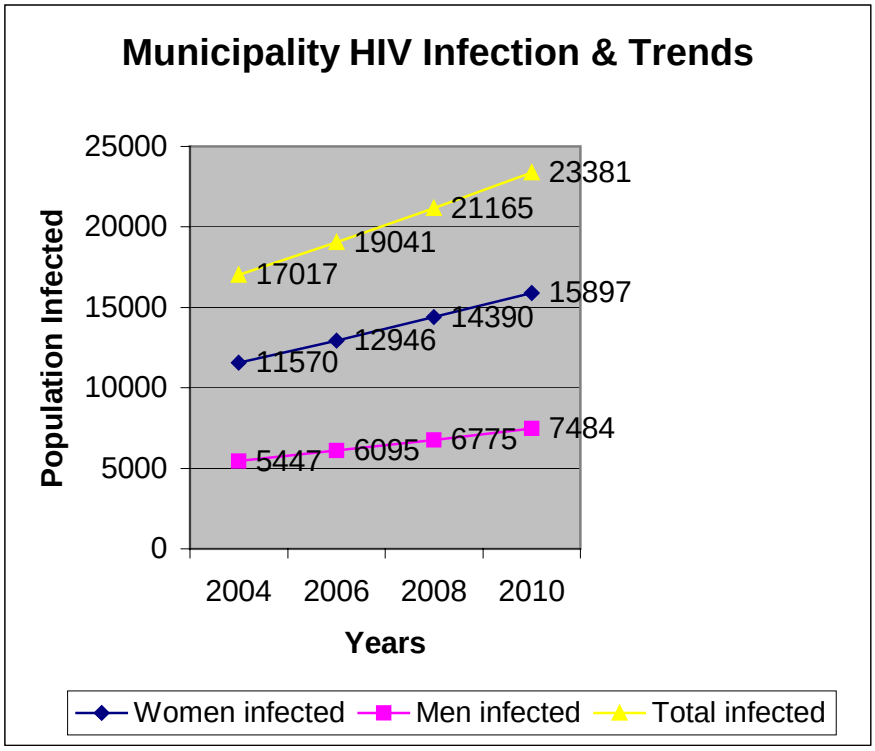


Fig 1

Based on the Zomba HIV infection estimates and if other factors remain constant, the number of infected people in Zomba Urban in 2006 is estimated at 19,000 including 13000 women.

[3] Projected Mid- year Population Source: NSO, 1998

In 2003 about 1million Malawians were already infected with HIV (HIV/AIDS in Malawi, 2003 Estimates and Implications, NAC). The Zomba DHO projected estimates for 2005 was 15,313 for Zomba Urban and rural. However, statistics from local VCT clinics and other publications indicate that the number of infected people in the urban area was likely to be higher than the national urban prevalence (in the range of 20 - 33%).

The Malawi Demographic and Household Survey (MDHS) estimated that the prevalence rate for Zomba District (Zomba Municipality inclusive) in 2004 was at 18% and therefore placed fifth in the country. Blantyre is the highest infected district in Malawi (22.3%) followed by Thyolo (21%). Among these highest districts, HIV prevalence for women was highest in Zomba (25%) followed by Mulanje (23.3%) and then Thyolo (23.1%) then Blantyre (22.5%)and Mangochi (21.4%) and for men the highest was Blantyre (22.1%) then Mangochi (19.9%) followed by Thyolo (18.6%) and then Mulanje with 15% and Zomba (11%).

Women at high risk of HIV

In Zomba, women have twice as much chances of being infected as their male counterparts and the annual rate on increase was higher in the females. Overall, the infection rates show a modest decline. It is estimated that more than half of new infections occur in young people aged 15-24.

The study found that about 721 women and 340 men in the urban area would be infected annually implying that 1061 residents would be dying from AIDS related illnesses annually. If prevalence rates remain stabilised between the year 2004 and 2010 the Municipality would register close to 6000 such deaths with majority in their prime age (15-49). In 2003 about 87,000 people were expected to die from AIDS in Malawi and projections show that by the year 2010 over 1million people would have died from AIDS in Malawi (HIV/AIDS in Malawi, 2003 Estimates and Implications, NAC).

The mission noted that although HIV infection rate based on quarterly findings may not be representative, the April- June findings of the Quarterly Service Report for 2004/2005 (NAC, 2005) could provide useful information about Zomba Municipality. Out of the 4136 clients who tested for HIV at VCT sites in Zomba District 48% were female and about 33% i.e. 1349

of both sexes tested HIV positive of which 57% were female. About 39% of the female and 28% of the male clients tested positive. 91% of those who tested positive were aged above 13 years (majority in 15-49), which still implies that the main mode of HIV transmission in Zomba was through sex.

The study found that though the findings of the quarterly service report was for Zomba District, majority of the infected would be from the urban area considering that urban adult prevalence rate (17%)was higher than the rural rate (11%) and urban women were at 18% while their rural counterparts are at 13%. For men (16%), it is almost double as much as their rural counterparts (9%) (see table 2) i.e. if the findings of the MDHS, 2004 was anything to go by. Furthermore, HIV testing was generally considered to be an urban phenomenon.

Table 4: CLIENTS TESTED HIV POSITIVE AT 3 SELECTED CLINICS[4]

	2004		2005		Total	Total	
Name of Clinic	Men	Women	Men	Women	Men	Women	Total
Police College	23	51	58	134	81	185	266
Matawale Health Centre	71	106	142	211	213	317	530
Hope for Life	360	203	702	430	1062	633	1695
Total	454	360	902	775	1356	1135	2491

In table 4 the mission noted that Matawale Health Centre, Police College and Hope for Life VCT clinics registered 2491 positive cases between 2004 and 2005 and about 46% of the cases were female. Hope for Life registered the most clients in both years and in fact their numbers almost doubled in 2005. Overall the clients registered in 2005 were double those in the previous year.

Table 5 shows that Police College alone tested 375 clients and 590 clients in 2004 and 2005 respectively and registered 74 (20%) and 192 (31%) positive cases during the same period. Of those who tested positive at Police College, 81 were men and 185 were women. Laboratory test showed that about 70% of admitted patients in Zomba were HIV positive.

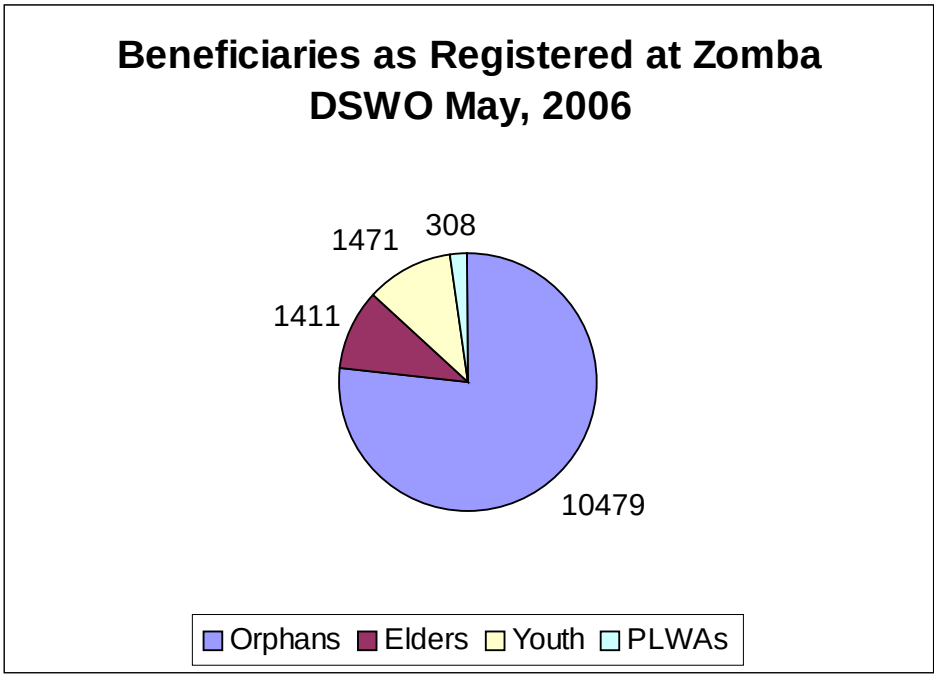
National 2003 HIV prevalence estimates was at 14.4% from 15% in 2001 and the rural prevalence rate was at 12.4% .In 2004 the adjusted national prevalence rate was 12.4% and for men and women it was 14.4% and 10.8 respectively (MDHS, NSO 2004).

PEOPLE LIVING WITH HIV/AIDS (PLWAs)

In Appendix 1 CBOs and other support institutions registered with the District Social Welfare Office were providing support to a minimum of 308 PLWAs in Zomba Municipality and Fig 2 shows the proportion of the PLWAs in relation to other vulnerable groups such as the orphans, youth & the aged.

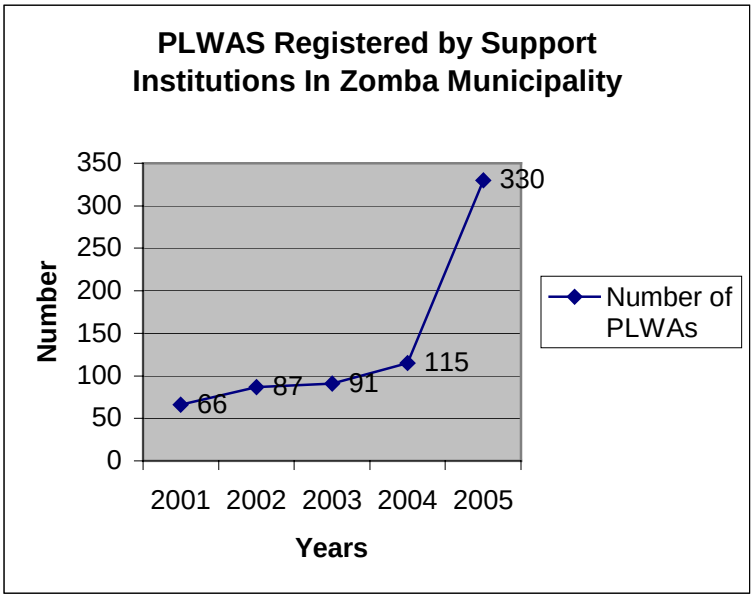
[4] Source: Zomba VCT Clinics May, 2006

Vulnerable Groups registered with the District Social Welfare Office[5]



The number registered by The District Social Welfare Office was about the same as captured by this study and as presented in Figure 3 and in Appendix 2.

Trends in PLWAs registered by Support Institutions in Zomba Municipality[6]



[5] Source: District Social Welfare Office, May 2006
[6] Urban CBOs May 2006

Fig 3 shows the trend at which Zomba Urban CBOs were registered PLWAs during a 5-year period. The mission found that the number of registered PLWAs was increasing at the median and average annual rate of 28% and 23% respectively. If other factors remained the CBOs were likely to register between 422 and 515 by the year 2010. The number rose drastically in 2005 because Zomba Prison registered almost half the number in that year and for the first time. In all cases data was however not gender segregated and no age brackets were indicated although the majority were likely to be aged 15-49. Some of the CBOs were providing nutrition and psychosocial/spiritual support to the PLWAs.

VCT CLINICAL SERVICE AND RESPONSE

The goal of VCT in the national HIV/AIDS policy was to promote and provide high quality and cost effective and totally confidential, accessible VCT services with the aim that people who undergo VCT are given supportive pre- and post test counseling, and should be likely to change risky behaviour so that if infected, they should prevent infecting others and getting re-infected. When need arose the infected should get treatment of opportunistic infections (OIs), ARV therapy and prevention of mother –to- child transmission (PMTCT) programmes in the case of women.

The study noted that there were 17 VCT clinics in Zomba District and 8 of those were in Zomba Urban namely; Zomba Central Hospital, Police College Hospital, Army Hospital, Matawale Health Centre, Banja La Mtsogolo (BLM) Hope for Life and Chinamwali Private Clinic. Data on VCT client tests were collected from Police College Hospital, Cobbe Barracks and Hope for Life and all the three clinics opened in 2004.

Table 5: VCT SERVICE IN 3 SELECTED CLINICS[7]

		Male		Female		Total			
Year	Name of VCT Clinic	24 yrs& less	Above 25 yrs	24 yrs& less	Above 25 yrs	Male	Female	Total	Couples Screening
2004	Police College	91	72	137	75	163	212	375	0
	Cobbe Barracks	17	30	14	17	47	31	78	0
	Hope for Life	259	91	121	61	350	182	532	10
	Total	367	193	272	153	560	425	985	10
2005	Police College	88	102	215	181	190	396	586	2
	Cobbe Barracks	68	112	61	81	180	142	322	0
	Hope for Life*	250	73	136	59	323	195	518	22
	Total	406	287	412	321	693	733	1426	24

* Data collected 3 months before end of year

Table 5 presents information on the VCT service in 3 selected sites namely; Police College, Cobbe Barracks and Hope for Life. The study noted that none of the clinics carried out outreach clinical service. About 48% of those who attended the clinics were female and it was encouraging to find that 60% were aged below 24 years and that couples were also attending the service. On average each centre registered 475 clients in 2005, which translates to about 4000 for the 8 centres and the response rate increased by 46% in that year. The

[7] Urban VCT Clinics May 2006

figures could be higher since Malawi AIDS Counseling & Resource Organisation (MACRO) alone registered 1642 clients including 369 females in 2005.

The study found that most of the VCT clinics were only 3 years old and MACRO opened only in 2005.Assuming that the clients did not undergo HIV re-tests and if other factors remained, VCT clinics would test about 16,000 clients by the year 2010 and with a projected population of 131,628 this would only represent 12% response rate. National HIV testing rate was 39% for women and 38% for men and 83% of both sexes had never tested for HIV (MDHS, NSO.2004).

The study noted that Police College Clinic, MACRO and Cobbe Barracks open from Monday to Friday between 8.00am and 4.00pm while Hope for Life opens same times except on Friday when they open between 7.30am and 12.00noon .On Wednesday Cobbe opens only up to 12.30pm and Police and MACRO open on Saturdays between 8.00am and 12noon.

It was found that the major preventive counseling measures taken for those tested positive include pre-test and post test counseling, correct condom use and demonstration to avoid infection and re-infection, faithfulness, abstinence, life skills training, use of role models and testimonies. The clinics were generally roomy, noise free, within reach, confidential and youth friendly. Other close service providers named included Catholic Development Commission In Malawi (CADECOM), Diginitas International, Zomba Central Hospital and the DHO. The clinics were sensitising the wider community, of all age groups including schools, workplaces, markets and health institutions. Specifically Hope for Life carried out peer education training of VCT counselors, life skills training for both in- and- out of school youths and encouraging the formation of PLWA clubs.

The mission found that some of the VCT post service perceptions and misconceptions included stigma and discrimination. Others felt that condom use increased promiscuity and that this was for prostitutes and also for those who were sexually active. The positive perceptions were that it helped to know one's serostatus.

ARV THERAPY (ART)

In the national HIV/AIDS Action Framework 2005- 2009, ARV drug procurement and distribution had been regarded a key issue and in the treatment and care priority area, the goal was to provide and expand equitable treatment of PLWAs in order to mitigate the impact of HIV/AIDS. ARVs have been known to encourage people's willingness to seek VCT services. Other clinics such as Chancellor College were expected to open in due course.

The study noted that there were 3 ART clinics in Zomba Urban, which included Zomba Central Hospital, Police College Hospital and Cobbe Barracks

Table 6: ARV THERAPY[8]

Year	Name of VCT Clinic	Male		Female		Total		
		24 yrs& less	Above 25 yrs	24 yrs& less	Above 25 yrs	Male	Female	Total

[8] Zomba Urban CBOs May 2006

2004	Police College	0	0	0	0	0	0	0
	Cobbe Barracks	0	11	1	11	11	12	23
	Total	0	11	1	11	11	12	23
2005	Police College	2	35	2	44	37	46	83
	Cobbe Barracks	3	41	1	33	44	34	78
	Total	5	76	3	77	81	80	161

Table 6 presents the number of AIDS patients receiving ARVs at 2 clinics (Police College opened in 2005) and the study noted that about 95% of the clients were aged above 25. At Cobbe the numbers almost doubled in 2005. Assuming that all who tested positive went back to the same clinic (table 5) for ARV, Police College estimates showed that about 9% of those who were tested in the 2 years were receiving ARV therapy and 50% of them female. Overall the clients receiving ARV at both clinics increased 8 fold within the 2 years depicting the extent of need for the service. The national goal was to provide 32,000 clients with ARVs by 2005 (MOH, Feb. 2005) and 70,000 by December 2006.

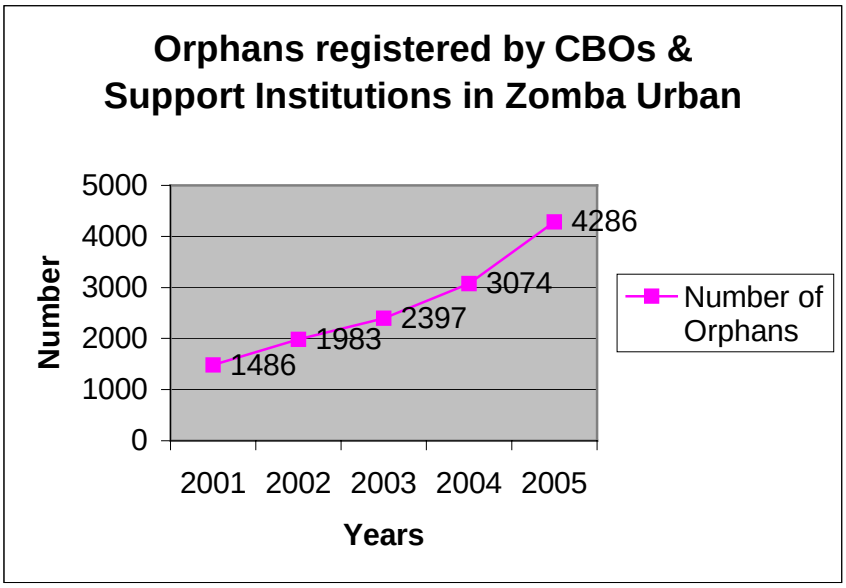
ORPHANS AND OTHER VULNERABLE CHILDREN (OVC)

The National Policy on Orphans and Other Vulnerable Children (OVCs) is "to facilitate support for care, protection and development of OVC in a coordinated manner in order to provide them with an environment in which they realize their rights and potential".

The study found that information on orphans in the Municipality varied because there were yet no effective mechanisms for collecting it. Relevant service providers such as CBOs, NGOs and support groups reported to various institutions i.e. while some reported to the District Social Welfare Officer (DSWO) (see Appendix 3), others reported to the assembly and still others directly to the funding agencies such as NAC and MASAF.

Appendix 3 shows 33 CBOs and support groups and 1 NGO with the number of orphans registered at the DSWO as at May 2006. The mission noted that there were about 10479 orphans in Zomba Municipality but it was not clear whether all the institutions shown in the appendix were indeed restricted to the urban area or were still operating at all since 15 institutions besides CADECOM who registered about 2431 orphans were not captured by the study (figure 4 below).

The growing number of support institutions for orphans aimed at improving the capacity and to implement proper mechanisms for the care of the orphans mainly at family and community levels. However the mission found that monitoring efforts by the local lead agency i.e. Zomba Municipal Assembly, were irregular to the extent that some support institutions may be duplicating efforts. The study also found that information on orphans was not gender disaggregated.



*** The numbers exclude those not captured by this study[9]**

However, from this study, the estimated minimum number of orphans up to 18 years registered by most service providers in 2006 was 5409.

Fig 4 presents the trend in the number of orphans registered in Zomba Urban showing an average annual increase of about 30% and this means that all factors being equal the number was expected to rise further by the year 2010 reaching an alarming 15,000 majority left unattended due to the AIDS related deaths of their parents. This situation would require an enormous amount of resources and integrated planning. The study found that the kind of support the orphans got included psychosocial, nutrition and other domestic and medical.

The study found that according to the April to June HIV/AIDS Quarterly Service Coverage Report (NAC, 2005), Malawi targeted 100,000 but finally reached 158,706 orphans in 2004/2005 including about 8490 for Zomba rural and urban. Lilongwe registered highest i.e. 15,807 while the lowest was Chitipa with 157.

IMPACT ON HIV/AIDS RELATED SERVICE DELIVERY

Most institutions have been compelled to do something about the HIV epidemic, which has devastated families, outstretched health care and particularly social services and has severely crippled institutional performance to the extent that time, human and financial resources have been lost.

The study noted that the demand for ARV therapy was on the rise and that there was need to increase ART clinics apart from the 3 in Zomba Urban because as observed earlier, clients in need of ART at Police College and Cobbe Barracks alone increased almost eight fold in 2 years.

[9] Source: Urban CBOs (May, 2006)

It was also noted that almost all service providers had witnessed frequent absenteeism resulting from recurrent opportunistic infections (OIs) for PLWAs. This situation has led to low productivity as a result of people attending funerals and to the sick. Some organisations lost productive people due to AIDS related illnesses and some of the members were apparently living with the HIV. Health services were being overstretched leading to pressure on resource needs including hospital based care and drugs besides the congestion in the hospital wards.

The mission found that support organisations had to cope with the increasing number of orphans and PLWAs and the number of patients under community home based care to the extent that despite the good will, any support was far from being adequate. Some well wishers and support institutions such as CRECOM were assisting orphans with school fees while others such as Red Cross were assisting the sick with nutritional support.

The study noted that community participation and involvement was key to managing the impact of the epidemic through mobilizing the community at local level for provision of care, psychosocial and other support to the chronically and terminally ill patients at home.

The pandemic has also greatly affected the quality and quantity of service delivery in the Municipality. If antenatal mothers did not have access to prevention of mother to child transmission (PMTCT), many children would be born HIV positive.

2. MUNICIPAL PROFILE

LOCAL GOVERNMENT STRUCTURE

Administrative Structure

1. The Secretariat
Zomba Municipal Assembly was established under the Local Government (Urban Councils) Act, Cap 22.01 of the Laws of Malawi. Currently, it is regarded as a district on its own whose corporate body/ secretariate is headed by the Chief Executive. The secretariate consist of five departments, which are under the direct supervision of directors. They are responsible for the implementation of Assembly resolutions.

2. The Local Assembly
The Municipal Assembly has 14 geographical wards namely; Chikupira, Chirunga, Chinamwali, Masongola, Mpira, Matiya, Likangala, Zomba Central, Chambo, Sadzi North, Sadzi South, Mbedza, Mtiya and Zilindo. The Assembly is composed of councilors elected from each of the 14 wards. The Mayor selected from among the ward councilors heads it. They are responsible for making policies at the Local Assembly level. Councilors have played a commendable role in mobilisaing local communities to set up CBOs and ADS support groups.

The Assembly also has five additional ex-official members that constitute the Member of Parliament for Zomba Central constituency and four Traditional Authority Chiefs (T/As) namely: Chikowi, Mlumbe, Mwambo and Malemia. The Assembly has five service committees as follows; Finance, Health and Environment, Works, Development and Education. The Health and Environment Committee is expected to play a key role on HIV/AIDS related programmes.

3. Assembly Budget

The Assembly's annual budget has been increasing over the years due to the corresponding rise in cost of living. The budget is made up of both recurrent and development expenditures where the former consist of administration and operational costs while the later consist of development project investments. The development expenditures constitute 25% of the Assembly's total annual budget. The Assembly's financial / budget year runs from July to June the following similar to that of national government. Table 7 below shows the Assembly's total annual budget for the past five years. The Municipality is expected to set aside at least a mandatory 10% of the Development Expenditure for HIV/AIDS related issues.

The Assembly` Annual Budget[10]

Year	Recurrent Expenditures (MK)	Development Expenditures (MK)	Total Annual Budget (MK)
2001/02	33,026,030	11,026,030	44,104,120
2002/03	55,783,821	18,594,607	74,378,428
2003/04	79,849,500	26,616,500	106,466,000
2004/05	85,564,500	36,670,500	122,235,000
2005/06	135,067,800	57,886,200	192,954,000

4. Sources of Funding

Zomba Municipal Assembly has two main sources of funds namely locally generated revenues and government transfers. Locally generated revenues include property rates, ground rent, fees and licences, service charges and proceeds from commercial undertakings. Besides, the Assembly also receives grants from government and some funds from both local and international donors.

5. Municipal Services

Zomba Municipal Assembly provides a wide range of services through its five functional and service departments. Specifically, the department of Administration is the core of all Municipal operations. It manages and oversees the delivery of high standard social and public services through human resources management.

The department of finance is responsible for the mobilisation of monetary resources through its Revenue Section as well as overseeing actual use and utilisation of the acquired resources through the Expenditure Section.

The department of engineering on one hand champions physical infrastructure development. It is the Assembly's implementing arm that services, provides and construct public assets like roads, bridges, buildings street lighting etc. The department also undertakes rescue operations through the fire brigade. It also propagates and plants trees and flowers for urban beautification. It is also involved in urban transport and traffic control management.

The department of planning and development on the other hand is responsible for overall development control and urban planning, ensuring orderly land use planning and construction to make the Municipality habitable and beautiful. Specifically it scrutinises building plans

[10] Source: Zomba Municipal Assembly, 2006

and inspects buildings on construction to ensure adherence to urban planning and building standards. It is also responsible for housing estate development and management through provision of serviced plots.

Refuse Collection Truck

Plate 5

The department of Public Health and Environment manages and maintains clinics, home craft centers and markets. It also deals with Municipal sanitation through street cleaning, solid and water waste collection, treatment and disposal. It carries out health inspections and infectious disease control.

What remains to be done is the HIV/AIDS mainstreaming into all the above services.

Population Characteristics

1 Population Size

The Municipality of Zomba had a total population of 65,915 in 1998 (table 8). This population is growing at an intercensal growth rate of 3.6% per annum, which is higher than the national growth rate of 2.0% per annum. When projected to date, the Municipality has a population of about 107, 195. About 10% of this population is transient and unstable because it constitutes people from Educational institutions, Barracks and Police College that are very unstable. The study noted that among the occupational risks for fuelling the HIV/AIDS pandemic, highly mobile groups such as those mentioned earlier are at high risk.

Population Projections for the Municipality[11]

[11] Source: National Statistics Office 2003

Year	Mid Year Population
1998	65,915
2000	74,915
2002	85,016
2004	95,797
2006	107,195
2008	119,150
2010	131,628

2 Population Structure and Composition

The town has a slightly higher proportion of males to females in the ratio of 107:100. Thus, 51.7% of the total population are males while 48.3% are females. However, it has been observed earlier that HIV Infection among females was about twice as much as men. In 1998, Zomba had 40.3% of its population aged below fourteen (14), a percentage that is lower when compared to 44% in 1987. About 1% of its population was aged 65 and above, while 17.1% were children below the age of five.

3 Life Expectancy

In 1998 life expectancy for the Municipality was 44.6 years for males higher than the national indicator of 40.0 while for females at 42.2 years and was higher than the national indicator of 44.0. The life expectancy is expected to decline further in the years to come mainly as a result of AIDS related deaths.

4 Literacy

Literacy rates in Zomba are high, where 29.6 % had no education while 84.2% lacked formal skills as of 1998. However the MDHS, NSO 2004 noted that people with higher education were generally at higher risk of contracting HIV.

5 Poverty

Zomba Municipality is placed third in terms of poverty headcount (78%) in Malawi after Ntcheu (84%) and Phalombe (83.9%) (MPRSP, 2002). Likangala ward has the highest poverty headcount with more than 80% living below poverty line while Chirunga and Zomba Central wards were at 50% (An Atlas for Social Statistics NSO, 1998).

When asked to mention factors fuelling HIV/AIDS in the Municipality most respondents mentioned poverty as one the main driving forces for HIV prevalence.

Municipality Infrastructure

1 Health Facilities

The Municipality is blessed with a wide range of health facilities that range from Hospitals, Health Centre and Clinics both public and private. Zomba Central and Zomba Mental Hospitals are the two main referral hospitals that also cater for the surrounding districts besides serving the Municipal population. These health facilities offer a wide range of curative, preventive and support services such as health education, immunization, prenatal and postnatal care, provision of contraceptives, VCT services and treatment of ailments as well as running nutrition clinics for underweight children.

2 Education Facilities

There are several educational institutions in the Municipality that offer pre- primary, primary, secondary and tertiary education and both public and private. The Municipality has 16 government primary schools, 8 private primary schools. There are 20 secondary schools comprising 2 conventional, 2 grant aided, 4 CDSS, 6 registered and 6 unregistered private secondary schools. Tertiary education is offered at Chancellor College, Theological College and several private institutions in the Municipality. These institutions are currently playing a role in preventive particularly targeting the youth. Apart from including HIV/AIDS in the curriculum, they also have HIV/AIDS Toto Clubs as a way of promoting peer education among the in-school youth.

3 Social Facilities

Social facilities in the Municipality include the Zomba Community Centre, Gymnkhana Club, several sports fields and recreational halls in education institutions and the Botanical Gardens.

Socio Economic Activities

1 Commerce

Trade and distribution constitutes about 28% of medium enterprises in the Municipality and is the commonest non-farm business activity making it second to manufacturing. The sector is perceived as having fewer barriers to entry as it often requires minimum outlay of capital.

The medium and large scale trading includes retailers, supermarkets, large-scale wholesalers, travel agency, filling stations and courier services. Only PTC and McConnell are public while the rest are privately owned. Most of the trading involves imported goods.

The overall value added by this sector is estimated at 80% and provides employment to about 51 % of the off-the-farm economically active population of which 75% is male. At national level this sector also added employees at a relatively rapid rate (MSE Business Survey 2000).

The informal trading sub-sector includes individuals conducting business at the various trading centres, Assembly Markets and cottage groceries. Indigenous Malawians are most active in the informal sector but the greatest challenge is that in terms of orderly business conduct, it remains underdeveloped. As a result, the sector has problems to access support services including training and credit.

Although there are no clear policies guiding it, the sector is helping to generate informal employment in the Municipality.

2 The Commercial Services Sector

The commercial service sub-sector comprises about 22% of urban medium scale enterprises and was thus the third most significant.

a) Banking and Insurance

There are 6 banks and the infrastructure has remained the same in the past 5 years. The banks are: National Bank of Malawi, (NBM), Stanbic Bank, New Building Society Bank (NBS Bank), Malawi Rural Finance Company (MRFC), First Merchant Bank and Malawi

Savings Bank (MSB). In 2004 New Building Society introduced additional bankers products and changed their name slightly to New Building Society Bank.

Until 2003, there was only one insurance company i.e. Citizen Insurance Company but recent months have seen the opening of 2 more i.e. Charter Insurance Company Ltd. and Prime Insurance Company Ltd. This entails that the sub-sector should become more competitive thereby attracting some of the residents who go to Blantyre for insurance covers.

There are only 2 private forex bureaux in the Municipality, which compliment the banks' efforts.

b) Telecommunications Service

The sector has almost been revolutionised by high-tech telecommunication systems. There are two main private service providers i.e. Telecom and Celtel. Malawi Telecom Limited (MTL) is the retail service provider of fixed telephone lines while Telecom Network Malawi (TNM) provides mobile telephone service. Zomba Telecom Network Office has registered about 13,000 subscribers representing around 70% of the local market share. This is a result of registering about 3,600 clients annually.

By October 2004 the Municipality recorded 4617 subscribers for MTL fixed lines including 31 new public telephone booths. The number of retail provision of services for telephone booths, bureaux, Internet and e-mail cafes and fax has increased over the years.

c) Transport

The Minibus Operators Survey report (NSO: 1998) revealed that there were 19 sole owned Zomba Urban minibuses representing about 18% of all enterprises in the Southern region operate on selected routes within the urban area. This is in addition to 15 taxis now plying some routes. There are also 15 Freight vehicles and the entire transport systems operate in the Municipality and beyond.

d) Small and Medium Business Support Services

There are 16 non-bank institutions 5 of which offer policy advocacy while the rest extend to credit financing. The 11 financing institutions offer informal banking atmosphere ie small short term loans, non-traditional collateral requirements, simple application procedures with rapid turn around flexible loan requirements

The heavy presence of support institutions has hardly led to significant increase in enterprise support and so did 94% of SME (s) in the National MSE Baseline Survey (NSO 2000)

The financing institutions often support business associations/clubs, which undergo basic training in group dynamics, business and credit management and control. Most of the institutions also encourage the savings and investment culture amongst their clients.

e) Utility and other Service Providers

The Southern Region Water Board (SRWB), Electricity Supply Commission of Malawi (ESCOM) and Malawi Postal Corporation (MPC) are the major retail providers of water, electricity and postal services respectively.

Other service provider sectors include: privately owned security services construction, maintenance and repairs, electrical, plumbing, carpet cleaning, automobile and bicycle repairs.

2 Industrial Enterprises

a) Light Processing Enterprises in the Municipality

The sector constituted about 51% of medium enterprises in the Municipality. They include the production sectors of urban agriculture (crop and animal production), forestry and fisheries on one hand and manufacturing and agro- processing on the other. However, apart from Wood Industries Company (WICO) and Bilal Timber Supplies, both owned by male non-indigenous operators, (who perform major mechanical saw milling, carpentry and joinery) high productivity sectors such as manufacturing are non-existent.

The agro-processing sources of income in the urban area include tailoring, grain milling, bakery, beer brewing and distilling.

The underdeveloped manufacturing status of the Municipality can partly be attributed to underdeveloped industrial sites. Currently there are two designated zones; one in Masongola Ward opposite Southern Bottlers Ltd and the other in Zomba central ward, the area covering ADMARC depot, WICO showroom and beyond. Part of these designated sites have been invaded by illegal developers and one building previously housing the Mulunguzi Winery, is no longer used for industrial activities.

b) Tourism

Zomba Urban, a former colonial capital of Malawi enjoys a national heritage status of having magnificent colonial relics and classical buildings erected in the early 1900s. It also boasts of modern amenities such a revolutionised telecommunication system and international standard banking industry that can enable tourists enjoy their stay. There is excellent hotel, motel and lodge accommodation.

The Municipality's hotel industry remains under developed. There is only 1 Malawian and privately owned Hotel Masongola, a motel and 2 lodges (one is female owned) for the cost conscious, there are also rest houses and restaurants although most of them are substandard.

However, there is Kuchawe Inn, an international standard hotel, and situated 8-KM away from the CBD in the neighbouring rural district.

c) Tourist attraction centres within the Municipality

Places of interest in the Municipality include;

a. Botanical Gardens and Parks with rare species of plant life
b. Kings African Rifles Memorial Tower
c. Chancellor College, a constituent college of the University of Malawi.
d. Gymkhana Club for recreation
e. CCAP primary school, Top Hospital, CCAP church

However the Municipality lacks Zoos, Cultural Development Centres, Curio Markets and Regulations for basing defined standards for tourist facilities.

3 Labour Force

Table 9: People Seeking Employment at Zomba Labour Office[12]

	Total Registrations		Total Employed	
Year	**Male**	**Female**	**Male**	**Female**
2000	1264	298	739	173
2001	578	178	358	118
2002	666	141	376	81
2003	467	117	280	62

Table 9 shows that an average of 20% per year of those seeking employment and about the same ratio of those actually employed were female. Proportionally, more people got employed in the years 2001 and 2003.

The types of employment sought at the district labour office include; agricultural, clerical, sales, community social and personal service, labourers, production, professional and administrative workers. However, the community and personal service was the most common followed by building and construction.

Of the economically active only 11% are salaried workers, majority of whom are working under institution such as Chancellor College, Government Print, Municipal Assembly, NSO, Southern Region Water Board, ESCOM, Ministry of Education and the general Civil service sector.

Less than 35% of the economically active are in the primary sector (agriculture, forestry, fishing) and between 4.4% and 8.0% are in the manufacturing or construction sector, while the rest are in the tertiary sector (trade and services). About 75% of those in the tertiary sector are male.

With a very underdeveloped private/industrial sector, the Municipality's 73% of labour force is either self-employed (in informal sector) or unemployed altogether.

According to the 1998 Malawi Population and Housing Census, only 0.7 percentage of Malawi's economically active had formal employment.

3. MUNICIPALITY HIV/AIDS AND IMPACT ASSESSMENT

SERVICE PROVIDERS IN RESPONSE TO HIV/AIDS

As at May 2006, Zomba Municipality had 36 service providers (Appendix 18) addressing various HIV/AIDS issues in areas of prevention, treatment, care and support and impact mitigation. Out of the 36 service providers, there are 14 Community based support groups, 5 religious organisations, 8 government institutions, 4 Non-governmental organisations, 4 Community based Organisations and 1 private institution.

12

Three organisations have their offices located outside the Municipality while the rest are within the Municipality. However, most of the organisations have their service coverage beyond the Municipality despite leaving some areas within the Municipality like the whole of Masongola Ward uncovered.

EXISTING SERVICES IN RESPONSE TO HIV/AIDS

There is a wide range of services being offered in the Municipality in response to HIV/AIDS in the areas of prevention, treatment, care and support and impact mitigation. Specifically, services being offered under prevention are; awareness campaigns, advocacy for VCT, PMTCT, abstinence, condom use and behavioral change, counseling, life skills training, peer education, family planning services, surveillance and condom distribution.

Home Based Care services, support to PLWAs, nutrition support, provision of ART, treatment of opportunistic diseases and general medical care are the services being offered under treatment, care and support.

Services being offered under impact mitigation include; orphan care, provision of vocational training to vulnerable groups like orphans, education support through nursery schools and provision of basic necessities such as food and clothing to the infected and affected.

However, the service coverage is not equitably distributed in terms of geographical coverage. Much as they cover almost the whole of Zomba Municipality, in essence, one institution, carrying out specific activities does not provide services to the entire Municipality.

HIV/AIDS SERVICE GAPS

The service gaps existing in the Municipality in the delivery of HIV/AIDS activities are categorised as follows:

Gaps related to HIV/AIDS service providers

- VCT & ARV Clinics not adequate
- There were no offices for MANASO, NAPHAM, MANET,
- Lack of service for the elderly, widows & disabled especially the deaf & dumb.
- Lack of resources leading to low CBO activities
- Lack Knowledge on HIV/AIDS among young people
- Lack of care and support to people in need
- Advocacy for abstinence
- Knowledge gap
- Lack of economic empowerment and lack of skills to young people and orphans

Gaps related to HIV/AIDS support interventions

- Entertainment activities,
- Use of improved technology for delivery of HIV/AIDS messages i.e TV, DVDs and computers

Gaps in HIV/AIDS activities operations

- Lack of follow-ups and supervision of CBOs by Municipal Officials
- Services not reaching intended/ targeted people,
- Lack of funding and training for volunteers
- Lack of donors, facilitators for the smooth running of CBOs, Lack of funding
- Lack training, Training of trainers,
- Lack of support from private sectors in the Municipality
- Poor networking, lack of collaboration, coordination & participation of all stakeholders, approaches not focusing on real problems

SOURCES OF FUNDING

Most service providers in the Municipality are donor funded, as such their operations and existence depends on availability of donor funds. Thus such organisations are active when donor funds are available. However these organisations though driven by availability of donor funds have an impact on the community. Organisations that depend on their own funds (self contributions) are less active and have little impact on the community in terms of overall service delivery

TARGET GROUPS

The services are targeted at the community as whole but with a special focus and emphasis on PLWAs, Orphans, youth, women, disabled, aged, prisoners and community leaders.
However, the targeted groups have left out other high-risk groups like; commercial sex workers (prostitutes), uniformed officers, drivers, and street kids.

Youths have been ranked as the highest risk group due to peer pressure, alcohol and drug abuse, poverty, ignorance and lack of basic knowledge, lack of entertainment, lack of life experience and tendency to experiment on sex.

HIGH AND LOW RISK GROUPS IN THE MUNICIPALITY

Table 10: High Risk Groups

No	High Risk Group	Reason
1	**Youth**	• *Peer Pressure* • *Alcohol & drug abuse* • *Poverty* • *Ignorance* • *Eager to experiment & practice sex experimenting because they are still learning school drop outs engage in bad habits because of idleness* • *Lack of counselling* • *Lack of control & parental care* • *Lack of civic education* • *Orphan hood* • *Sexually active & attractive.* • *Most of them don't know their HIV status* • *Not using condoms*
2	**Women & Girls**	• *House wives often infected by husbands*

		• *Dangers of child bearing* • *Poverty*
3	**Married people**	• *Contracting it from spouse*
4	**Prostitutes/Commercial sex workers**	• *Very mobile,*
5	**Uniformed officers**	• *Nature of their work, very mobile*
6	**Drivers**	• *Nature of their work*
7	**Prisoners**	• *Sharing every thing*
8	**Street kids & Disabled**	• *They don't have enough protection*

Low Risk Groups

No	Low Risk Group	Reason
1	**Elderly people/ Aged**	• *There is no peer pressure* • *Sexually inactive* • *Tired with many issues* • *They are very responsible* • *Most of them already married, aware of dangers of HIV/AIDS*
2	**Under 5 children**	• *Their bodies still premature*
3	**School going students**	• *They learn about AIDS issues, condom use*

FACTORS FUELING HIV/AIDS EPIDEMIC

The following were identified as factors fuelling HIV/AIDS in the Municipality;

- Poverty, ignorance, peer pressure, culture beliefs/ practices (fisi, kusasa fumbi & kupita kufa), orphanhood, prostitution, promiscuity
- Alcohol and drug abuse, social mixing of girls & boys, night clubs and beer drinking
- Unemployment/ lack of job opportunities, lack of civic education & sensitization,
- Lack of social and recreation activities/ facilities to keep youth busy
- Lack of parental care, practicing unprotected sex, bad company, poor health facilities
- Availability of drinking joints, improper dissemination of HIV/AIDS messages
- Low risk perception, having unprotected sex with multiple partners
- Remarrying because of short marriages (serial monogamy).
- Poor communication in families on sexual issues
- Work shops and non-condom users.
- TVs and pornography, attractiveness of most widows
- Copying foreign cultures, behavior and dressing
- Widow hood, rape
- Mobility of businessmen and women

HIGH IMPACT AREAS

HIV/AIDS has highly impacted most of the locations in the Municipality namely; Mtiya, Chinamwali, Chikanda, Skinner, and 3 miles. The most affected age group is between 15-45 years encompassing the youths and women in childbearing age.

MUNICIPALITY'S EXISTING POLICIES IN RESPONSE TO HIV/AIDS

It was noted that the Municipal Assembly had not yet developed its HIV/AIDS Workplace Policy although there were strong indications that the process would start soon. They nevertheless have a workplace HIV/AIDS intervention committee .It was notable however that 3 institutions including Police College, YONECO and Diginitas International had already developed theirs.

4. PROFILE ON HIV/AIDS ACTIVITIES AND FUTURE PROJECTIONS

The overall goal of the HIV/AIDS framework for 2005-2009 was to prevent HIV infection among Malawians, provide access to treatment for PLWAs and mitigate the health, socioeconomic and psychosocial impacts of the pandemic on individuals, families, communities and the nation.

Appendix 17 presents the activity profile of HIV/AIDS from a study of some 33 organisations including CBOs, NGOs, health facilities and AIDS support groups in Zomba Urban. In line with the HIV/AIDS framework, the organisations have been carrying out the activities along some of the priority areas listed in the framework.

ACTIVITIES ON PREVENTION AND BEHAVIORAL CHANGE

The study found that under this pillar, support organisations had made progress although there was need to scale up interventions that would see their efforts being translated further into meaningful behavioral change.

A focus group discussion with an organization called Tilimbike, comprising sex workers and commonly considered to have high levels of risky behaviour, demonstrated that attempts were being made towards the promotion of safer sex through distributing condoms in drinking places in the municipality as well as encouraging fellow members and the target groups such as youth on the importance of abstinence and/ or the correct use of condoms. The study learnt that much as some of them would have wanted to abstain sometimes there was no choice otherwise there would literary be no food at home.

It was noted that other activities in this priority area included sensitisation through drama performed in prisons, market places, workplaces, and schools. Some oganisations such as Chitsime Orphan Care, St Charles Lwanga CEPARUM and Hope for Life introduced sports and indoor games as part of the recreation for the youth. Other organisations introduced indoor games for the teenage mothers. It was also found that faith based organisations such as Zomba Theological College were also reaching out to both church and para- church targets for spiritual and holistic approach to behavioral change. Some organisations conducted training for CHBC volunteers apart from teaching life skills for orphans. Hope for Life used role models and testimonies for the communities from those who had been tested.

Most of the organisations were also engaged in the distributing of IEC materials such as brochures and booklets and posters on HIV/AIDS. The study noted however that television and radio programs were not being seriously pursued in the municipality.

Health institutions were providing integrated medical and preventive health services including VCT advocacy and services, peer education, family planning, provision of condom and non human dispensing, awareness meetings, health education session, open days and trainings targeting all.

The study noted that some organisations were encouraging the communities and those suspected to have HIV/AIDS patients to go for VCT. Other organisations followed up on HIV positive clients and recommended the PLWAs for ARVs if need be and others advocated for the formation of PLWAs such as the one at Cobbe Barracks.

ACTIVITIES UNDER TREATMENT, CARE AND SUPPORT AND IMPACT MITIGATION

The key issues under this area included the growing pressure and expectations from the community, inadequate resources, ARV procurement and appropriate interventions aimed at addressing the needs of PLWAs, OVC and other vulnerable groups.

The study noted that local organisations were carrying out activities under community home based care (CHBC) particularly for orphans and PLWAs and the old aged. No organization was providing care for the widows/widowers. Some organisations such as Tithandizane Orphan Care were carrying out door-to-door registration of PLWAs while Chikamveka AIDS Support Organisation provided bicycle ambulances, home based care kits including medical care for the vulnerable groups such as PLWAS and orphans.

It was noted that some orphans were getting various forms of support through provision of nutrition, health care, school fees, counseling, clothing school uniform. The other support provided to orphans included nursery school and psychosocial assistance. Some organisations such as Ndola Orphan Care provided vocational skills for orphans i.e. tailoring while other organisations like Global Love provided faith based mitigation.

The mission noted that some organisations were making efforts to raise funds for mitigating the socioeconomic impact on the vulnerable groups through income generating activities such as raising poultry.

ACTIVITIES UNDER HIV/AIDS MAINSTREAMING, CAPACITY BUILDING, PROGRAM COORDINATION AND RESOURCE MOBILISATION

Key issues here include lack of effective coordination and capacity of various partners, lack of common understanding of mainstreaming, lack of effective use of resources, failure of umbrella organisations to timely disburse funds to the implementing agencies and limited accessibility to resources especially for the CBOs and local AIDS support groups.

The study noted that inter-organisational coordination meetings were rarely conducted and that very few organisations carried out capacity building initiatives. Only Chikamveka A.S.O. was conducting training for HBC volunteers and other task force members while Cobbe conducted training for peer educators and VCT counselors and Hope for Life conducted group therapies and legal counseling clinics and facilitating the formation of post- test clubs.

The study noted that financial support through the assigned umbrella organization was so confused and as a result majority of support organizations were severely limited in their service delivery.

FUTURE PLANS AND PRIORITY (EMERGING) AREAS OF INTERVENTIONS

The study noted that some 5 community based organizations, Chinamwali Private Clinic and the Zomba Municipal Assembly were interested to open VCT clinics and therefore increase accessibility to VCT services in the urban area. Police College planned to scale up VCT services and the provision of condoms.
It was noted that Cobbe was planning to intensify awareness campaigns and faith based organizations planned to scale up advocacy for abstinence and establishing a religious coalition against HIV/AIDS. Other organizations planned to operate recreational centres meant to keep the youth preoccupied.

The study found that provision of nutrition and improved economic status for PLWAs and orphans was an emerging issue in the communities. It was learnt that Zomba Prison, Matawale Health Centre, YODEP, Police College were planning to start or improve on the nutrition status particularly for HIV/AIDS patients besides providing supplementary feeding to orphans. Another emerging issue was the access to ARVs and scaling up the treatment of opportunistic infections otherwise it would be problematic to effectively promote voluntary counseling and testing in the absence of that service.

It was noted that some organizations such as Chikondi Orphan Care and Likhubula A.S.O. were planning to carry out self-help initiatives through local contributions such as moulding bricks for the construction of Early Childhood Development Centres (ECDs) apart from operating IGAs to raise resources for increasing orphan and PLWA care services.

It was learnt that other organizations were planning for capacity building initiatives including the training of counselors, volunteers, peer educators, CBHC providers and ARV dispensers. The study noted that some organizations such as Jesus Clinic were planning to conduct vocational skills for orphans including knitting and weaving while others wanted to construct vocational skills centres for women and orphans.
The study found that some organizations including Zomba Municipal Assembly were planning to have their workplace policy.

5. BEST PRACTICES AND MEANS OF APPLICATION

NUTRITION SUPPLEMENT

The key issue here was that some of the HIV/AIDS patients were low -income earners who could hardly manage balanced diet on regular basis and in order to improve the body weight for those who start ARV therapy, nutrition support was inevitable. Studies have shown that with proper and sustained nutrition support AIDS patients could easily regain their Body Mass Index within three months.

This study noted that some organisations such as Hope for Life were providing food to AIDS patients on a monthly basis while Zomba Prison, Matawale Health Centre, YODEP and Police College were planning to start or improve on the nutrition status particularly for HIV/AIDS patients besides providing supplementary feeding to orphans. It was important

that along with the ARV provision other associated nutrition programs be developed to specifically target needy HIV/AIDS patients.

It was also noted that within the Municipality, there were orphans, some living under child headed households, who were in dire need of nutrition assistance and it was encouraging to note that some organization provided that support although in order for the program to be sustained it was necessary to target the most vulnerable households.

As far as possible nutrition support should emphasize on the locally available food varieties.

HOME BASED CARE AND MITIGATION STRATEGIES FOR THE INFECTED AND AFFECTED

The study noted that as the number of PLWAs and orphans continued to increase the need for setting proper mechanisms and appropriate interventions aimed at addressing the needs of PLWAs, OVC and other vulnerable groups at family and community levels could not be further emphasised. In particular hospitals and other institutions alone could no longer sustain the care and support needed for the huge numbers of the chronically and terminally ill patients and orphans.

The mission noted that various local organisations and the communities were carrying out activities under community home based care (CHBC) particularly for orphans and PLWAs and the old aged. Chikamveka A.S.O. was conducting training for HBC volunteers and other task force members in order to equip them on relevant knowledge and skills for rendering psychosocial support to both the infected and affected families. In particular some organisations were providing nutrition support.

There was thus need to enhance the skills for the caregivers and community involvement with the support from the health institutions and other organisations.

VOLUNTARY COUNSELING AND TESTING AND HIV SCREENING BEFORE MARRYING

Voluntary counseling and testing allows people to know their HIV status and how to protect themselves as well as others and in particular the youth. The mission was encouraged to note that about 60% of those who attended VCT clinical service at three centres namely Police College, Cobbe and Hope for Life were aged below 24 years, that couples were also attending the service and that the response rate had increased by 46% by the year 2005. This was an indication that behavioral change initiatives were producing desirable impact particularly for the youth.

The study found that most of the VCT clinics were opened in the past 3 years and MACRO opened only in 2005. The study noted that VCT clinics in Zomba municipality open from Monday to Friday between 8.00am and 4.00pm while others open on Saturdays between 8.00am and 12noon and the clinics were generally roomy, noise free, within reach, confidential and youth friendly.

ARV THERAPY, OI AND STI TREATMENT

The study noted that within the municipality there were 3 public sector referral ART clinics providing free ARV drugs. It was important that this program should not frustrate the VCT response especially if referred AIDS clients fail to access that service. It was found that ART therapy included the training of family members or volunteers who help to monitor the patient's drug intake.

HIV/AIDS WORKPLACE POLICY

An HIV/AIDS Workplace Policy was aimed at mainstreaming the implementation of HIV/AIDS activities in order to: protect employees and their families against HIV infection, mitigate the impacts of HIV/AIDS among employees and their families and to minimize the disruptions of service provision to the clients.

The study noted that institutions such as YONECO, Police College, and Diginitas International had already developed HIV/AIDS Workplace policies. Other institutions including the Zomba Municipal Assembly were in the process of developing theirs.

REDUCING STIGMA AND DISCRIMINATION AND PROTECTION OF HUMAN RIGHTS FOR PLWAs

The study noted that organisations had intensified efforts to sensitise the wider community to enhance acceptance and therefore reduce stigma and discrimination for the infected. Notable also was the fact that organisations such as Hope for Life offered legal counseling in their sensitisation programs.

RECREATION, PROMOTION OF LIFE SKILLS AND CHARACTER DEVELOPMENT FOR THE YOUTH

The study noted that some organizations were training orphans on life skills.
Lack of recreation for the youth was cited as one factor fueling the HIV/AIDS epidemic and as one way of scaling up interventions targeting the youth it was encouraging to note that some organizations were seriously planning to build recreational centers.

RESEARCH

In order to implement evidence based decisions it is important to institute research and it is envisaged that this situation analysis will be useful for making effective decisions that can help to reduce uncertainties about the epidemic.

ORGANISED GROUP OF SEX WORKERS AND FREE CONDOM DISTRIBUTION

It was noted that in Zomba municipality, there was Tilimbike Peer Educators, an organized group of about 20 sex workers who were actively involved in implementing interventions particularly on HIV prevention awareness and behavioral change. This group had been carrying out sensitisation campaigns including trainings on the correct use of condoms and was also distributing free condoms in red light areas such as bars, bottle stores and nightclubs as well as rest houses. Free condoms were also readily available in family planning clinics in the urban area.

6. MONITORING AND REPORTING KEY PERFORMANCE INDICATORS

PREVENTION AND BEHAVIORAL CHANGE

Number of

- Condoms distributed in the urban area by type (male or female) and by whether for sale or free
- Young people aged 15-24 exposed to life skills based HIV/AIDS education by gender
- People exposed to HIV/AIDS education by gender
- PMTCT sites
- Copies of HIV/AIDS brochures/booklets produced versus # distributed
- Media HIV/AIDS programs by # of hours
- Clients tested and counseled at VCT by age brackets: up to 24, 25 and above by gender
- Clients tested HIV positive and counseled at VCT by age brackets: up to 24, 25 and above by gender
- Pregnant women tested and counseled at VCT by age brackets: up to 24, 25 and above
- Pregnant women tested HIV positive and counseled at VCT by age brackets: up to 24, 25 and above
- Children prevented from acquiring HIV at PMTCT sites

SUCCESS INDICATORS:

- Reduced HIV infection rates
- Increased # of children prevented from being infected during pregnancy
- Increased # of people attending VCT clinics in particular the youth
- Increased # of PLWA organizations
- Reduced stigma and discrimination
- Reduced STIs
- High profile personalities declaring their HIV serostatus
- Increased quality and quantity of VCT clinical service
- Legal protection for OVCs, women and girls internalised

TREATMENT, CARE AND SUPPORT AND IMPACT MITIGATION

ORPHANS

- # OVCs by sex and age bracket and by whether they lost one or both parents
- # of OVCs receiving psychosocial support by sex
- # of OVCs receiving nutrition support by sex
- # of OVCs receiving by type of financial support
- # of child headed households by sex of head
- # of OVCs with disabilities by sex
- # of OVCs caring for the aged members of the extended family by sex
- # of OVCs visits from other agencies receiving psychosocial support

- # of OVCs accessing ART by gender

PLWAs

- # of PLWAs registered by sex and age bracket
- # of PLWAs receiving support by whether the support is psychosocial, nutrition,
  financial or other
- # of PLWAs accessing ARVs by sex and age bracket and quarterly targets
-

WIDOWS AND WIDOWERS

- # receiving psychosocial support by sex by whether one is a widow or widower
- # receiving nutrition support by sex by whether one is a widow or widower
- # receiving by type of financial support by whether one is a widow or widower
- # visits from other agencies receiving psychosocial support

IGA

- Type of IGA
- # and type of beneficiaries being supported by the IGA by age bracket and sex

SUCCESS INDICATORS

- Equitable access to ARVs
- Increased involvement of PLWAs and their associations
- Provision of CHBC improved
- Nutritional support for vulnerable PLWAs, widows, widowers and OVCs
- Improved local community capacity for care and support for the vulnerable groups
- Improved collaboration and coordination among key players
- Sustainable IGA for supporting the vulnerable groups

MAINSTREAMING, PARTNERSHIPS AND CAPACITY BUILDING

- # of coordination meetings
- # of trainings conducted
- # of monitoring/supervision visits from the local assembly
- Amount of allocated local funding
- # of institutions/ sectors with developed workplace strategies/policies and succession plans
- # of institutions in the process of developing workplace policies
- # of institutional technical and steering committees

SUCCESS INDICATORS

- Updated database of service providers
- Participatory planning developed
- Steering committees established
- Workplace policies and strategies developed
- AIDS Coordinator/ contact person appointed

PROGRAMME MANAGEMENT, COORDINATION AND RESOURCE MOBILISATION

- Integrated Annual Work plan (AWP)
- Type of local resources mobilised including IGAs

SUCCESS INDICATORS

- Timely disbursement of funds
- Integrated AWP developed
- Improved access to resources by local community institutions

7. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

ZOMBA IN THE UNIQUE POSITION AS COORDINATOR OF HIV/AIDS ACTIVITIES: SUMMARY AND CONCLUSIONS

The Zomba Municipal Assembly is in a unique position at the local level to manage the local response considering that is legally backed by several legislations including the Malawi Constitution, Local Government Act and especially that it can make by laws to moderate development plans, resource mobilization and utilization and community mobilization for socioeconomic development.

Support institutions at the local level have a tendency to report to organizations that funded them and often the Assembly does not get reports from some of the service providers

It was noted that the Assembly almost entirely relies on external support from NAC, to carry out planned HIV/AIDS activities. This situation often affects the sustainability when the external resources are not timely accessed.

The major HIV/AIDS supportive infrastructure i.e. hospitals, VCT clinics, NGOs etc is located in the urban area apart from institutions of higher learning such as Chancellor College.

RECOMMENDATIONS

- The Assembly should use its legal status to pass by laws that can moderate the operations of HIV/AIDS service providers, information management, local mandatory registration, monitoring and reporting system and operational geographical coverage
- As much as possible the Assembly should allocate/mobilize resources by establishing an HIV/AIDS fund from the 2% mandatory budget allocation (about MK2m in 2006/2007) so that the activities at the local level including monitoring could be sustained.

- Zomba Municipality should build on the opportunities it has such as institutions of higher learning and its proximity to HIV/AIDS supportive infrastructure and the overwhelming response for supporting the vulnerable groups.
- The gravity of the HIV/AIDS epidemic dictates the need for Zomba Municipal Assembly to engage a full time AIDS Coordinator who should be provided with resources for monitoring and managing coordination of the local response.

HIV/AIDS MAINSTREAMING AND SITUATION ANALYSIS: SUMMARY AND CONCLUSIONS

The mission noted that information on HIV/AIDS activities including that from the local institutions was not documented and that until high-level personalities within the Municipality openly declare their serostatus majority of staff will remain stigmatised. So far no member of staff has declared their HIV status

RECOMMENDATIONS

- The Assembly should provide clear policies and support on HIV/AIDS matters as well institutionalize a gender disaggregated database and situation analysis
- The Municipal Assembly should develop an HIV/AIDS information base which should be regularly shared with stakeholders
- The Assembly should intensify monitoring on behavioral change intervention targeting both in and out of school youth

HIV PREVALENCE: SUMMARY AND CONCLUSIONS

HIV prevalence in Zomba District (Municipality inclusive) can best be described as catastrophic as it is ranked the fifth highest infected district in Malawi with women being the hardest hit. At least 1 in 4 women are expected to have the HIV virus and data obtained from local clinics suggest that HIV prevalence in Zomba Municipality could be as high as 1 in 3 residents. It is estimated that 7 in every 10 admitted patients in Zomba are HIV positive.

In general HIV prevalence in Zomba Municipality is so alarming that if no action is taken to reverse the trends especially in regard to new infection among the youth, the epidemic will continue to devastate the livelihood systems and cause far reaching repercussions in the Municipality.

The urban population increase and intercensal growth rate in Zomba Municipality are one of the highest in the country and the population is largely comprising youth aged 24 and below. Infection rates in the population aged 15 –24 remains generally low although about half of this age group are likely to acquire new infections.

RECOMMENDATIONS

- The findings on the severity of HIV prevalence in Zomba Municipality should be widely disseminated through user friendly packages so that action including community dialogue is taken at the earliest possible times
- Stakeholders should intensify efforts on behavioral change strategies particularly targeting the youth age group in which the prevalence is still quite low.

- Strategies should be developed to integrate population issues along the HIV epidemic and other mainstreaming development issues otherwise the Municipality's population will rise from 43250 in 1987 to the projected 131628 in 2010 (200% increase) and the Municipality may not be able to sustain this.
- As much as possible data on HIVAIDS should capture various age groups and be gender disaggregated.

POVERTY, GENDER AND HIV PREVALENCE: SUMMARY AND CONCLUSIONS

Zomba District (Municipality inclusive) is a clear example of how the HIV epidemic could be linked to the poverty situation. The Municipality is the 5th district in Malawi in HIV prevalence severity and third in poverty headcount situation.

The study noted that poverty particularly among women and girls is one factor that is fueling the HIV/AIDS epidemic in the Municipality. This situation coupled with the widening gap between the haves and have-nots means that women and girls are forced to engage into transactional sex in order to survive.

In addition about 73% of the population in Zomba Municipality are either unemployed or engaged in informal business sector including vending. This situation puts the women and girls and youth at very high risk.

RECOMMENDATIONS

- The Municipality should clearly focus on the underlying causes of poverty in the Municipality in order to address the problems associated with HIV/AIDS. Unemployment for instance could be addressed through promotion of productive sector that can absorb part of the excess labour.
- The Municipality should focus developmental issues that aim at addressing income inequality with particular bias towards women and girls socioeconomic empowerment

PEOPLE LIVING WITH HIV/AIDS (PLWAs): SUMMARY AND CONLUSIONS

The local community and CBOs in Zomba Municipality are playing an important role in supporting the plight of PLWAs through providing community based care and support but these people are currently working in difficult situation due inadequate supportive working environment, financial services, education, training, medical services, supervision tools and materials and economic empowerment

It is noted that the local community are now generally developing a culture of acceptance for the PLWAs and that some local institutions have been training PLWAs on group therapy and how to live positively , a situation which can assist to promote openness among the infected as well as the joining of solidarity groups such as PLWA organisations.

The increase in the number of PLWAs registered by support organisations requires pragmatic planning, as these people will need clinical treatment and psychosocial support and legal rights protection. This means the local communities who provide home based care will require substantial external support to complement their efforts in mitigating the impact of the epidemic

RECOMMENDATIONS

- The local communities should be assisted through improved management and coordination between health and social sectors.
- Community involvement through promotion of communication, information sharing and dialogue on home based care issues for PLWAs among stakeholders should be enhanced
- The stakeholders should critically address issues of local economic empowerment, gender inequalities and promotion of human rights for PLWAs
- PLWAs organisations should be supported with incentives so that people can open up and in particular through timely access to ARVs and VCT services which can enable one to live a healthy life.
- Both sexes should be involved in the care for PLWAs and specific focus should be on food provision and setting of transparent IGAs based on their sustainability and needs of the PLWA and the affected families.

VCT CLINICAL SERVICE AND ANTIRETROTHERAPY: SUMMARY AND CONLUSIONS

Voluntary counseling and testing is critical in behavioral change intervention affecting both the infected and the non-infected groups in the Municipality thereby reducing the transmission of HIV and its effects. Some 8 VCT clinics are still inadequate to provide equitable access to the service.

Antiretroviral Therapy is key to motivating peoples interest and willingness to seek VCT services and it is noted that the numbers seeking VCT services in the Municipality have been increasing in particular the youth aged 24 and below

RECOMMENDATIONS

- In order to promote people to seek VCT, AIDS patients who need ARVs should access these timely and easily
- Post –test clubs should be promoted in order to intensify behavioral change among the residents

ORPHANS AND OTHER VULNERABLE CHILDREN (OVCs): SUMMARY AND CONCLUSION

The number of OVCs in Zomba municipality continued to increase mainly as a result of the HIV/AIDS related deaths of people aged 15-49. This situation is weakening the local community's resilience and therefore their vulnerability.

The OVCs have become helpless victims immediately when parents or their caretaker becomes ill. Some guardian are unable to fend for household basic needs and some children have been detached, engaged in child labour, heading households, victims of HIV risky behaviour, dropping out of school, engaged in early marriages/pregnancies, street destitute and victims of juvenile justice.

RECOMMENDATIONS

- There is need to take a holistic approach towards intervention aimed at addressing the needs of OVCs
- Community participation and involvement are key to managing the plight of OVCs for the provision of care , psychosocial, financial and material support .
- The Assembly should enact by-laws that will specify guidelines for care, support and protection of the OVCs and so that activities become harmonized, resources maximised and duplication of efforts avoided

8. REFERENCES

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5. 1998 Malawi Population and Housing Census Analytical Report (NSO, February, 2002)
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7. Malawi National GEMINI MSE Baseline Survey 2000 (NSO)
8. Malawi An Atlas for Social Statistics (NSO)
9. Managing the HIV/AIDS Pandemic at the Local Level in Africa a Review Workshop 29-31st August, 2005, Nairobi, Kenya UN HABITAT
10. End of Term Review of Malawi National HIV/AIDS Strategic Framework (NSF) (NAC 2004-2009)
11. Malawi Demographic and Health Survey, (NSO, 2004)
12. Malawi Poverty Reduction Strategy Reduction Paper (GOM, 2002)
13. National Behavioral Change Intervention Strategy for HIV/AIDS and Sexual Reproductive Health, (NAC, 2003)
14. National HIV/AIDS Policy a Call for Renewed Action (GOM, 2003)
15. NAC Website Source: www.aidsmalawi.org.mw

9. APPENDICES

APPENDIX 1

ORGANISATIONS REGISTERING PLWAs IN ZOMBA URBAN

NO	NAME	REGISTERED PLWAs
1	Mtiya ECD*	6
2	Chikondi*	10
3	Tithandizane*	4
4	Zuwa ECD*	11
5	Shukurani ECD	10
6	Thandizo	1
7	Chitsime	14
8	Ndola*	6
9	Chikanda Poultry*	16
10	Makungula	2
11	Chaof Poultry	13
12	Together for Action*	3
13	Together 11 ECD	6
14	Chifundo	4
15	Tiwasamale	5
16	Passion	0
17	Mawandianthu	6
18	Hope for Life	0
19	Malowa	6
20	Tiyambe Poultry	5
21	Rivers of Joy*	4
22	Tilimbike Support*	15
23	Love and Faith Ministries	3
24	Jesus Clinic	35
25	St. Charles Lwanga	11
26	Chikamveka A.S.O.*	6
27	Mbeza	2
28	Cobbe VCT H.B.C.	86
29	Global Love Foundation*	0
30	Likhubula A.S.O.*	16
32	Minbus Callers	2
	Total	308

* Also registered with Municipal Assembly

Source: District Social Welfare Office, May 2006

APPENDIX 2

CBOs REGIST ER OF PLWAs- AT ZOMBA MUNICIPAL ASSEMBLY						
	YEAR	2001	2002	2003	2004	2005
1	Ndola Orphan Care*	0	0	0	0	0
2	Mawa ndi Anthu	20	23	19	21	25
3	CEPARUM	0	0	0	0	0
4	Global Love Organisation*	0	0	0	0	0
5	Chancellor College	7	12	16	11	13
6	Maranatha AIDS Support	0	0	0	5	8
7	Chikanda HIV/AIDS*	0	0	0	0	0
8	St Charles Lwanga	17	23	24	27	28
9	Police College CBO	0	0	0	0	0
10	Tithandizane Orp Care*	9	7	5	8	8
11	Chikamveka A.S.O.*	0	0	0	4	6
12	Sadzi CBO	0	0	0	0	0
13	Tilimbike Peer Educators*	0	0	0	0	0
14	Municipal Assembly Workplace	0	0	0	0	0
15	YODEP	12	20	22	27	32
16	Theological College Student HIV/AIDS	0	0	0	0	0
17	Together for Action *					
18	Chinamwali AIDS & Orphan Care Foundation	1	1	2	0	3
19	Rivers of Joy*	0	0	0	0	0
20	Chitsime Orphan Care	0	0	0	0	5
21	Jesus Clinic Foundation	0	0	0	7	8
22	Zuwa*	0	0	0	0	4
23	Chikondi Orphan Care*	0	1	3	5	10
24	Takumana HIV/AIDS Theatre	0	0	0	0	0
25	Likhubula AIDS Support* Group	0	0	0	0	0
26	Zomba Prison	0	0	0	0	180
27	Mtiya AIDS & Orphan Care*	0	0	0	0	0
	TOTAL	66	87	91	115	330

*** Also registered with DSWO**

Source: Urban CBOs, May 2006

APPENDIX 3
ORPHANS AND OTHER VULNERABLE CHILDREN

NO	NAME	DIRECTOR/ CHAIR	Orphans
1	Mtiya ECD*	C. Mpesi	1500
2	Chikondi*	F. Mkova	300
3	Tithandizane*	G. Gwaza	650
4	Zuwa ECD*	M. Imani	400
5	Shukurani ECD	S. Abdul	85
6	Thandizo	J. Msoma	52
7	Chitsime	S. Botomani	335
8	Ndola*	G.Sosola	220
9	Chikanda Poultry*	R. Kasenda	391

10	Makungula	B. Lisimba	95
11	Chaof Poultry	S.Dissi	195
12	Together for Action*	J.Utumbe	400
13	Together 11 ECD	J. Utumbe	137
14	Chifundo	J.D. Mdala	351
15	Tiwasamale	M.Masamba	125
16	Passion	P. Chibwana	65
17	Mawandianthu	M. Zipita	155
18	Hope for Life	A. Namondwe	250
19	Malowa	S. Mainuka	198
20	Tiyambe Poultry	Mr R. Buda	158
21	Rivers of Joy*	A.Y.Tanaposi	100
22	Tilimbike Support*	Ethel Jusu	15
23	Love and Faith Ministries	I. Nyamafumba	30
24	Jesus Clinic	M. Nyirongo	3125
25	St. Charles Lwanga	Mrs. Samalani	85
26	Chikamveka A.S.O.*	T.Manda	280
27	Mbeza	J.L. Lihoma	86
28	Cobbe VCT H.B.C.	F. Mkoma	0
29	Global Love Foundation*	F. Mendulo	7
30	Likhubula A.S.O.*	I. Samson	0
31	Geological Survey	K. Kathe	
32	Minbus Callers	M. Jusu	38
33	Prison AIDS Group	Mr. Nyaroo	
		Sub- total	9828
NON GOVERNMENTAL ORGANISATIONS (NGOs)			
34	CADECOM	A. Michongwe	651
		Sub total	651
		Totals	10479

** Also registered with Municipal Assembly*

APPENDIX 4

CBO QUESTIONAIRE

SITUATION ANALYSIS OF HIV/AIDS IN ZOMBA MUNICIPALITY

Section 1 General Information

DATA COLLECTION SHEET

Date & Time		Session Number	
Name of Facilitator		Names of other Facilitators	
Method/Tool used		Duration of Session	

Number of Respondents at beginning		Number of Participants at end	
Place Session Held		Special Conditions	
Materials Used		Other Information	
Description of Respondents			
No of Men			
No of Women			
Age Group(s)			
Main Work Activity Areas			
Marital Status			

NB: If the space provided for response is not adequate use the backside of the sheet

Section 2: Information on

Research Topic with Areas for Probing		Response
	Research Area No 1: To assess the scope, scale and trends of HIV/AIDS epidemic in the Municipality	
1	What is the number of people living with HIV/AIDS under your organisation	2001 2002 2003 2004 2005
2	What is the number of orphans 0-17 years registered by your organisation	2001 2002 2003 2004 2005
3	How has your organisation been affected by HIV/AIDS	
4	Mention the centres you are providing ARV therapy by geographical coverage	
Research Area No 2: To assess the HIV/AIDS Profile in the Municipality		
5	Mention the goals, vision and aims of your organisation in relation to collective response to HIV/AIDS in the Municipality.	
Research Area No 3: To assess the database and profile of HIV activities and future projections		
6	What activities/initiatives is your organization doing in response to HIV/AIDS	
7	What future plans does your organization have in response to HIV/AIDS	
Research Area No 4: To assess the high and low risk populations in the Municipality		
8	List down the high and low risk groups you know and explain the	Group

	reasons for your answer	Reason
Research Area No 5: To assess high areas of impact, and high risk factors that fuel the HIV/AIDS Pandemic and Protection factors		
9	Which areas (locality, sector, age group) has the pandemic impacted highly	
10	List down the factors that are fueling HIV/AIDS pandemic in the Municipality	
Research Area No 6: To assess the Service Providers in the Municipality		
11	Provide an organizational profile of your (name of organization, physical and postal address, statement of purpose target groups and areas, services provided)	See attached table
Research Area No 7: To assess the Service Gap Identification in the Municipality		
12	Mention any gaps identified in the service delivery of HIV/AIDS related activities	
Research Area No 8: To assess the Best Practices and Means of Application		
13	From the services you are providing, what would you regard as the best practices in response to HIV/AIDS	
14	How are the best practices being applied	

ORGANISATIONAL PROFILE

DETAILS	RESPONSE
Name of organization	
Type of organization (*tick)*	NGO
	Government
	Religious
Statement of purpose	
Contact Details	Physical Address
	Postal Address
	Telephone
	Fax
	E- mail
Description of services	Prevention
	Treatment

	Care and support Impact mitigation
Target Groups	
Geographical Coverage	
Source of Funding	

APPENDIX 5

NGO QUESTIONAIRE
SITUATION ANALYSIS OF HIV/AIDS IN ZOMBA MUNICIPALITY

Section 1 General Information

DATA COLLECTION SHEET

Date & Time		Session Number	
Name of Facilitator		Names of other Facilitators	
Method/Tool used		Duration of Session	
Number of Respondents at beginning		Number of Participants at end	
Place Session Held		Special Conditions	
Materials Used		Other Information	

Description of Respondents	
No of Men	
No of Women	
Age Group(s)	
Main Work Activity Areas	
Family Status	

NB: If the space provided for response is not adequate use the backside of the sheet

Section 2: Information on

Research Topic with Areas for Probing		RESPONSE
	Research Area No 1: To assess the scope, scale and trends of HIV/AIDS epidemic in the Municipality	
1	How many HIV/AIDS positive cases did your institution register in the past 5 years in Zomba Municipality by sex	2001 2002 2003 2004 2005
2	What is the projected number of HIV/AIDS positive cases by 2015 in the Municipality	
3	What is the number of orphans 0-17 years registered by your organisation	2001 2002 2003 2004 2005
4	What is the Projected number of orphans by 2015	
5	How has your organisation been affected by HIV/AIDS	
6	List down the centres you are providing ARV therapy by geographical coverage	
7	List down VCT centres are you running by geographical coverage	
Research Area No 2: To assess the HIV/AIDS Profile in the Municipality		
8	Do you have an HIV/AIDS work place policy as an organisation	
9	If not, are there plans to have an HIV/AIDS work place policy	
10	Which other institutions in the Municipality have HIV/AIDS work place policies	
11	Mention the goals, vision and aims of your institutions in relation to collective response to HIV/AIDS in the Municipality.	
Research Area No 3: To assess the database and profile of HIV activities and future projections		
12	What activities/initiatives is your institution doing in response to HIV/AIDS	
13	What future plans does your institution have in response to HIV/AIDS	
Research Area No 4: To assess the high and low risk populations in the Municipality		
14	List down the high and low risk groups you know and explain the reasons for your answer	Group Reason

Research Area No 5: To assess high areas of impact, and high risk factors that fuel the HIV/AIDS Pandemic and Protection factors		
15	Which areas (locality, sector, age group) has the pandemic impacted highly	
16	List down the factors that are fueling HIV/AIDS pandemic in the Municipality	
Research Area No 6: To assess the Service Providers in the Municipality		
17	Provide your organisational profile (name of organization, physical and postal address, statement of purpose target groups and areas, services provided)	use attached table
Research Area No 7: To assess the Service Gap Identification in the Municipality		
18	List down any gaps identified in the service delivery of HIV/AIDS related activities	
Research Area No 8: To assess the Best Practices and Means of Application		
19	From the services you are providing, what would you regard as the best practices in response to HIV/AIDS	
20	How are the practices being applied	
Research Area No. 9: To assess the potential indicators for Monitoring and Evaluation		
21	What are the potential indicators for monitoring and evaluating HIV/AIDS activities in the Municipality	

ORGANISATIONAL PROFILE

DETAILS	***RESPONSE***
Name of organization	
Type of organization (*tick)*	NGO
	Government
	Religious
Statement of purpose	
Contact Details	Physical Address
	Postal Address
	Telephone
	Fax
	E- mail
Description of services	Prevention
	Treatment
	Care and support
	Impact mitigation
Target Groups	
Geographical Coverage	

Source of Funding	

APPENDIX 6

HEALTH INSTTUTIONS QUESTIONAIRE
SITUATION ANALYSIS OF HIV/AIDS IN ZOMBA MUNICIPALITY

Section 1 General Information

DATA COLLECTION SHEET

Date & Time		Session Number	
Name of Facilitator		Names of other Facilitators	
Method/Tool used		Duration of Session	
Number of Respondents at beginning		Number of Participants at end	
Place Session Held		Special Conditions	
Materials Used		Other Information	
Description of Respondents			
No of Men			
No of Women			
Age Group(s)			
Main Work Activity Areas			
Family Status			

NB: If the space provided for response is not adequate use the backside of the sheet

Section 2: Information on

Research Topic with Areas for Probing		Answer
	Research Area No 1: To assess the scope, scale and trends of HIV/AIDS epidemic in the Municipality	

1	How many HIV/AIDS positive cases did your institution register in the past 5 years in Zomba Municipality by sex	2001 2002 2003 2004 2005
2	What is the projected number of HIV/AIDS positive cases by 2015 in the Municipality	
3	What is the HIV/AIDS prevalence rate for Zomba Municipality	2001 2002 2003 2004 2005
4	What is the ranking of Zomba Municipality on HIV/AIDS infection	
5	What is the death rate in relation to HIV/AIDS pandemic	2001 2002 2003 2004 2005
6	How has your organization been affected by HIV/AIDS	
7	Mention the centres providing ARV therapy in the Municipality	
8	Mention the centres providing VCT in the Municipality	
	How many laboratory tests of admitted patients are HIV positive	2001 2002 2003 2004 2005
Research Area No 2: To assess the HIV/AIDS Profile in the Municipality		
10	Mention health facilities in the Municipality by category and geographical coverage (hospitals, health centres, clinics, dispensary)	
11	Briefly describe the services provided by the above mentioned health facilities, target groups and geographical coverage	
12	Mention the existing services in response to HIV/AIDS in the Municipality in areas of prevention, care and support, treatment and impact mitigation	
14	Outline all service providers operating in the Municipality in response to HIV/AIDS depicting the type of services, target groups, geographical coverage and sources of funding	
15	Do you have HIV/AIDS work place policy as an organization	
16	If not, are there plans to have an HIV/AIDS work place policy	
17	Which other institutions in the Municipality have HIV/AIDS work place policies	
18	Mention the goals, vision and aims of your institutions in relation to collective response to HIV/AIDS in the Municipality.	
Research Area No 3: To assess the database and profile of HIV activities and future projections		
19	What activities/initiatives is your institution doing in response to HIV/AIDS	
18	What future plans does your institution have in response to HIV/AIDS	
Research Area No 4: To assess the high and low risk populations in the Municipality		
20	List down the high and low risk groups you know and explain the reasons for your answer	Group Reason
Research Area No 5: To assess high areas of impact, and high risk factors that fuel the HIV/AIDS Pandemic and Protection factors		
21	Which areas (locality, sector, age group etc) has the pandemic impacted	

	highly	
22	List down the factors that are fueling HIV/AIDS pandemic in the Municipality	
Research Area No 6: To assess the Service Providers in the Municipality		
23	Provide your organisational profile (name of organisation, physical and postal address, statement of purpose target groups and areas, services provided)	Use attached table
Research Area No 7: To assess the Service Gap Identification in the Municipality		
24	List down any gaps identified in the service delivery of HIV/AIDS related activities	
Research Area No 8: To assess the Best Practices and Means of Application		
25	From the services you are providing, what would you regard as the best practices in response to HIV/AIDS	
26	How are the best practices being applied	
Research Area No 9: To assess the Potential Indicators for Monitoring and Evaluation		
27	What are potential indicators for monitoring and evaluating HIV/AIDS activities in the Municipality	

ORGANISATIONAL PROFILE

DETAILS	RESPONSE
Name of organization	
Type of organization (*tick)*	NGO
	Government
	Religious
Statement of purpose	
Contact Details	Physical Address
	Postal Address
	Telephone
	Fax
	E- mail
Description of services	Prevention
	Treatment
	Care and support
	Impact mitigation

Target Groups	
Geographical Coverage	
Source of Funding	

APPENDIX 7

ZMA QUESTIONAIRE

SITUATION ANALYSIS OF HIV/AIDS IN ZOMBA MUNICIPALITY

Section 1 General Information

DATA COLLECTION SHEET

Date & Time		Session Number	
Name of Facilitator		Names of other Facilitators	
Method/Tool used		Duration of Session	
Number of Respondents at beginning		Number of Participants at end	
Place Session Held		Special Conditions	
Materials Used		Other Information	

Description of Respondents	
No of Men	
No of Women	
Age Group(s)	
Main Work Activity Areas	
Family Status	

NB: If the space provided for response is not adequate use the backside of the sheet

Research Area No 2: To assess the HIV/AIDS Profile in the Municipality		
1	What is the structure for Zomba Municipal Assembly	
2	How many councilors does the assembly have by sex	
3	What is the annual budget for the Assembly	
4	Mention sources of funding for the Assembly (being local revenues or national government	
5	Outline all Municipal services	
6	What is the Assembly's total population by sex?	
7	Describe the stability of the Municipality's Population	
8	What is the prevalence Rate for HIV/AIDS in the Municipality	
9	What is the number of orphans in the Municipality by sex	
10	What is the poverty rate for Zomba municipality	
11	What is the Municipal's unemployment rate	
12	What is the adult literacy rate by sex	
13	List down health facilities in the Municipality by category and geographical location (hospitals, health centres, clinics, dispensary)	
14	Briefly describe the services provided by the above mentioned health facilities, target groups and geographical coverage	
15	List down education facilities are in the Municipality by category and geographical coverage(primary, secondary and tertiary)	
16	Briefly describe the services provided by the above mentioned education facilities, target groups and geographical coverage	
17	Mention recreational and sporting facilities in Zomba Municipal Assembly	
18	Briefly describe the services provided by the above mentioned recreational and sporting facilities, target groups and geographical	

	coverage	
19	What are the main economic activities in the Municipality	
20	Mention the existing services in response to HIV/AIDS in the Municipality in areas of prevention, care and support, treatment and impact mitigation	
21	Outline all service providers operating in the municipality in response to HIV/AIDS depicting the type of services, target groups, geographical coverage and sources of funding	
22	Does the Municipality have an HIV/AIDS work place policy	
23	If not, are there plans to have an HIV/AIDS work place policy	
24	Which other institutions in the Municipality have HIV/AIDS work place policies	
25	Mention the goals, vision and aims of the institutions in relation to collective response to HIV/AIDS in the Municipality.	
Research Area No 3: To assess the database and profile of HIV activities and future projections		
26	What activities/initiatives is your institution doing in response to HIV/AIDS	
27	What future plans does your institution have in response to HIV/AIDS	
Research Area No 4: To assess the high and low risk populations in the Municipality		
28	List down the high and low risk groups you know and explain the reasons for your answer	
Research Area No 5: To assess high areas of impact, and high risk factors that fuel the HIV/AIDS Pandemic and Protection factors		
29	Which areas (locality, sector, age group) has the pandemic impacted highly	
30	List down the factors that are fueling HIV/AIDS pandemic in the Municipality	
Research Area No 6: To assess the Service Providers in the Municipality		
31	Provide your organisational profile (name of organization, physical and postal address, statement of purpose target groups and areas, services provided)	
Research Area No 7: To assess the Service Gap Identification in the Municipality		
Research Area No 8: To assess the Best Practices and Means of Application		
32	From the services you are providing, what would you regard as the best practices in response to HIV/AIDS	
33	How are the best practices being applied	
Research Area No. 9 : To assess the Potential Indicators for Monitoring and Evaluation		
34	What are the potential indicator for monitoring and evaluating HIV/AIDS activities in the Municipality	

ORGANISATIONAL PROFILE

DETAILS	***RESPONSE***
Name of organization	
Type of organization	NGO

(*tick)*	Government
	Religious
Statement of purpose	
Contact Details	Physical Address
	Postal Address
	Telephone
	Fax
	E- mail
Description of services	Prevention
	Treatment
	Care and support
	Impact mitigation
Target Groups	
Geographical Coverage	
Source of Funding	

APPENDIX 8

MUNICIPALITY QUESTINAIRE 2

SITUATION ANALYSIS OF HIV/AIDS IN ZOMBA MUNICIPALITY

STRATEGIC POSITIONING OF THE MUNICIPALITY IN VIEW OF THE HIV/AIDS PANDEMIC

Section 1 General Information

DATA COLLECTION SHEET

Date & Time		Session Number	
Name of Facilitator		Names of other Facilitators	
Method/Tool used		Duration of Session	
Number of Respondents at beginning		Number of Participants at end	

Place Session Held		Special Conditions	
Materials Used		Other Information	
Description of Respondents			
No of Men			
No of Women			
Age Group(s)			
Main Work Activity Areas			
Marital Status			

NB: If the space provided for response is not adequate use the backside of the sheet

Section 2: Information on

Research Topic with Areas for Probing		Response
	Research Area No. 10: To assess the Municipality's Strategic Positioning in view of the HIV/AIDS pandemic	
1	What is the Municipality's Competitive advantage on matters of HIV/AIDS	
2	What limitations is the Municipality facing in regard to HIV/AIDS	
3	Mention the favourable conditions in the environment in regard to matters of HIV/AIDS	
4	What constraints or barriers is the Municipality experiencing on issues of HIV/AIDS	
5	List down issues in which the Municipality has no control (political, Economic, Social, Technological, or legal) in regard to HIV/AIDS	
6	List down the locally based community structures including committees working on HIV/AIDS activities	
7	How is the Assembly mobilising resources for HIV AIDS activities	
8	What kind of trainings have been conducted on HIV/AIDS	
9	Do you have activity plans on HIV/AIDS and can you produce documentation	
10	How are activity reports conducted	
11	What kind of linkages (collaboration) exist with other stakeholder and what strategic partnerships do you need to build	
12	What motivation and morale strategies exist	
13	Can you produce documentation on Municipality's progress indicators	
14	Can you produce records on HIV/AIDS activities and meetings including monitoring	
15	How do you think the Municipality's core business might be promoting HIV	

	acquisition and transmission	
16	What is the Municipality's in-house capacity and resources (human, technical, financial) to implement HIV/AIDS impact mitigation strategies	
17	What further resources are required	
18	How can your operational system prevent the transmission of HIV to your employees	
19	How can your core business become a vehicle for HIV/AIDS behavioral change communication for your clients	
20	How do frequent illness of your clients and deaths affect your core business	
21	To what extent does political and public commitment already exist to build response	
22	What would you regard as emerging issues, concerns, needs and priority areas for intervention on HIV/AIDS in the Municipality	
23	What data is available to show the profile and extent to which HIV/AIDS is already a problem	
24	What practical employee programs have designed for care and to prevent workers from contracting the disease and for reducing the impact of AIDS	
25	What plans are there to promote voluntary testing ARV care regimes and other work place HIV related interventions	
26	Mention the kind of support given to families affected by HIV/AIDS, orphans and improve the quality of life for the infected	
27	How are information and education materials on HIV/AIDS displayed and disseminated	
28	What kind of non-discrimination (de -stigmatisation) policies are being implemented and monitored including anti stigma messages into public leisure events	
29	What arrangement is there to ensure that all health workers have adequate information about HIV/AIDS	
30	Is there a referral system for HIV/AIDS related testing, counseling, treatment and care for vulnerable families	
31	How are market structures being used to display HIV/AIDS prevention messages	
32	How is the Assembly integrating HIV/AIDS awareness activities into the slum areas	
33	How is the Assembly addressing the growing need for burial plots and what plans are there to establish burial societies	
34	List gender balanced approaches used in your programs, why you think they were a success and they can be replicated	
35	List down the kind of promotion and support for HIV protective interventions specially designed for young people	
36	Which health facilities or support organisations are offering nutrition supplements to AIDS patients	

APPENDIX 9

Q9 GUIDE TO FOCUS GROUP DISCUSSINS WITH WOMEN GROUPS AND OTHE RESIDENTS

SITUATION ANALYSIS OF HIV/AIDS IN ZOMBA MUNICIPALITY

STRATEGIC POSITIONING OF THE MUNICIPALITY IN VIEW OF THE HIV/AIDS PANDEMIC

Section 1 General Information

DATA COLLECTION SHEET

Date & Time		Session Number	
Name of Facilitator		Names of other Facilitators	
Method/Tool used		Duration of Session	
Number of Respondents at beginning		Number of Participants at end	
Place Session Held		Special Conditions	
Materials Used		Other Information	
Description of Respondents			
No of Men			
No of Women			
Age Group(s)			
Main Work Activity Areas			
Marital Status			

NB: If the space provided for response is not adequate use the backside of the sheet

Section 2: Information on

Research Topic with Areas for Probing		Response
Research Area No. 10: To assess the Municipality's Strategic Positioning in view of the HIV/AIDS pandemic		
1	What kind of trainings have been conducted on HIV/AIDS	
2	How do you think the Municipality's core business might be promoting HIV acquisition and transmission	
3	What would you regard as emerging issues, concerns, needs and priority areas for intervention on HIV/AIDS in the Municipality	
4	What practical employee programs have designed for care and to prevent workers from contracting the disease and for reducing the impact of AIDS	
5	What plans are there to promote voluntary testing ARV care regimes and other work place HIV related interventions	
6	Mention the kind of support given to families affected by HIV/AIDS, orphans and improve the quality of life for the infected	
7	How are information and education materials on HIV/AIDS displayed and disseminated	
8	What kind of non-discrimination (de -stigmatisation) policies are being implemented and monitored including anti stigma messages into public leisure events	

9	Is there a referral system for HIV/AIDS related testing, counseling, treatment and care for vulnerable families	
10	How is the Assembly integrating HIV/AIDS awareness activities into the slum areas	
11	List gender balanced approaches used in your programs, why you think they were a success and they can be replicated	
12	Which health facilities or support organisations are offering nutrition supplements to AIDS patients	
13	List down work place HIV related interventions	
14	Outline service providers operating in the Municipality in response to HIV/AIDS (type of service, target group, geographical coverage)	
15	List down the Municipality's activities on HIV prevention, care and support, and mitigation	
16	Have we ever known or seen an AIDS patient and the related measures to improve their quality of life	
17	What kind of assistance are orphans, affected households getting	
18	List down high and low risk groups you know and give reasons	
19	List down the factors that are fueling the HIV/AIDS pandemic in the Municipality	
20	How vulnerable are women to the risk of contracting the HIV	
21	Is the resource access and opportunities between men and women different	
22	Are cultural practices such as casual and ritual intercourse –initiation and widow inheritance a problem	
23	Do women have the capacity to negotiate for sex and do women have complete control on their live	
24	Are women still being taught to be submissive to males	
25	Who should please the other during sex	
26	Are women taught never to refuse sex with their husbands even when they know they are suspected to have HIV or STI	
27	What copying strategies do women have for dealing with poverty- can they exchange sex for gifts or money in light of the HIV/AIDS pandemic	
28	Whose responsibility is caring for the sick and nurturing orphaned children in a family	
29	How does HIV diagnosis affect the course of women's lives	
30	What is the perception on the services regarding the Prevention of transmission from mother to child during delivery	

MAINSTREAMING CHELIST

No.	Mainstreaming Aspect	Action Taken?
1	**Leadership support and commitment**	
	• Leadership support at all levels identified	
	• Leadership contact point developed	
	• Expected specific leadership activities defined	
	• HIV/AIDS key performance indicators at all leadership levels developed	
	• HIV on management agenda placed	
	• Leaders involved in inter- organizational committees	
	• Human, financial and material resources allocated	

2	*Policy, legislation and procedure*	
	• Existing policies and legislation for HIV/AIDS implications	
	• Sectoral policies and legislation to support HIV/AIDS prevention, care and discrimination revised	
3	*Participatory planning*	
	• Gender disaggregated data collected and database developed	
	• Gender based situation analysis conducted	
	• Audit of potential partners and stakeholders on human, financial and material resources conducted	
	•	
4	**Process of implementation (Management and Coordination)**	
	• Steering and technical committees established	
	• Human, financial and material resources required verified	
	• HIV/AIDS Coordinator appointed	
	•	
5	**Process of implementation (Implementation of action plans)**	
	• Capacity building and succession plans instituted	
	• Preventive measures i.e. distribution of condoms, provision of VCT services instituted	
	• Curative measures i.e. clinic based and home based care instituted	

APPENDIX 10

THE RESEARCH TEAM

1	W. M. PHIRI	Lead Consultant
2	O. B. CHING`OMA	Data Collection
3	F. NANKUYU	Data Collection
4	MRS. M. MCHOMBO	Data Collection

APPENDIX 11

TERMS OF REFERENCE

BACKGROUND:

The Situation Analysis will assist to establish the impact of the epidemic and identify gaps and needs for HIV/AIDS impact mitigation strategies for the Municipality.

OBJECTIVES OF THE CONSULTANCY

- To assess the Scope, Scale and trends HIV/AIDS epidemic in Municipality
- To develop city HIV/AIDS Profile
- To develop a database and profile for HIV/AIDS Activities
- To identify high and low risk population
- To identify high areas of impact and high risk factors that fuel the HIV pandemic
- To identify and describe services being provided in the Municipality, target groups, geographical coverage of the existing services and providers of services (mapping)
- To identify gaps in the service delivery in the city for HIV/AIDS related services
- To identify best practices and means of application

EXPECTED OUTPUT

- Provide Municipal Profile on HIV/AIDS
- Identify potential indicators for monitoring and evaluation of HIV/AIDS responses
- Provide Statistics and future projections of HIV/AIDS in the Municipality
- Provide a Situational Analysis Report on HIV/AIDS in the Municipality and recommendations

PERIOD OF CONTRACT

It is envisaged that the Situation Analysis should be concluded within 14 days, including the period of desk review, consultations and production of the report.

APPENDIX 12

THE HIV/AIDS MAINSTREAMING CHECKLIST

No.	Mainstreaming Aspect	Action Taken?
1	**Leadership support and commitment**	
	• Leadership support at all levels identified	
	• Leadership contact point developed	
	• Expected specific leadership activities defined	
	• HIV/AIDS key performance indicators at all leadership levels developed	
	• HIV on management agenda placed	
	• Leaders involved in inter- organizational committees	
	• Human, financial and material resources allocated	
2	*Policy, legislation and procedure*	
	• Existing policies and legislation for HIV/AIDS implications	
	• Sectoral policies and legislation to support HIV/AIDS prevention, care and discrimination revised	
3	*Participatory planning*	
	• Gender disaggregated data collected and database developed	
	• Gender based situation analysis conducted	
	• Audit of potential partners and stakeholders on human, financial and material resources conducted	
	•	

4	**Process of implementation (Management and Coordination)**	
	• Steering and technical committees established	
	• Human, financial and material resources required verified	
	• HIV/AIDS Coordinator appointed	
	•	
5	**Process of implementation (Implementation of action plans)**	
	• Capacity building and succession plans instituted	
	• Preventive measures i.e. distribution of condoms, provision of VCT services instituted	
	• Curative measures i.e. clinic based and home based care instituted	

APPENDIX 13

LIST OF VCT CLINICS

1 Banja La Mtsogolo (BLM)
2 Hope for Life
3 MACRO
4 Zomba Central Hospital
5 Matawale Health Centre
6 Police College Hospital
7 Cobbe Barracks Hospital
8 Chinamwali Private Clinic

APPENDIX 14

LIST OF ART CLINICS

1 Zomba Central Hospital
2 Police College Hospital
3 Cobbe Barracks Hospital

Appendix 15

VCT QUESTIONAIRE
SITUATION ANALYSIS OF HIV/AIDS IN ZOMBA MUNICIPALITY

Section 1 General Information

DATA COLLECTION SHEET

Date & Time		Session Number	

Name of Facilitator		Names of other Facilitators	
Method/Tool used		Duration of Session	
Number of Respondents at beginning		Number of Participants at end	
Place Session Held		Special Conditions	
Materials Used		Other Information	
Description of Respondents			
No of Men			
No of Women			
Age Group(s)			
Main Work Activity Areas			
Marital Status			

NB: If the space provided for response is not adequate use the backside of the sheet

Section 2: Information on

Research Topic with Areas for Probing		Answer
	Research Area No 1: To assess the scope, scale and trends of HIV/AIDS epidemic in the Municipality	
1	What is the frequency of your operation (days and times)	
2	Mention preventive counseling measures you conduct	
3	How suitable is your site for VCT and what are the reasons for selecting the site	
4	Name other close service providers e.g. who provide care and support	
5	What steps are you taking to sensitise the community on VCT benefits and de-stigmatisation	

6	What are some of the VCT post service perceptions and misconceptions	
7	Mention follow up strategies your centre conducts	
8	What has been the VCT client test trends	(Use the attached sheet)

VCT CLIENT TEST TRENDS

		MALE		FEMALE		TOTAL		
YEAR	**SITE**	**UP TO 24 YEARS**	**25+ YEARS**	**UP TO 24 YEARS**	**25+ YEARS**	**MALE**	**FEMALE**	**COUPLE SCREENING BEFORE MARRYING**
2001	Static							
	Outreach							
2002	Static							
	Outreach							
2003	Static							
	Outreach							
2004	Police Col							

2005	Static							
	Outreach							
TOTALS								

APPENDIX 16

ARV Therapy

Section 2: Information on

Research Topic with Areas for Probing		Answer
	Research Area No 1: To assess the scope, scale and trends of HIV/AIDS epidemic in the Municipality	
1	What is the frequency of your operation (days and times)	
2	Mention preventive counseling measures you conduct	
5	Name other close service providers e.g. who provide care and support	
6	What steps are you taking to sensitise the community on ARV benefits and de-stgmatisation	
7	What are some of the ARV post service perceptions and misconceptions	
8	Mention follow up strategies your centre conducts	

8	What has been the ARV client test trends	(Use the attached sheet)

ARV CLIENT TRENDS

		MALE		FEMALE		TOTAL		TOTALS
YEAR	**SITE**	**UP TO 24 YEARS**	**25+ YEARS**	**UP TO 24 YEARS**	**25+ YEARS**	**MALE**	**FEMALE**	
2001	Static							
	Outreach							
2002	Static							
	Outreach							
2003	Static							
	Outreach							
2004	Static							
	Outreach							
2005	Static							
	Outreach							

ZOMBA MUNICIPAL ASSEMBLY

HIV AND AIDS WORKPLACE POLICY

June 2006

CONTENTS

ACRONYMS USED IN THIS DOCUMENT:

Affected Employee: An employee who is affected in some way by HIV and AIDS e.g. an employee whose spouse has AIDS.
AIDS The Acquired Immuno-Dificiency Syndrome.
ARVs Anti-Retroviral drugs.
AMICAALL Alliance of Mayors Initiative for Community Action Against HIV/AIDS at Local Level.
C & T Counselling and Testing for HIV.
DFID Department for International Development.
HAC HIV/AIDS Coordinator
HIV Human Immuno-deficiency Virus - the virus that destroys the body's immune system and eventually leads to AIDS.
HIV Positive A person who has tested positive for HIV infection.
IEC Information, Education and Communication
ILO International Labour Organization.
Infected Employee An employee who has tested positive for HIV or who has been diagnosed as having AIDS.
STI Sexually Transmitted Infections.
TB Tuberculosis.

1.0 INTRODUCTION

Zomba Municipal Assembly is a local government area formed by Government under the Local Government Act of 1998. It is charged with the responsibility to provide infrastructural services, local governance and other social services to the people who reside in its area of jurisdiction.

To enable the Assembly deliver these services to the residents, it has a workforce of about 450 employees; 6% of whom are in senior management positions such as Chief Executive, Heads of Departments and Assistant Heads of Departments etc. The rest are junior members of staff such as labourers.

Currently, there are no records of how many members of staff are infected with HIV at the Assembly, although many may be affected; thus the need for the Zomba Municipal Assembly to come up with a Workplace Policy on HIV/AIDS in order to educate its employees on the disease so that people would open up and come forward to access the services on offer, in addition to preventing the disease from spreading further amongst the workforce and the surrounding community from which the Assembly draws most of its employees.

2.0 METHODOLOGY

The development of this Workplace Policy on HIV/AIDS has been guided by several consultation meetings with both senior and junior members of staff of the Assembly.

A number of documents such as the National HIV and AIDS Policy, Blantyre City Assembly HIV and AIDS Workplace Policy, the DFID and World Bank reports on Local Government response to HIV/AIDS pandemic, the International Labour Organization (ILO) guidelines on workplace policy development were utilized in coming up with the Zomba Municipal Assembly Workplace Policy on HIV and AIDS.

3.0 BACKGROUND INFORMATION

Malawi has a population of about 12,000,000 people, around 80% of whom live in rural areas, although there is a lot of rural to urban migration in search of business and work opportunities. Majority of these immigrants (90% according to 2006 UN HABITAT Report) live in squatter and informal areas where HIV/AIDS is one of the major threats apart from poor housing, poor access to social services and other infectious diseases such as TB and cholera.

Malawi is one of the countries that has been severely affected by the HIV and AIDS pandemic in SADC region with an adult (15 – 49 year old) prevalence rate of about 14% (NAC - 2005). The first case of AIDS was diagnosed in 1985 in Zomba and since then the disease spread in the country with prevalence rate reaching 15.5% before stabilizing at 14.0% in 2005. Almost twice as many adults (23%) are infected with the AIDS virus in urban areas compared to rural areas (12.3%).

The Municipality of Zomba is one of the four (4) major urban centres in Malawi (the others are cities of Blantyre, Lilongwe and Mzuzu). It has a population of 65,915 (according to the

1998 NSO figures). However, currently, the population is estimated to be about 108,000. The increase in the population is mainly due to natural increase and rural to urban migration.

Zomba Municipal Assembly, the only municipal assembly in the country and the old capital city of Malawi, was established as a planning area in 1955 and became a Municipality in 1976. It is home to the headquarters of the University of Malawi and one of its constituent colleges - Chancellor College.

According to the National AIDS Commission, 18% of the population of Zomba is living with HIV and AIDS (NAC – 2005 – Monitoring and Evaluation Report).

4.0 HIV/AIDS AT THE WORKPLACE - SITUATION ANALYSIS

The impact of HIV and AIDS is increasingly being felt at Zomba Municipal Assembly as a workplace. This is manifested in a number of ways, some of which are as follows:-

- Increased illnesses and deaths of Assembly members of staff and their spouses and family members.
- Increased Assembly expenses on illnesses, funerals and transport costs when ferrying dead bodies to employees' villages.
- Absenteeism due to illnesses and funerals.
- Increased Assembly expenses on emergency loan advances to members of staff.
- Reduced productivity at the workplace due to either illnesses or funerals as employees escort remains of dead colleagues.
- Increased costs of training and replacement of staff.

The Zomba Municipal Assembly is charged with the responsibility of performing and delivering various functions and services to the residents of the municipality. The services include:-

- Administrative and financial Services.
- Health and Community Services.
- Parks and Recreation.
- Fire and Emergency Services.
- Cleansing Services.
- Engineering Services.
- Town Planning and Estates Management.
- Urban Primary Education.

Just like any other organization in Malawi and as an employer, HIV and AIDS and the negative impacts of the pandemic as outlined above, have affected the Assembly.

Even though the exact number of people living with HIV and AIDS is not known at the Assembly, there is a general feeling that the number could be very high. Very few people have come forward to declare their status.

Although all employees of Zomba Municipal Assembly are at risk of HIV infection, there are certain cadres of staff that are thought to be at highest risk.

These include:-

- People working at rest houses, especially security guards
- Employees working in the Parks and Recreation Department
- Debt Collectors
- Drivers
- Sewerage workers
- General labourers, largely due to lack of knowledge on the subject.
    - Nurse/Midwives and Health Surveillance Assistants through occupational exposures.
- Firemen and Officers on night duty.

It is therefore imperative that Zomba Municipal Assembly develops a workplace policy on HIV and AIDS to act as a guideline to its activities on the pandemic.

5. OBJECTIVES

The overall objective of the Zomba Municipal Assembly Workplace Policy is to guide the implementation of HIV and AIDS programmes at the workplace for the benefit of both Zomba Municipal Assembly and the employees of the Assembly.

The specific objectives of the Zomba Municipal Assembly are as follows:-

- To ensure that employees of Zomba Municipal Assembly are treated equally whether they are infected or uninfected with HIV and AIDS.

- To provide care and support to sick employees through provision of food items, a bursary scheme for the education of their children, etc.

- To provide interest-free loans to employees who are affected or infected with the AIDS virus.

- To provide all employees of Zomba Municipal Assembly with accurate information on HIV and AIDS and other related subjects such as STIs in order to assist them in making informed decisions on prevention and seeking care and support timely.

6.0 COMMITMENT OF THE ZOMBA MUNICIPAL ASSEMBLY

Management and staff of Zomba Municipal Assembly have taken HIV and AIDS as a major threat in the Assembly drive to implement development programmes and deliver essential services to the residents of the Municipality. HIV and AIDS have the potential to weaken the institution and destroy its memory and capacity to deliver much needed services to the

residents. Zomba Municipal Assembly is therefore committed to implement and sustain an HIV and AIDS workplace programme.

The following issues are some of the evidence of such commitment:-

- Provision of a budget line on HIV and AIDS. The total allocation this year (2006 – 2007) stands at MK2.0 million.

- Some workplace activities on HIV and AIDS are already being carried out such as, condoms distribution, meeting and workshops on HIV and AIDS.

- An HIV and AIDS Coordinator (HAC) has been employed by this Assembly to spearhead the anti- HIV/AIDS activities.

- Alliance of Mayors Initiative for Community Action Against HIV/AIDS at a Local Level (AMICAALL) programme activities have been launched in the municipality.

7.0 GUIDING PRINCIPLES

The Zomba Municipal Assembly workplace policy on HIV/AIDS is based upon and shall be guided by the following principles:-

- **Non-discrimination**

The Zomba Municipal Assembly shall ensure that the workplace is free of discrimination in any form based on HIV status – whether perceived or real.

- **Confidentiality**

Members of staff of Zomba Municipal Assembly will be under no obligation to disclose their sero-status. However, members of staff will be encouraged to disclose their HIV status to their immediate supervisors who may offer them lighter duties depending on their physical strength or assist them by linking them with places where they can access care and support. Confidentiality shall be upheld where such disclosure is made.

- **Management and Care**

Zomba Municipal Assembly shall ensure that members of staff who test HIV positive or are living with AIDS have access to:-

- Medical care in form of treatment of opportunistic infections and ARVs.
- Advice on food, psycho social support
- Soft loans (to be sourced from donors and welfare committees at the Assembly).

Zomba Municipal Assembly HIV/AIDS Workplace Committee shall work hand in hand with the Maternal and Child Health Section of the Assembly to ensure that members of staff affected or infected with HIV/AIDS have access to quality care and support and Management of the Assembly shall ensure that Anti-retroviral drugs (ARVs) shall be budgeted for in the ORT budget of the Assembly. Additional funding for the HIV/AIDS activities at the workplace shall come from various fund raising activities that will undertaken by the Assembly. Another source of supplementary funding in the Assembly is from the

Government directive that two (2) percent of its departments' budgets be used for HIV/AIDS activities.

The HIV/AIDS Workplace Committee in collaboration with Management of Zomba Municipal Assembly shall ensure that conditions of service are revised from time to time in the face of the HIV and AIDS pandemic.

The HIV/AIDS Workplace Committee at Zomba Municipal Assembly shall be reporting to the HIV/AIDS Co-ordinator in the Public Health and Environment Department.

8.0 PROGRAMMES ON HIV/AIDS AT THE WORKPLACE

In order to slow down the spread of HIV and AIDS and other sexually transmitted infections amongst its employees and the surrounding communities, Zomba Municipal Assembly shall embark on the following activities:-

- Establish more recreation centres, such as football pitches in residential areas, for use by employees and residents of the municipality.

- Conduct more HIV and AIDS awareness campaigns and meetings targeting various groups in the Assembly.

- Promote and distribute condoms. The Assembly shall make condoms available freely at all its work stations. Procurement of condoms shall be budgeted for in the ORT budget or sourced from donors.

- Educate all employees living with HIV and AIDS on good nutrition and offer them psychosocial support in form of counselling.

- Procure IEC materials on HIV/AIDS. The HIV/AIDS coordinator shall initiate a process of HIV/AIDS information, education and communication process tailor-made for specific groups of employees. These processes would be done through drama, poster, lectures etc.

- Ensure that all new employees undergo medical check-up including tests for HIV. However, a qualified HIV positive prospective employee who is **medically fit, shall not be denied an opportunity to be employed by the Assembly.**

- The Assembly shall endeavour to provide protective clothing to its employees in order to reduce the risk of occupational exposure to HIV at the workplace.

▪ Peer Education

The Assembly shall train peer educators to carry out HIV and AIDS education at various workstations of the Assembly. This activity shall be supported by formation of HIV and AIDS clubs in various Assembly workplaces and involve staff at different cadres.

▪ Counselling and Testing

In order to encourage members of staff and their spouses to go for counselling and testing (C & T) as an entry point for care and support, the Assembly shall provide training for its own

counsellors and set up a testing centre in the staff clinic where ARVs will be provided to employees who need them.

9.0 COORDINATION OF HIV/AIDS ACTIVITIES

As a local authority, Zomba Municipal Assembly is responsible for coordination and management of HIV and AIDS activities in the Municipality. The HIV/AIDS Coordinator shall be responsible for facilitation and implementation of all activities on HIV and AIDS in partnership with other stakeholders such as civil society organizations in the municipality.

In addition to the above, the HIV/AIDS Coordinator shall be expected to plan, design, monitor and evaluate all HIV and AIDS activities in the Assembly. He/She will produce reports for the Head of Public Health and Environment, who in turn, will be expected to brief the Management Team and other relevant structures of the Assembly on all HIV/AIDS activities taking place in the municipality.

Management Team of Zomba Municipal Assembly shall demonstrate support of the workplace HIV/AIDS programme by amongst other things, funding HIV/AIDS activities, attending meetings and workshops on HIV/AIDS, etc.

Implementation of this workplace policy on HIV/AIDS shall be reviewed whenever a need arises to accommodate changing needs at the workplace. The Assembly shall make an annual assessment of the impact of the pandemic in the Assembly such as analysing medical bills, funeral costs, etc. for Management Team's consideration and mapping way forward

Employee benefits (including terminal benefits), training policy, recruitment policy, etc, shall be reviewed periodically in the context of HIV and AIDS.

10.0 MONITORING AND EVALUATION

Zomba Municipal Assembly shall monitor and evaluate its workplace activities on HIV/AIDS in order to assess the effectiveness of the interventions. The data collected shall assist the Assembly in coming up with new strategies to address the gaps that will be identified.

The Monitoring and Evaluation Officer shall take a leading role this exercise, however, the HAC with the support of top management and all members of staff shall decide on the next course of action once the data has been analysed.

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