

*Managing HIV/AIDS
at the Local Level in Africa*

*Project outputs and
achievements*

BLANTYRE, MALAWI

2006

*& Blantyre Case Study
& Blantyre HIV/AIDS City
Profile
& Blantyre City Assembly
Work Place Policy*

MANAGING THE HIV AND AIDS PANDEMIC AT THE LOCAL LEVEL

EXPERIENCE FROM THE BLANTYRE CITY ASSEMBLY, MALAWI

A. INTRODUCTION

Malawi is a small landlocked country in Southern Africa with a population of 12 million. For administrative purposes, the country is divided into three regions, namely Northern, Central and Southern regions, with the latter being the most densely populated compared to the other two regions.

The economy of Malawi is largely agro-based with tobacco, tea and sugar being the major export crops for the country. As a result, there is a lot of internal migration as families move from rural areas and other districts to the farm areas in search of employment.

HIV/AIDS SITUATION IN MALAWI

The first case of HIV infection in Malawi was diagnosed in 1985. HIV prevalence currently stands at 14.0%. The prevalence is highest in urban areas (17.1%) compared to rural areas (10.8%). According to the 2005 evaluation report, 930,000 Malawians are living with HIV and AIDS and the country has recorded a total of 430,000 orphans to date.

The Southern region of Malawi has the highest HIV prevalence in Malawi at 18.6%, followed by the Northern region, 13.5% and the Central region with 9.3% of the population infected with HIV.

HIV PREVALENCE AMONG PREGNANT WOMEN.

There has been slight drop in prevalence of HIV infections in pregnant women in Malawi between 2003 and 2005. In 2003, HIV prevalence was at 21.7% and dropped to 20.4% in 2005 in urban areas compared to rural areas, 14.5% in 2003 to 13.0% in 2005. The highest rate of HIV infection is found in young pregnant women aged between 25 to 29 years of age. Across the whole country, HIV prevalence in pregnant women has dropped from 19.8% in 2003 to 16.9%.

CITY OF BLANTYRE

The City of Blantyre is the oldest city in Malawi and in Southern Africa. It was established in 1876 when Scottish missionaries, led by Dr. David Livingstone, passed through the area in the early 1870s. Later more missionaries and traders followed to set up a church (the Blantyre Mission, which is still standing today) and businesses in the "City". It was called Blantyre in reference to a place called Blantyre near Glasgow, Scotland, the birthplace of Dr. Livingstone. Today, the City of Blantyre is the main industrial and commercial center for Malawi and nearly all industries in the country have their headquarters here. The major industries in the City are manufacturing and tourism.

HIV/AIDS SITUATION IN THE CITY OF BLANTYRE

The City of Blantyre has a population of 800,000 with an annual growth rate of approximately 3%. Being the industrial and commercial hub of the country, there is a lot of migration from the rural areas and the surrounding districts into the City in search of employment and business opportunities. Others come to the City in search of social services, such as education and health services.

Almost 60% of all new migrants to the City of Blantyre live in unplanned and squatter areas that have sprung up in the peri-urban areas of the City. Over-crowding, poor housing, drug and alcohol abuse,

low access to some social services such as safe water supply and infectious diseases such as diarrheal diseases, cholera and HIV/AIDS, are some of the major threats faced by the residents in these unplanned areas. According to reports from the National AIDS Commission for 2005, HIV prevalence in the City of Blantyre stands at 19%, a drop from 21.0% in 2003. This represents about 150,000 people living with HIV/AIDS in the City. This figure could be an under-estimate, as not all people have been tested for HIV, and could also be influenced by the fact that some people come to the City to seek medical care as the City is home to the biggest referral hospital in the country.

The City of Blantyre was home to the highest number of people living with HIV/AIDS in the country until recently, when the rural district of Nsanje in the Southern region of Malawi topped in number of PLWHA. In the City of Blantyre, most of the infections occur in young people aged between 15 and 24 years of age. Young females are twice as likely to be infected with HIV as young men, probably because older men have sexual relationships with young women. Other contributing factors playing a role in the high levels of HIV infections could be as follows:

- Important knowledge gaps about HIV/AIDS;
- Incorrect and inconsistent use of condoms;
- Harmful cultural practices;
- Gender inequalities;
- Poor socio-economic status of women;
- Stigma and discrimination;
- Low risk perception, especially among the youth who may view HIV/AIDS as a problem for the “grown ups”, and;
- Lack of dialogue and the culture of silence (spouses, families, workplaces and in the communities).

Because of the high prevalence rate of HIV infection in the City prior to 2002, a number of interventions were taking place in the City of Blantyre through the District AIDS Co-ordinating Committee, (DACC) for Blantyre District, some Non-Governmental Organizations (NGOs) and Faith Based Organizations (FBOs), but the activities were not coordinated. It was therefore very common to find several organizations working in the same area without relating to each other, leading to the duplication of efforts and waste of scarce resources. Blantyre City Assembly (BCA) was not aware of what was going on the ground and neither the City Assembly nor the other organizations working on HIV/AIDS knew much about the magnitude of the HIV/AIDS situation in the City.

Nearly all local communities in the City of Blantyre were mere “spectators” of the projects, as they were never involved in the planning and execution of HIV/AIDS project activities for ownership and continuity when and NGO left the community. The relationship between the City Assembly and most civic groups working on HIV/AIDS was not good because most of them were well resourced and felt that the City Assembly was there to control their activities.

B. BACKGROUND TO THE BLANTYRE CITY ASSEMBLY HIV/AIDS INITIATIVE

In February 2002, the Blantyre City Assembly, upon invitation from the Malawi Local Government Association (MALGA,) took part in a regional workshop on “Strengthening Civic Participation in Municipal Governance and Development in Eastern and Southern Africa” organized by Municipal Development Partnership for Eastern and Southern Africa (MDP-ESA) and the World Bank Institute in Mozambique. Following this workshop, Blantyre City Assembly requested MDP-ESA to assist with a study to work at the existing work relationship between BCA and civic groups that were based in the city. A good number of big civil society organizations are headquartered in the City of Blantyre but concentrated their work in the rural areas. They felt that the Blantyre City Assembly was well resourced and can work without their support. They also felt that the problems of the urban areas

were too complex for the organizations, and that communities in the urban areas were not easy to mobilize.

A study was therefore commissioned in May 2002 to look at the relationship between civic groups and BCA and find ways in which this social capital could be utilized to benefit the urban poor in the form of social services delivery, etc. In addition, the study sought ways of strengthening the relationship between BCA and the civil society organizations, building on the Local Government Act of 1998, which provides a legal framework for decentralization and promotion of democratic decision making by local authorities in the country by leveling the playing field to allow people to decide, plan and implement projects at the local level.

The study was conducted through literature reviews, focus group discussions, seminar feedback and interviews with stakeholders such as civil society groups, officials from the City Assembly (members of staff and councilors), private sector, other Government Departments and institutions and individuals. The results of the study indicated that even though there is a legal framework for more formal interaction between the City Assembly and civil society organizations, most of the interactions were on an informal basis, including such initiatives as clean-up campaigns, cholera taskforces, Local Agenda 21 activities, etc. There was also an indication from the study that some NGOs, just like some residents, were ignorant on issues of governance and development in the City. This could be attributed to the fact that at the time of the study, no civic group was involved in civic education on development and governance issues.

The findings of the study also indicated that officials from the City Assembly viewed civic groups as having narrow and short term project focus and as not willing to participate in long term development programmes of the City. The City Assembly also felt that some civic groups lacked legal mandate, were formed for personal benefit or indulged in local politics.

In conclusion, the study demonstrated a deep-seated mistrust between civic organizations and Blantyre City Assembly. At the same time, there was a yearning for collaboration from both the civic groups and the City Assembly.

METHODOLOGY

The results on the study on strengthening civic participation in Municipal Governance in the City of Blantyre were presented at a City-wide consultation workshop organized by Blantyre City Assembly with assistance from MDP-ESA and Urban Management Programme-South Africa Office in December 2002. Various stakeholders attended from civic groups, private sector, rate payers, City Assembly officials, members of the Community Development Committees, etc. After two days of discussion, it became evident that there was need for a very close working relationship between the civic groups and the City Assembly. The civic groups indicated three major areas in which they could collaborate with the City Assembly and these areas were as follows:

- Municipal HIV/AIDS management.
- Participatory Budgeting.
- Public-Private Sector development partnerships.

Following further consultations with the stakeholders, it was finally decided to pilot on collaboration between the City Assembly and the civic groups on management of HIV/AIDS at the local level with technical and financial assistance from MDP-ESA and UMP and Southern Africa AIDS Information Dissemination Service (SAfAIDS).

The decision to pilot on management of HIV/AIDS at the local level was made for the following reasons: -

- HIV and AIDS have negative effects on the socio-economic development of the City of Blantyre.

- There is an increased demand on health services as patients with HIV/AIDS related illnesses occupy over fifty percent of medical beds at the main referral hospital in the City.
- There is an increase in morbidity and mortality because of HIV/AIDS related illness, such as tuberculosis, leading to increased demand for cemetery space.
- There has been a noticeable increase in child-headed families at the community level.
- There have been increases in school-drop out as financial resources are re-directed towards sickness of parents or breadwinners.
- The number of orphans and street children who require care is increasing.
- Significant institutional memory loss occurs when well trained member of staff get sick and die.
- There are increases in medical and funeral costs as many organizations and Government Departments struggle to care for their sick employees and transport dead bodies to their respective villages.
- The number of families below the poverty line is rising, again, as more and more family financial resources are spent on illness and funerals.
- Deaths of productive members of families have led to food insecurity in some families and communities.
- Early payments of death benefits on newly result from recruited employees who fall sick and die.
- There has been reduced participation in self-help projects at the ward level because of illnesses and deaths of very active members of the communities.
- Many institutions and organizations have faced reduced productivity.
- The effectiveness of local government service delivery has been reduced through higher staff turnover and absenteeism due to funerals and illnesses.
- Capabilities for families to pay for services from City Assembly and other service providers, such as water boards, has decreased.

OBJECTIVES

The objectives of the Blantyre City Assembly HIV/AIDS Initiative were as follows: -

Broad Objective:

To come up with a broad based multi-sectoral and well-coordinated intervention against the HIV/AIDS pandemic in the City of Blantyre.

Specific Objectives:

- To improve the relationship between Blantyre City Assembly and civic groups and community organizations in the fight against HIV/AIDS in the City of Blantyre.
- To coordinate anti HIV/AIDS activities at the local level.
- To mobilize adequate resources for the fight against HIV/AIDS at the local level.
- To improve the capacity of Blantyre City Assembly in leading the fight against HIV/AIDS.
- To promote partnership with local, regional and international organization in the fight against HIV/AIDS.

Following a citywide workshop, eight priority areas were identified as focus areas for the Blantyre City Assembly, and these were as follows:

- Information dissemination.
- Condom promotion.
- Stigma and discrimination.
- Women/girls and HIV/AIDS.
- Harmful traditional practices that promote spread of the virus.
- ART
- Behavioural change in the face of HIV/AIDS.
- Counselling and testing.

ROLES OF BLANTYRE CITY ASSEMBLY

At the city wide consultative workshop, the Blantyre City Assembly was asked to provide leadership in the fight against the pandemic. They were asked to coordinate all activities at the local level for the maximum utilization of resources, since at that time, the Assembly was already carrying out some anti-HIV/AIDS activities such as workplace activities, school-programmes on HIV/AIDS and reproductive health, condom promotion and distribution, sexually transmitted infections (STI) screening and treatment. In addition, local government is closest to the people and is charged with responsibility to safeguard the well being of residents in its area of jurisdiction. It is also possible for local government to mobilize citizens through elected councilors, mobilize resources through linkages with other partners and promote local community participation in various activities.

C. PROCESS

Following the citywide consultation, Blantyre City Assembly has successfully undertaken the following:

- Prepared and produced a catalogue of all CBOs, NGOs, FBOs, and Community organizations working on HIV/AIDS in the City Assembly. This exercise has helped with the mapping of HIV/AIDS activities in the city.
- Worked with local organization to identify gaps in terms of capacity and resources and sought ways of filling these gaps.
- Mobilized local communities at the ward level to take part in planning, execution and monitoring of community based activities on HIV/AIDS. This has empowered local communities to own and continue with activities once an NGO or CBO has left an area. In addition, the process has encouraged local communities to identify local cultural and socio-economic factors fuelling the spread of HIV at this level and come up with possible solutions.
- Mobilized resources both locally and internationally to enable local organizations (including the City Assembly itself) to carry out many anti HIV/AIDS activities.

ACTIVITIES CARRIED OUT UNDER THE HIV/AIDS INITIATIVE

Since the inception of the Blantyre City Assembly HIV/AIDS initiative, the following activities have been carried out:

(a) City of Blantyre HIV/AIDS Profile. This activity was carried out at the early stages of the initiative to identify the extent of the HIV/AIDS problem in the City of Blantyre, and which organization is doing what and where. It also identified the most common modes of HIV transmission, most commonly infected groups of people and the associated risk factors. The HIV/AIDS Profile also made some recommendations to Blantyre City Assembly and its partners as to which areas needed urgent attention in the fight against the pandemic.

(b) Transformational Leadership Training. Sixty volunteer interviewers drawn from local stakeholders including the City Assembly were elected to undergo training conducted by a team of international partners (UNDP, UMP, MDP-ESA, UN-HABITAT). Over half of those trained came from NGOs, CBOs and FBOs. The objective of the training was to equip trainees with the skills to carry out “appreciative inquiry” interviews in the City on the respondents’ aspirations about HIV/AIDS; the good things that they have done or seen happen in the city on HIV/AIDS. This approach emphasized the positives and successes rather than the negatives so that the Assembly and its partners could build on these success stories for future activities on HIV/AIDS and other related subjects.

(c) Community Conversation Facilitators Training. One of the objectives of BCA’s HIV/AIDS initiative is to empower communities at the local level to take an active role in the fight against the HIV/AIDS pandemic. With this in mind, out of the forty-six (46) participants to the training workshop, thirty (30) came from Ward Health Committees, which are sub-committees of Community Development Committees.

The facilitators were trained to enable them to trigger conversation on HIV/AIDS by engaging local people in a discussion on HIV/AIDS and related subjects. This allowed them to discover what the people know already about the subject matter. It also created a safe environment for people to ask questions and get feedback from the trained facilitators and their peers on the spot to remove fears, myths and other misconceptions that community members have on HIV/AIDS, in addition to the benefit of mutual learning.

The training changed the way information on HIV/AIDS is passed on from one person to another in the City of Blantyre. The norm in the past was for officials from BCA to go out and give out leaflets and posters to the residents at various workplaces. Success was measured by the number of leaflets and posters that were distributed without much regard as to whether the recipients of these leaflets were going to understand, let alone read them. However, following the training on Community Conversations, residents are now engaged in a dialogue/conversation on the subject before any leaflets are handed out. This often generates into discussion on the subject whereby the residents are given an opportunity to ask questions on HIV/AIDS and other related issues such as condom use, TB, ART, C&T, etc and answers are provided on the spot in most cases. There are also opportunities for the facilitators to demonstrate on proper use of condoms and their disposal.

The trained facilitators visited different work places such as produce markets, street, bars, taverns, bottle stores and brothels etc. During such visits, BCA and its partners have taken other services such as Counseling and Testing (C&T) mobile units for HIV. This has proved very popular, as many people are not able to leave their business premises to go for C&T service at stationary sites which were often far away. The Malawi AIDS Counseling and Resource Organization (MACRO) and Malawi Red Cross have been very helpful in this regard by providing the HIV testing kits, counselors and shelter in form of tents. In almost all the areas that the facilitators have visited, BCA has been requested to continue with the dialogue sessions so that many more people are reminded about HIV/AIDS. In other cases owners of bottle store and bars have asked BCA to go to their premises and hold discussions with the patrons.

Community Conversations have proved to be a very powerful method of passing on information about HIV/AIDS to the general public and are probably superior to leaflets, posters and use of media, as they engages the recipient of the information in a dialogue. The recipient is more than a mere “receiver” with no chance of asking questions. Since the training took place in 2003, almost every corner of the City has been visited several times to engage communities in discussions on HIV/AIDS, STI, TB, condom promotion and disposal, ARVs etc.

(d) HIV/AIDS Activisms. Using Community Conversations as a technique of communicating with the general public, Blantyre City Assembly, together with its local partners, carried out two major activism sessions on HIV/AIDS and many minor ones since 2004, targeting specific hotspots such as bars, rest houses, brothels, produce markets and other places frequented by sex workers in the City of Blantyre. The first major Activism was held over 10 days, the second over 20. During the sessions, male and female condoms were distributed and demonstrations were held on correct use and disposal. Information on HIV/AIDS, TB, STIs, ART, Counselling and Testing, and more, was shared. Clients identified to have clinical conditions were referred to Government and City Assembly clinics.

In addition to the above major events, the City Assembly has been involved in many local events organized by community organizations, youth groups, etc. Since 2004, five more community-based activisms have been held in specific “hot spots” in the city. BCA and UN-HABITAT have both contributed funds to these events. In March 2005, the City Assembly organized local World AIDS Day commemoration activities in the City with assistance from the National AIDS Commission.

(e) Launch of AMICAALL. The Alliance of Mayors’ Initiative for Community Action against HIV/AIDS at Local Level (AMICAALL) Malawi Chapter was launched in the City of Blantyre in

November 2003 with financial and technical assistance from NAC, UNDP and UN-AMICAALL Headquarters in Namibia. All Mayors and Chairpersons of cities, towns and district assemblies in Malawi signed a declaration to put HIV/AIDS high on their agendas in their respective local authorities.

MALGA has taken the challenge to up-scale the lessons that have been learnt in Blantyre to other local authorities in Malawi with technical assistance from UN-AMICAALL Headquarters and financial assistance from NAC and UN-HABITAT.

(f) **MACRO – Counselling and Testing**

When the Blantyre HIV/AIDS Initiative started, there were only two testing centres in the city: the Queen Elizabeth Central Hospital and the Malawi AIDS Counselling and Resource Organization (MACRO). This made it very difficult for residents who wanted to access the services to do so because of the long distance from their homes to these two centres. Stigma was also associated with these stand-alone centres.

However, as at the end of 2005, there are now 15 testing centres that have been opened in health centres in the city, and 9 more centres that are going to be opened in the near future, including BCAs own staff clinic.

The number of clients at the 15 testing centres currently ranges from 60 to 1,500 per month, with MACRO and QECH doing most of the testing. The number of clients goes up whenever BCA conducts mini activisms open days on HIV/AIDS as temporary testing centres are set up the venues. On these events between 60 and 150 clients are seen.

Patronage at our activism and open days on HIV/AIDS vary depending on the locality, but ranges between 3,000 and 10,000 people, with the open days attracting more people than the mini activisms that are usually localised. To date, it is estimated that BCA and its local partners has had direct contact with about 350,000 and 400,000 residents over the past 2 years with information on HIV/AIDS and related subjects.

FUNDING

In three years, the Blantyre City Assembly HIV/AIDS Initiative has cost nearly US\$800,000.00 from both local and international sources. At the beginning of the initiative, most of the financial and technical assistance came from MDP-ESA, SaFAIDS and UMP. However, the initiative was later linked up with other donors such as UNDP and UN-HABITAT for more financial, technical and human resources to assist the Assembly conduct training workshops for our volunteer interviewers and facilitators for community conversations and also to enable the Assembly carry out activism sessions on HIV/AIDS. SaFAIDS of Zimbabwe assisted the City Assembly with financial, technical expertise and capacity building assistance in order to set up a Resources Center on HIV/AIDS at the Civic Center.

In the later years of the HIV/AIDS Initiative, BCA started mobilizing financial and other resources locally. For example, a budget line on HIV/AIDS in the Health and Social Services Department and the City Community HIV/AIDS Challenge Fund was created, linking up NGOs, CBOs, FBOs and other community organizations with NAC for financial, technical and capacity building support to enable these organizations carry out anti-HIV/AIDS activities at the local level. To date, NAC has been the major donor of local level activities on HIV/AIDS in the City of Blantyre. In just over one year, over US\$400,000.00 has been dispersed to local organizations in the City through SAVE the Children (US) as an Umbrella Organization.

Another important source of funding for local activities on HIV/AIDS, especially in the area of impact mitigation, has been the Malawi Social Action Fund (MASAF). MASAF has been assisting local organizations with income generating activities to support orphans, single parent families, etc.

BCA gets its funding directly from NAC for CACC activities and also to carry out its own activities as an Assembly. CACC activities include meetings, CBO networking, community mobilization, community dialogue on HIV/AIDS, gender issues, community drama and video shows, etc. CBO/FBO NGO monitoring and evaluation activities are also funded by NAC directly to BCA. In addition, BCA can apply to NAC for funding for activities that are not included in the district implementation plan (DIP).

SAVE the Children (US), as an Umbrella Organization (UO), had its contract with NAC extended for another 2 years from May 2006 to give a chance for SAVE to improve the capacity of BCA to carry out the functions of the UO on its own by the end of 1 year. Thereafter, the UO will only give technical support to BCA when needed until the contract expires at the end of 2 years.

D. CHALLENGES

There have been a number of challenges that the Blantyre City Assembly HIV/AIDS Initiative has been facing in its three years of existence. These are as follows:

(a) **Low level of confidence in the City Assembly.** When the initiative got off the ground, many civic groups and the general public were very skeptical that the Assembly would manage to effectively lead the fight against the HIV/AIDS pandemic in the City, especially a programme like this one involving many organizations both local and international. Even the City Assembly itself was not sure what would happen considering the low levels of both financial and human resources at the Assembly level.

The Assembly felt that it was important to be as inclusive as possible when it came to decision-making process to ensure that many civil society groups were part of the process. This helped the Assembly to learn from its more experienced local partners, especially the international NGOs and the influential citizens in the city, whilst at the same time the partner felt that their expertise is wanted.

The Assembly also thought that it was important to be as transparent as possible with donated financial resources and be realistic with our plans. Our stakeholders knew how much money has been donated to the Assembly and for what use. Members of Assembly (councillors) were briefed were updated at every opportunity so that they would in turn brief people at the ward level. They decided to build up capacity at its level by creating position for HIV/AIDS Coordinator and it also came up an HIV/AIDS team made up of Officers from different Departments of the Assembly.

(b) **Lack of or delays in mobilizing resources.** As mentioned earlier, in the initial stages of the initiative, our international partners provided most of the financial resources. These were meant for major events such as training of facilitators. However, for all other activities, such as meetings with local partners, the resources had to come from within the City Assembly. Because of the financial difficulties that the Assembly was facing at that time, it was not possible to mobilize resources at very short notice.

BCA decided to create a budget line on HIV/AIDS in the ORT Budget of the Health and Social Services Department to cater for some meetings, campaigns, etc that may not funded from external sources. In the next financial year's budget, BCA has set aside MK18.0 million (US\$15,000.00) FOR HIV/AIDS activities.

The Assembly has linked up with NAC for financial and technical assistance from 2005. Since then, there has been regular flow of funds and reading materials to BCA from the national body.

(c) **Changes in Participants at Workshops and Training sessions.** Frequent changes in persons representing organizations at the Assembly's workshops and training sessions were another

challenge. This practice created difficulties in that some participants at the workshops and meetings had problems in contributing to the discussions because the issues were new to them.

This problem was sorted out by working with the organizations and institutions from which these participants came from and emphasizing that BCA would like to build up a team of dedicated team of participants for the initiative. The organization was requested to choose 2 Officers that would regularly be attending our workshops and meeting for continuity. Nearly all organizations agreed with the suggestion.

E. ACHIEVEMENTS

The Blantyre City Assembly HIV/AIDS Initiative has made several strides since it was initiated in 2002. Amongst the most notable ones are the following:

- BCA now works with 223 CBOs, NGOs, and FBOs on the HIV/AIDS programme. These civil society organizations have been mapped as to their catchment areas and their NAC pillars, i.e. HIV prevention, HBC, Treatment, etc. Whenever BCA is carrying out an activity in an area, it calls upon all civil society organizations in that area to work with it. In big events such the commemoration of the World AIDS Day, as many civil society groups from across the city take part.
- BCA procures and supplies ARVs to its members of staff who need it for free. This has been going on since 2004 July, under the Workplace Policy on HIV/AIDS. In addition, Ministry Of Health and Population has started providing ARVs to BCA (the only local authority at the moment) for members of the general public using our staff clinic as one of the outlets for the Government's ART expansion programme. Again, these ARVs are free.
- There has been an increase in the flow of financial resources to the City Assembly from the National AIDS Commission and other donors to support HIV/AIDS activities at the local level.
- BCA has managed to come up with a well-coordinated fight against the HIV/AIDS pandemic in the City with support from its local and international partners.
- SFAIDS, a regional NGO based in Harare in Zimbabwe, has assisted BCA establish a Resource Center on HIV/AIDS. The Resource Center is an important reference center for youth groups, researchers, NGOs, CBOs, FBOs and others working on HIV/AIDS proposals.
- The HIV/AIDS Initiative has assisted BCA to mainstream HIV/AIDS in its activities and triggered the development of Blantyre City Assembly's HIV/AIDS Workplace Policy.
- The City Assembly has been invited to a number of international fora to present its experience on management of local response to HIV/AIDS pandemic. These have exposed BCA to new information on what is happening around the world and enriched BCA's own approach to the problem.
- The Blantyre City HIV/AIDS Profile that was done at the beginning of the initiative assisted the City Assembly and its partners to realize the extent of the HIV/AIDS problem in the City for a more focused and effective approach instead of just "shooting in the dark".
- Following recommendations from NAC, BCA has formed an HIV/AIDS activities coordinating body – City AIDS Coordinating Committee (CACC) to assist the City Assembly coordinate all activities on HIV/AIDS at Assembly level. CACC is made up of key stakeholders in the field of HIV/AIDS including PLWHA, Women groups, Youth groups and

those with disabilities. In addition, a Standing Committee on HIV/AIDS, made up of elected councilors, has also been set up to critique and approve project proposals coming from local organizations before making recommendations to NAC.

- The Initiative has helped improve the relationship between Blantyre City Assembly and civic groups in the City.
- Involvement of communities at the ward level and PLWHA has helped improve capacities at that level to enable community groups come up with project proposals and look at the cultural and socio-economic factors fuelling spread HIV at the level and collectively come up with mitigation factors.
- District Implementation Plans on HIV/AIDS are now being prepared annually with contributions from all local civic groups and local communities and submitted to NAC for funding.
- New staff positions have been created in the Department of Health and Social Services, such as the HIV/AIDS Coordinator and Communicable Disease Control Officer to assist with day-to-day running of the programme on HIV/AIDS. An HIV/AIDS Team, made up of representatives from all City Assembly Departments, has been set up to take on board interests of all members of staff in this initiative. Training sessions targeting specific Assembly staff, e.g. those from Finance Department, have helped build capacity at all levels of the City Assembly structure.

F. LESSONS LEARNT

By getting involved in this initiative on HIV/AIDS, Blantyre City Assembly has learnt a number of important lessons such as:

- Strength in partnerships. Blantyre City Assembly has been able to harness power of many local organizations in the City to reach out to many more people with messages on HIV/AIDS. This would not have been possible if the City Assembly did it alone. There has been willingness by every stakeholder in this fight against HIV/AIDS to fight towards our vision – “an HIV/AIDS free Blantyre”.
- As the level of government closest to the grass roots, local government can effectively lead a fight against HIV/AIDS at a local level given good political and secretariat leadership and resources. Local Government can support civic groups and community organizations with leadership, funding for small local events, donation of land (to put up offices or start income generating activities), facilitation and offering moral support e.g. by attending local activities organized by local organizations.
- Resource mobilization can be enhanced through partnerships. Blantyre City Assembly has been able to mobilize resources through partnerships with both local and international organizations such as MDP-ESA, UMP, UN-HABITAT, NAC and MASAF to carry out important HIV/AIDS activities. One major lesson learnt in resource mobilization is that of over subscribing a subject when there are no adequate resources to support the interest that is aroused afterwards, as it happened in Blantyre.
- Use of local talent to deliver messages on HIV/AIDS is probably more effective than bringing talent from outside the District. During our various activities on HIV/AIDS, BCA and its local partners used more local drama groups, comedians, speakers, (for testimony), and others to convey the messages. It was satisfying to see that the local population was associating with these groups easily during their performances.
- Community conversation as a technique of communicating with people is a more powerful tool than the use of media e.g. radio, leaflets, etc. Community conversation provides for

dialogue on the subject matter, allowing people to ask questions and get immediate answers from their peers. It also allows for other demonstrations, e.g., how to put on a condom.

G. CONCLUSION

The Blantyre City Assembly HIV/AIDS Initiative has demonstrated that Local Government, being a government closest to the grass root level, can play an important role in the fight against the HIV/AIDS pandemic. However, because of limited resources, both human and financial, there is need for political will and presence of a champion at an Assembly level can drive the process for the benefit of residents in a local government area and beyond. In addition, partnerships with local, regional and international stakeholders will help to mobilize or leverage resources for the course. Involvement of members of the communities at the ward level is crucial to bring a sense of ownership of the project to the communities at that grass root level and continuity of the activities afterwards.

ACRONYMS USED IN THIS DOCUMENT.

AIDS – the Acquired Immuno-Deficiency Syndrome, a group of diseases including some opportunistic infections and cancers that persons with HIV often suffer from.

AMICAALL – Alliance of Mayors' Initiative for Community Action against HIV/AIDS at Local Level.

ANC – Ante-Natal Clinic.

ARVs – Anti-retroviral drugs used in HIV and AIDS patients.

BCA – Blantyre City Assembly.

CACC – City AIDS Coordinating Committee for City of Blantyre

CBO – Community Based Organization.

FBO – Faith Based Organization.

HIV – the Human Immuno-Deficiency Virus, a virus that destroys the body's immune system and eventually leads to AIDS.

MALGA – Malawi Local Government Association

MASAF – Malawi Social Action Fund.

MDP-ESA – Municipal Development Partnership for Eastern and Southern Africa.

NAC – National AIDS Commission.

NGO – Non-Governmental Organization

PLWHA – People Living with HIV/AIDS.

SAfAIDS – Southern Africa AIDS Information Dissemination Service.

STIs – Sexually Transmitted Infections.

TB – Tuberculosis.

UMP – Urban Management Programme.

UN-HABITAT – United Nations Center for Human Settlement

UNDP – United Nations Development Programme

C&T – Counseling and Testing for HIV

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PREPARED BY DR. LYCESTER R. BANDAWE, MAY 2006

THE HIV/AIDS EPIDEMIC IN BLANTYRE

10 th February 2004

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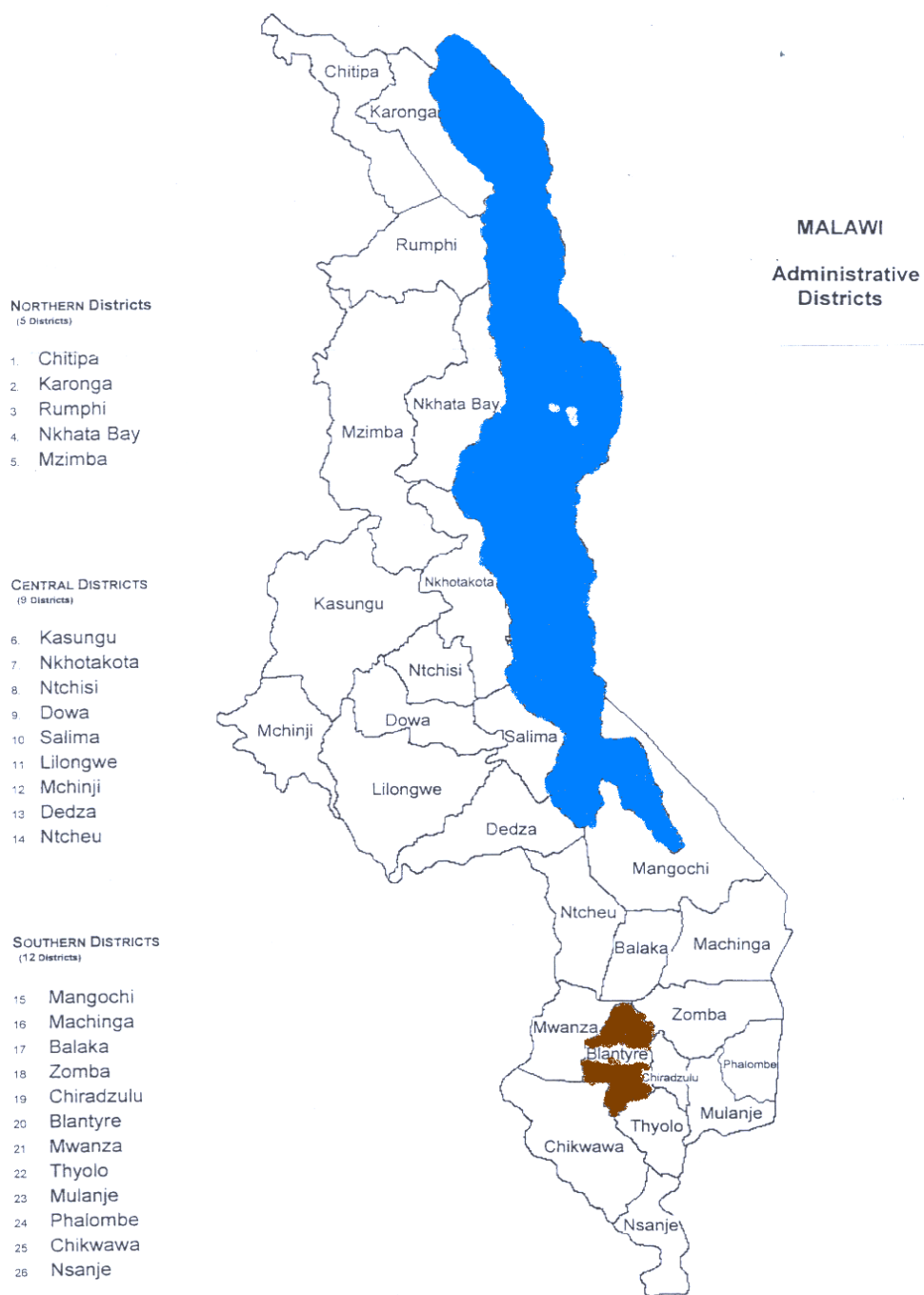


Fig 1: Map of Malawi showing Blantyre District

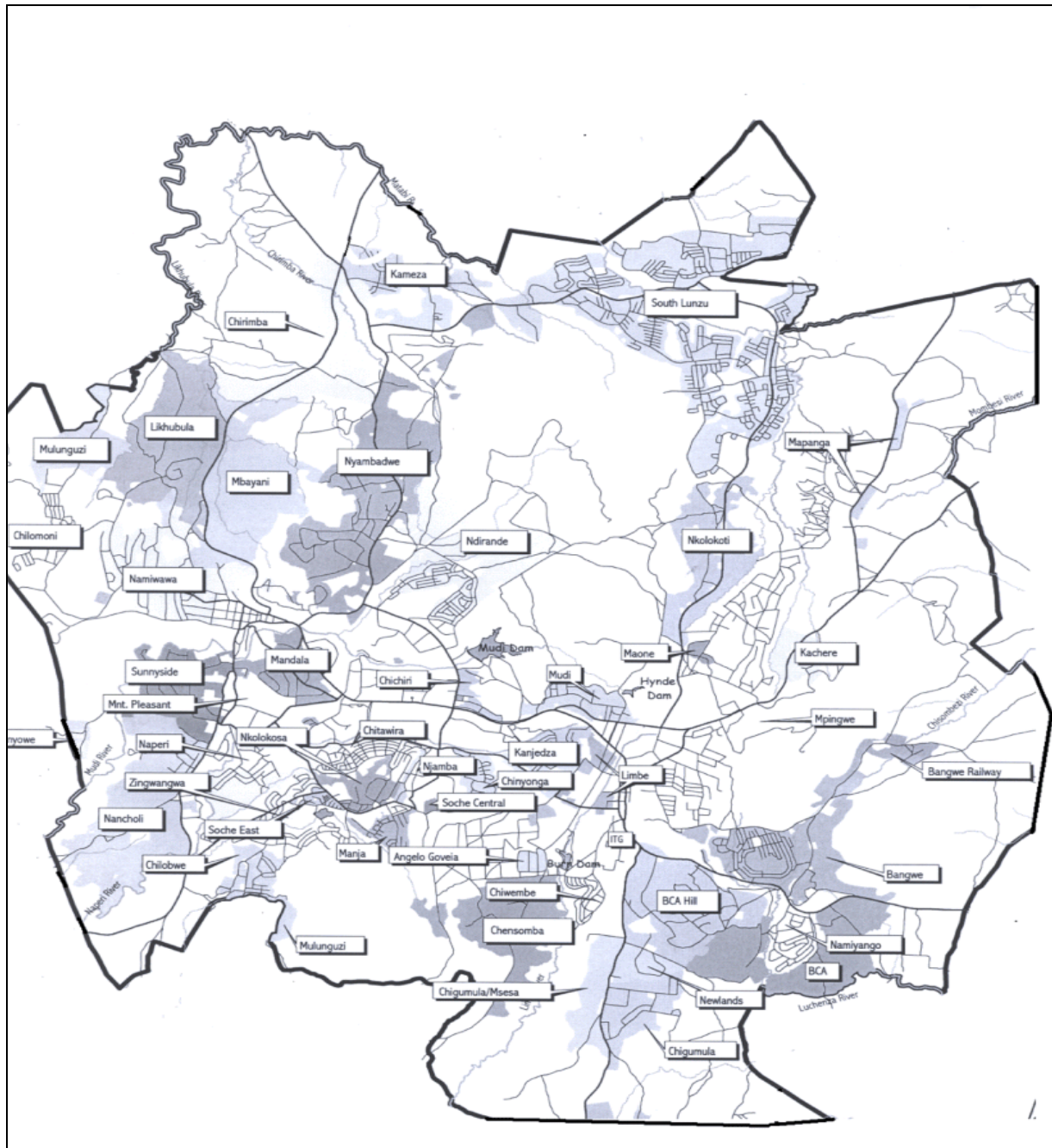


Fig 2: Blantyre City Assembly Map

LIST OF ACRONYMS/ABBREVIATIONS

ARV	Antiretroviral
AIDS	Acquired immunodeficiency syndrome
AZT	Azithromycin
BCA	Blantyre City Assembly
CESI	Community Empowerment and Social Inclusion
CBO	Community Based Organization
CHAM	Christian Health Association of Malawi
CSW	Commercial Sex workers
GFATM	Global Fund on AIDS Tuberculosis and Malaria
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HIPC	Highly Indebted Poor countries
HBC	Home Based Care
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
MACRO	Malawi AIDS Counseling and Resource Center
MANASO	Malawi Network of AIDS Services Organization
MANET	Malawi Network of People Living with HIV/AIDS (MANET+)
MDP	Municipal Development Partnership
MDHS	Midterm Demographic and Health Survey
MOHP	Ministry of Health and population
MTCT	Mother to Child Transmission
MGFCC	Malawi Global Fund Coordination Committee
NACP	National AIDS Control Program
NVP	Nevirapine
NAS	National AIDS Secretariat
NAPHAM	National Association of People Living with HIV/AIDS in Malawi
NGO	Non-Governmental Organization
OI	Opportunistic Infection
PAP	Poverty Alleviation Program
PRSP	Poverty reduction Strategic paper
PMTCT	Prevention of Mother-to-child transmission
PLWA	People Living with AIDS
PWHA	People with HIV/AIDS
SAP	Structural Adjustment
QECH	Queen Elizabeth Central Hospital
STI	Sexually Transmitted Infection
SUCOMA	Sugar Company of Malawi
UNAIDS	United Nations Joint Program on AIDS
VCT	Voluntary Counseling and Testing

A. INTRODUCTION

Blantyre is the main commercial and industrial city in Malawi. It is situated in the Shire highlands in the Southern Region of the country and it has five bordering districts; Chiradzulu, Zomba, Thyolo, Chikwawa and Mwanza. Blantyre has total surface area of 2,012 square kilometers. Figure 1 is the Map of Malawi showing the geographic location of Blantyre District in the Southern Region while Figure 2 shows the Blantyre City Assembly (BCA) area.

According to the 1998 population census, the total population of the district is about 800,000. About 48.0% of the population is below the age of 18, and 26% below the age of 15. About 61.1% of the population lives in the urban area of the district. There are 9 Traditional Authorities in the district and the population is predominated by two tribes; Mang'anyanja and Yao. Within the city area many local tribes from other parts of the country can be found mainly attracted by employment opportunities. There is also a relatively large community of Asian origin.

In spite of the relatively high urbanization, unemployment is high due to the limited capacity in the public and private sector. A major proportion of retail private business predominated by the Asian community.

According to reports unemployment rate in Blantyre is 57.4% and the average income for 46% of the households is less than MK4000 per month. Access to services is poor with 55% of the population living in squatter areas. The major health challenges for Blantyre City Assembly are indicated to be seasonal cholera, HIV/AIDS, as well as waste disposal particularly in traditional housing areas

In the recent collaborative work with its international partners the BCA identified HIV/AIDS as an important area to address. The main objective of this report is to provide a comprehensive view of HIV/AIDS within the BCA which may help the authorities and stakeholders to develop or initiate the comprehensive response to the HIV/AIDS epidemic.

B. OBJECTIVES AND METHODS

This section presents methods of data collection used in order to address the main objective. The section also provides the main limitations in considered in the interpretation of the data. Below are the terms of the work carried out.

Terms of Reference

HIV AIDS IN BLANTYRE

- \$ Statistics and Trends in HIV/AIDS in the city
- \$ Context of HIV/AIDS in the city compared to other urban centers/rural district in Malawi
- \$ Major determinants of HIV/AIDS transmission in the city
- \$ Current disclosure practices in the city
- \$ Identification of vulnerable groups to HIV/AIDS infection in the city
- \$ Impact of HIV/AIDS in the city and the following levels: Individual, household, community, business, local government, the city as a whole.
- \$ Review of access to information about HIV/AIDS in schools, medical facilities and other places.
- \$ Review of access to care and treatment of people living with HIV/AIDS
- \$ Analysis of current attitudes including review of : are parents talking to their children about HIV/AIDS?
- \$ Does a state of denial about HIV/AIDS exists? How important is stigma? Is there active discrimination against people living with HIV/AIDS?

Who Is Doing What in Blantyre?

Summary review of activities by the following organizations in terms of care , treatment, testing, counseling and prevention (a table format could be used

- \$ Blantyre city Assembly both programs and policies that target HIV/AIDS
- \$ NGOs (include NAPHAM, CBOs, Religious organizations
- \$ The private sector - businesses and companies, informal sector vendors
- \$ National programs active in the city from National Ministries, Donor organizations, UN system.

Analysis & Assessment of the Response to Date

- \$ Are the responses to date effective in reaching the city population?
- \$ Which are the most effective responses?
- \$ What responses need to be developed?
- \$ Where are their gaps in terms of providing information?

In view of the time given for the work and limited resources, it was not possible to carry relevant surveys to provide prospective and comprehensive data or information on some of the topics. The data and information presented here have been obtained mainly through review of reports and published data. Available data on HIV/ AIDS from Blantyre are presented focusing on epidemiological, morbidity and mortality rates. Where specific data from Blantyre related to these areas were found to be limited or unavailable, national rates have been used to provide

the most probable scenario for Blantyre. Using the national rates has the advantage of being more robust or stable than rates obtained from smaller population such a cities or towns. However, for HIV/AIDS national infection rates are likely to underestimate infection rates in urban area such as Blantyre because urban areas have been the main centers of the spread of the epidemic as well as where the epidemic was first established compared to the rural areas.

During this process there were constant consultations with officials of the Blantyre City Assembly to ensure that all relevant available data were included.

First, data on the estimated magnitude or burden of HIV/AIDS are presented by way of prevalence data. Available data on incidence rate although limited are also presented. Morbidity and mortality rate data are then present to provide an understanding of serious direct impact of the epidemic on quality of life or health status within Blantyre. Factors known or considered to be direct or indirect factors influencing infection with HIV among individuals or the spread of the epidemic in general are then discussed. Finally, the response to the epidemic by the Blantyre City Assembly and its partners is presented. A summary of existing prevention, care and support programs in Blantyre are also presented to demonstrate the type of response to the epidemic.

Many gaps in data or information on HIV/AIDS in Blantyre are identified. Some of the of the data are critical to providing an accurate HIV/AIDS profile. This paucity of data is not unique to Blantyre and is common to many other countries or cities. It is hoped that the need for response to the epidemic will stimulate collection of such relevant data because it is necessary for monitoring and evaluation any HIV/AIDS programs which may implemented in future.

Limitations:

While data on some biomedical aspect of HIV/AIDS in Blantyre can be found in the literature and published reports, data on the social, behavior and economic aspects are not so readily available. Aspects such as stigma, discrimination, vulnerability, IEC , disclosure practices and many others were not readily available or accessible.

C. THE HIV/AIDS BURDEN IN BLANTYRE

HIV Prevalence Rates

Prevalence data is normally obtained through population based surveys or through sample surveys. However, in Malawi and many other countries such data are not available because population surveys are logistically difficult and expensive to conduct. Most prevalence data are obtained from special population groups. These data are used to estimate rates in the general population. These special population groups include pregnant women attending antenatal care clinics, blood donors, commercial sex workers (CSW) and sexually transmitted Infection (STI) patients. In this report we present HIV prevalence rate data obtained among some selected population groups within Blantyre.

Pregnant Women The first HIV seroprevalence survey in Malawi was conducted in 1985 among

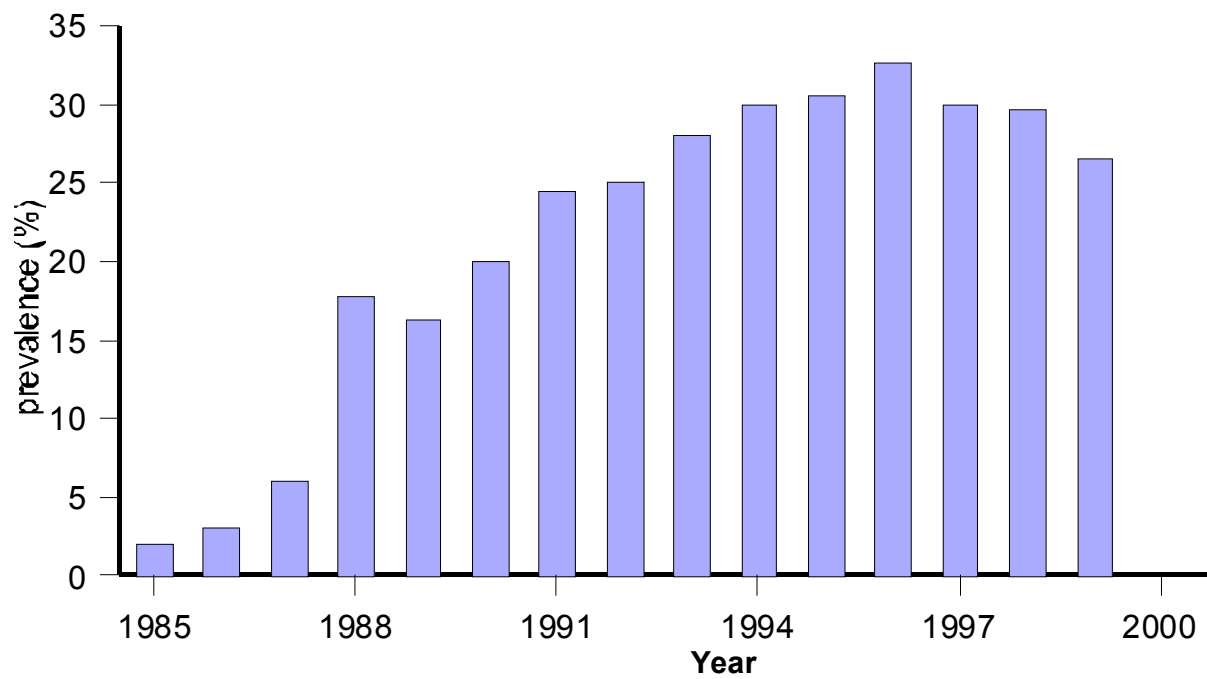


Fig 2: HIV seroprevalence rate among pregnant women attending antenatal care clinic at Queen Elizabeth Central Hospital (1985-2001)

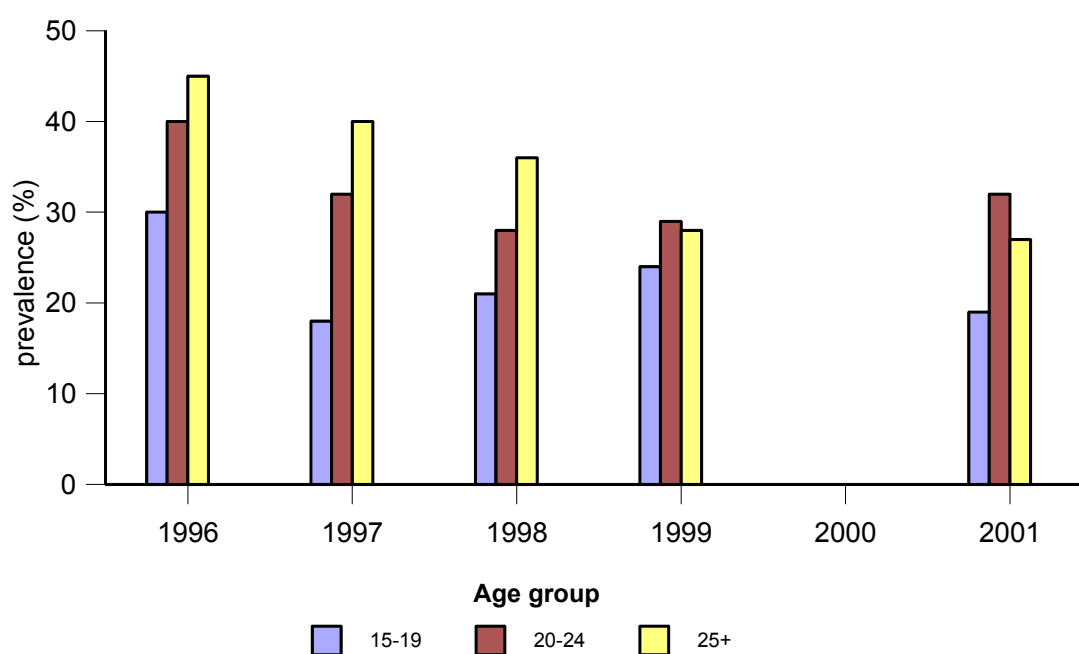


Fig 4: Age specific HIV prevalence among pregnant women attending ANC at QECH

Blood Donors

Blood donors have also traditionally presented as a special population group in which data on HIV prevalence have been obtained. During the early 1990s, HIV prevalence among blood donors at QECH, in Blantyre, was found to be about 20%. However, in 1998 the rate was found to be 18%. In a recent survey in Ntcheu district, the HIV seroprevalence rate among blood donors was 10.7%. In Thyolo, between January 1998 and July 2000 Médecins sans Frontières (MSF) found that HIV seroprevalence among blood donors was 22%. These data also showed that prevalence was lower among rural donors, students, and males ages 15-19. Urbanization appears to be strongly associated with increased infection rates among blood donors in Malawi.

According to UNAIDS, in 1997, unsafe blood products accounted for 1.7 % of HIV transmission in Malawi. Although these data are limited, they suggest that blood transfusion remains a significant factor in the spread of HIV in Blantyre and Malawi. Data on the number of units of blood transfused or screened per year to determine risk of HIV posed by this route in Blantyre was not available. However, based on the UNAIDS estimates, the risk of HIV through blood transfusion in Malawi remains significant and requires intervention.

Sexually Transmitted Infection (STI) patients

Reports indicate that a survey among STI patients seeking care at QECH in the late 1990, revealed HIV seroprevalence rate of about 50%. However, data obtained from this population are limited and cannot be generalized. In 1990, data obtained from the medical records showed that about 300,000 cases of STI, a rate of 339/per 10,000 population, were reported in the Southern region of the country. STIs were the eighth leading cause of outpatient visits in the region. However, the data are not provided by district or health facility to determine STIs reported from Blantyre. QECH being the biggest hospital may be contributing a high proportion of the reported cases.

Special prevalence Surveys

According to the NACP HIV prevalence in the Southern Region in Malawi is estimated to be 18% in the general population. Data among adult men in SUCOMA showed prevalence rates of about 22% in 1994, and 21% in 1998. A survey conducted at Mwanza showed similar HIV seroprevalence rate among 1000 adult tested in the year 2000.

There are no data on HIV seroprevalence from Commercial Sex workers (CSW) in Blantyre. However, surveys from Ntcheu and other places during the late 1980s showed a rate of about 76%. Since there are no data on the exact total population of this group it is difficult to determine the relative contribution toward the rapid spread of HIV in Blantyre.

Voluntary Counseling Testing (VCT) also provides additional data on for estimating HIV prevalence in a population. The Malawi AIDS Counseling and Resource Organization (MACRO) is the main provider of VCT in Blantyre and Malawi. Among all those who were counseled and tested in the year 2000 about 25% were found with HIV infection. However, VCT clients are considered to be a highly selected group and may not be representative of the general population. Data from MACRO in Blantyre also showed that the majority of their clients were unmarried, young and male.

From these data the estimate is that HIV prevalence in Blantyre lies between 18% and 25% in the general population. Based on the 1999 census, the estimate is that the number of HIV/AIDS of cases in Blantyre is between 80,000 and 120,000. This estimate is consistent with NACP HIV AIDS projections in 2001.

Mother -To-Child (MTCT) HIV Infection rates

In Africa, mother-to-child HIV transmission is the second most common mode of HIV transmission. About 10% of all HIV transmission in Malawi is estimated to be through MTCT. Studies have also shown that in Africa MTCT rate is between 25-and 40% compared to only 10-15% in the developed countries.

In Malawi, the MTCT rate is well documented from several studies conducted among women delivering at QECH. In 1995, 27.8% of babies born (6,000) HIV infected mothers at QECH were found infected with HIV. In another study in 1996, 28% of babies born to 986 HIV infected mothers were found infected. Several other studies at QECH have found consistent results and this corroborates the widely estimated 30% MTCT rate. These data also suggest that in Blantyre about 30% of HIV positive pregnant women transmit HIV to their infants.

According to records at QECH, between 12,000 to 15,000 deliveries occur every year. If the true prevalence rate among pregnant women is 20-30%, about 1,000 to 1,500 babies will be infected with HIV every year at QECH alone. Considering that deliveries occur at many other clinics, hospitals and Traditional Birth Attendants in Blantyre, the number of babies being infected with HIV every year will be much higher.

C. THE SPREAD OF HIV/AIDS IN BLANTYRE

HIV Incidence rate

While prevalence rate provides information on the magnitude or burden of the disease or infection in a population, incidence rate is the number new cases occurring in a period of time. Incidence rate shows how fast the disease or infection is spreading in a population. It also provides a better and more effective indicator for evaluating disease prevention programs.

Most of the data on HIV incidence in Malawi have been obtained from studies among pregnant and postpartum women at QECH, in Blantyre. Between 1990 and 1995, 1173 HIV negative women were followed-up in a study at QECH. HIV incidence rate in this group declined from 21.3% in the first year to 1.1% in the final year of the study. These data are consistent with those found among men working at a sugar estate in Chikwawa where incidence rate declined from 17.1% in 1994-95 to 3.1% thereafter. In another group of about 1,200 uninfected men in 1999, the HIV incidence rate was 3.8%. In a more recent study at QECH, HIV incidence rate among 1000 child -bearing-age women was found to be 4.2%. Although these data are limited they suggest that the incidence of HIV in the Southern Region and Blantyre is high (3-5%) per year. These data also confirm that prevention programs are needed. Figure 3 shows HIV incidence rate among different groups in Malawi.

Table 1: HIV incidence rate in selected population in the Southern Region

POPULATION	TOTAL PYO	SITE (YEAR)	NEW CASES	INCIDENCE RATE	95 CI
ANC	338	QECH (1990)	27	7.9	4.9-11
POSTNATAL	2864	QECH (1990)	97	3.6	2.99-6.17
MEN	1200	SUCOMA (1995)	-	3.1	
MEN	1100	SUCOMA (1998)	-	3.8	
WOMEN REP. AGE	983	QECH (2002)	-	4.2	

These data also suggest that despite signs of stable HIV prevalence among pregnant women attending ANC in Blantyre, the epidemic is still spreading at a high rate. These data also suggest that current prevention programs are having little or no impact on the spread of HIV in the community. These data directly reflect on the incidence rate of HIV in Blantyre. For HIV incidence rate as reported in Blantyre it is of serious concern because it indicates continued rapid spreading of the infection. The data among the child bearing women in Blantyre has remained very high for many years. It is clear that more effective prevention method are required and approaches focusing behavior change should be intensified in order to reduce the spread of HIV in Blantyre or Malawi.

E. MORBIDITY AND MORTALITY

HIV/AIDS Cases

The first AIDS case in Malawi was reported in 1985 and by 1995 a cumulative total of 39,989 AIDS cases had been reported to the National AIDS Program (NACP), and by June 1999, more than 53,000 cases had been reported. In 2001, the National AIDS Commission estimated that 845,000 Malawians were infected with HIV. According to UNAIDS, there are between 720,000 and 1.1 million people living with AIDS in Malawi. The majority are adults (age 15- 49). BCA estimates indicate that 69,000 people in Blantyre are HIV infected. However, the estimates by the NAC indicate that this figure is about 117,000.

In 1996, the NACP indicated that the highest cumulative number of AIDS cases in the country, were reported from Blantyre. The fact that the major referral and specialist hospitals in the country are located in Blantyre may contribute to higher number of cases being reported. According to NACP, problems in the reporting system and limited diagnostic facilities mean that the reported number of AIDS cases are perhaps as much as 50% under-reported. Figure 4 shows the total number of AIDS by age group reported the National AIDS between 1995 and 1998. This figure also demonstrates that the age group 20-49 is the most affected in Malawi.

Since AIDS develops after many year following HIV infection, the number AIDS cases in Blantyre

and Malawi are likely to continue increasing for several years to come. The increase in those developing AIDS will also increase the burden on resources especially health services. The limited availability of ARVs means that most of those developing AID will die quickly leading to increased mortality rate due AIDS.

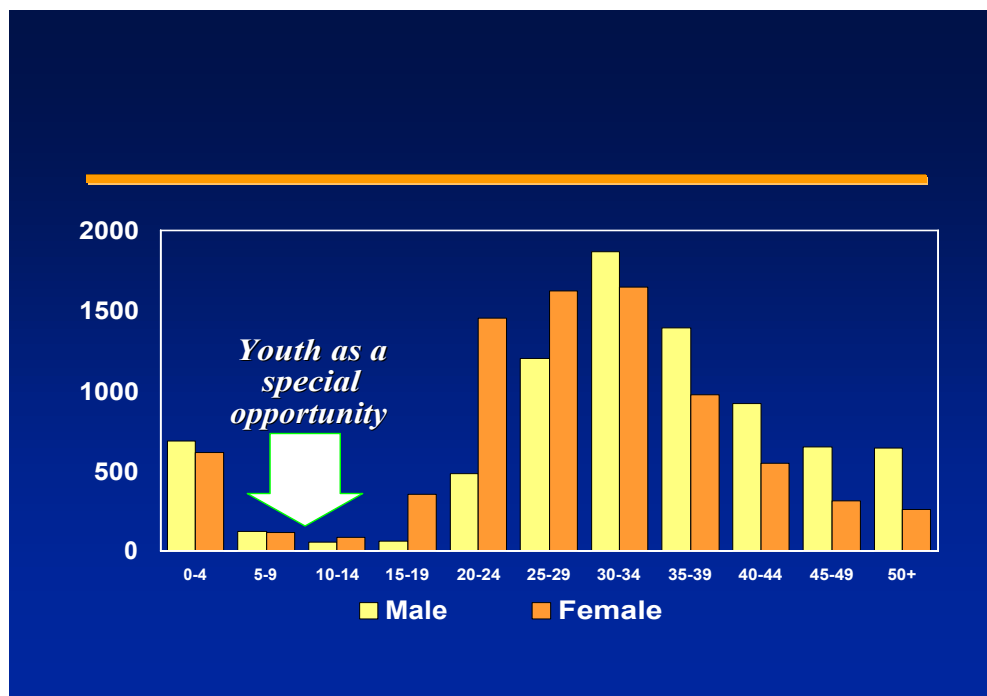


Fig: 4: Reported total number of AIDS cases by age-group 199-98 (Source : NAC, 2002)

Mortality Rate from HIV/AIDS

In 2001, UNAIDS estimated that 80,000 adult and children died of AIDS in Malawi and the U.S. Bureau of the Census estimates that the crude death rate in Malawi in 2002 was 22.3 per 1,000 instead of 12.0 without AIDS. The projection is that these rates will be 23.1 and 9.9, respectively. HIV/AIDS is now the leading cause of death among those ages 20 to 49 in Malawi.

In 1996, the highest number of deaths were reported from Blantyre district in Malawi. In a study conducted at QECH among 702 infants who survived their first year of life, 83 of them died by age 24 months. At 36 months, only 55% of those who were HIV infected survived. Most of the deaths were due to failure to thrive or respiratory conditions. In general data on AIDS mortality in Malawi is very limited. Figure 5 shows the projected number of deaths from AIDS among the 15-49 age group in Malawi. The data clearly suggest that AIDS is having significant impact of mortality rate in Malawi. From the projections by 2012 mortality rate will be twice as that

without the HIV/AIDS epidemic.

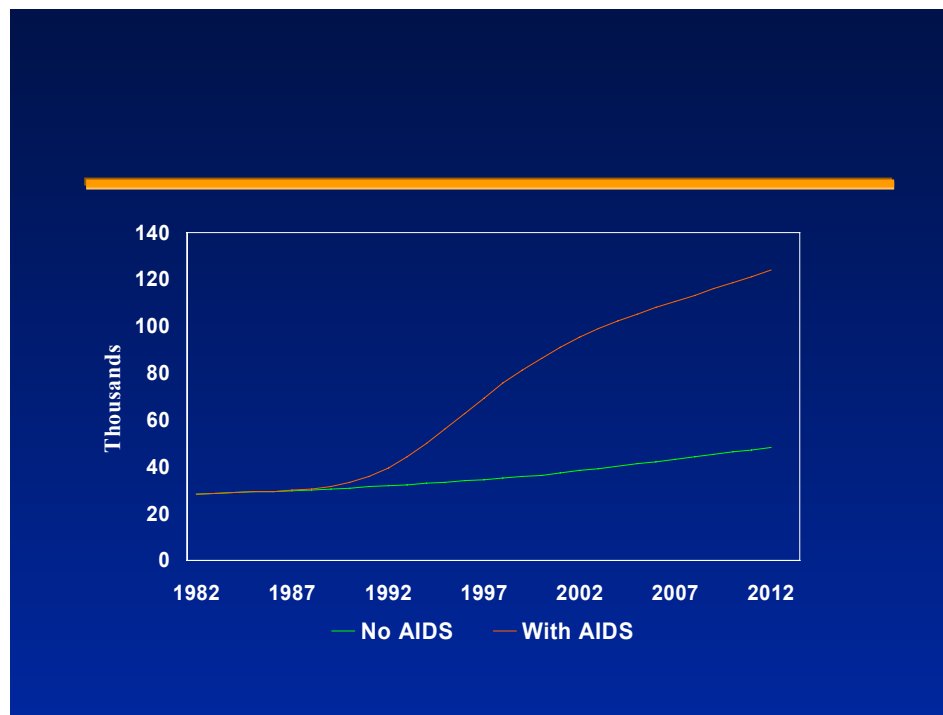


Fig 5: Projected number of deaths per year with and without AIDS , among 15-49 age group in Malawi (Source: National AIDS Commission, 2002)

There are no district specific HIV/AIDS mortality data. However, prevalence data from pregnant women attending ANC at QECH suggests that the infection rate in Blantyre is higher than the national average. It is also likely that mortality rate due to HIV/AIDS in Blantyre is higher than the national average or projection.

F. FACTORS THAT FACILITATE SPREAD OF HIV/AIDS

Heterosexual transmission accounts for about 90 % of HIV infection in Malawi. There are many factors which are known to increase the risk of sexual transmission or acquisition of HIV. Sexual behavior and practices and presence of STIs are among such factors. In this section some of the factors and their significance in the HIV transmission in Blantyre are discussed. However, determining the significance of factors requires availability of accurate data. In most cases surrogate markers are used in order to determine the level and significance of some risk factors.

Sexual Behavior

The sexual behavior is considered a major factor contributing to HIV prevalence and incidence rate in Malawi. The National HIV/AIDS strategic framework acknowledges that culture prevents critical discussions sex or sexuality issues and development of curricula to address HIV/AIDS through formal and informal education systems. Having multiple sexual partners and sexual interaction between sexes and age groups are also known to play a major role as risk factors.

Age and sex are found to be strongly associated with HIV infection. This association is strongly linked to sexual behavior and practice. Data on reported AIDS cases from NACP in Malawi indicate that on average women get infected at an earlier age compared to men. This may partly be due to the fact that women are reported to be sexually active at an earlier age compared to men. It may also confirm the belief that older men tend to prefer younger women for sexual partners for various reasons. According to the 2000 MDHS, the median age at first sex for women is 16.8 for the age cohort 25-49. Among adolescent women, 57.3% have had sex versus 61.1% among men. For all women, the median age at first sex is about one year earlier than the median age at first marriage. Among men age at first sex appears to be declining, 17.7 among those 20-24 and 18.4 among those 25-54. These data indicate that in Malawi men begin having sex about five years before first marriage. Perhaps more important, these data suggest that more young people are at risk of HIV infection in Malawi because they become sexually active early.

Number of Sexual Partners

Having multiple sexual partners is known to be a major risk factor for HIV infection. According to the 2000 MDHS, among those who are married, 99.3 % of women and 82.5 % of men report having no sexual partner other than spouse/cohabiting partner in the past year. Among unmarried women 15 -19, 65.4% of those reported having had sex in the last year, had one sexual. Among men in the same age group, these figures are 56.1 and 14.5 %, respectively. Fifty-two percent of Unmarried men who have ever had sex report one sexual partner in the past year. However, 14.5 % report two or more sexual partners.

In studies conducted among women at QECH, the average reported number of sexual partners is about 1.2. However, in studies among men this figure seem to be slightly higher than among women. In a study at SUCOMA the average reported number of sexual partners was 1.8. In the 2000 MDHS, 17.0 % of married women reported being in polygynous unions. Among women with no formal education, 20.9 % are in polygynous unions, compared with 15.5 % with primary education and 8.4 % with secondary or higher education.

There is a strong belief in Malawi that the prevalence of HIV is much higher in urban compared to rural areas mainly due to the erosion of cultural values on sex among urban dwellers, such as acceptance of multiple sexual partners.

Intravaginal Practices

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

In a study conducted at QECH in Blantyre among women attending ANC (6,603) 13 % reported using intravaginal agents for tightening, to increase male sexual pleasure, and 34 % reported using them for self-treatment for discharge and itching. A higher proportion of HIV-infected than uninfected women (17 vs. 14 %) reported use of intravaginal agents for treatment. These data show the significance of this practice in Malawi especially Blantyre. If intravaginal product use is a risk factor approaches to discourage the practice are needed.

Condom Use

Overall, condom use in Malawi is very low. According to the 2000 MDHS, 77.0 % of women and 87.2 % of men knew a source for condoms. Men and women in urban areas with higher education are more likely to know a condom source and report personal access to them. Among 15 -19, 69.1 % of women reported knowing a source for condoms; 48.2 % reported being able to obtain one if desired. For men, these figures were 83.8 and 71.5 %, respectively.

The data also indicates that among women who had sexual intercourse in the last 12 months, 4.7% used a condom with any partner. Among men, this figure was 14.0 %. Condoms are used far less frequently during sex with a spouse/cohabiting partner than with a casual partner. Of women who had sex in the last 12 months, 2.5 % used a condom with a spouse or cohabiting partner, whereas 28.7 % used a condom with a non-cohabiting partner. Among men, these figures were 5.9 and 38.9 %, respectively. Comparing with 1996 demographic data, the 2000 MDHS estimates that condom use within marriage declined during this period. However, condom use increased among women with regard to non-cohabiting partners.

In Blantyre, data obtained among women at QECH in 1989 and 1993 showed that reported condom use increased from 6% to 15% during this period. However, in both surveys consistent condom use was less than 1.0%. The data also showed that rate of condom use was higher in HIV positive women (18%) than in HIV negative women (13%). The major sources of free condoms are health facilities. However these condoms are mainly from family planning and not HIV/STI prevention. There are no data on availability or coverage of distribution. Condoms are also available through the Population Services International (PSI) social market program in major retail grocery and other.

In order to increase accessibility to condoms for HIV prevention in Blantyre it is necessary to identify more appropriate places and methods of distribution. The health facilities may not be ideal for accessing free condoms. However, there is need to obtain data on availability, access and use of condoms in Blantyre in order to design and assess its impact on HIV prevention efforts.

Male Circumcision

Male circumcision is uncommon in Malawi. Some observational studies from parts of Africa indicate that male circumcision may reduce the risk of HIV acquisition although circumcision does not appear to affect transmission from HIV-positive men to their partners. The limitations of these studies have been highlighted, and further study is needed on both biomedical and socio-behavioral issues before promoting male circumcision as a public health intervention.

In the study of male workers from the SUCOMA sugar plantation, lack of circumcision was associated, though not statistically significantly, with increased HIV acquisition. However, only 15% of the 1700 men reported being circumcised.

Sexually Transmitted Infections (STIs)

Both, ulcerative and non-ulcerative STIs are known to increase the risk for HIV acquisition or transmission. Although the role of STI treatment for HIV prevention has had conflicting results in studies in Mwanza Tanzania, and Rakai in Uganda, STI treatment is considered an integral part of any HIV prevention efforts.

Available data from a study among male workers in Nchalo sugar estate conducted in 1994/98 showed that having a positive syphilis test and reported history of STI were significantly associated with HIV acquisition. In this population prevalence of herpes (HSV) was 88.1 % among HIV-positive men and 64.3 % among those who were HIV-negative. Among 279 HIV-positive and 280 HIV-negative of male workers a positive test for HSV was strongly associated with HIV infection.

Sexually transmitted infections are among the 10 leading causes of out patient visits in the southern region of Malawi according data from the national Health information system. However, due to the collapse of the surveillance system it is not possible to accurately determine the relative importance of STIs on the spread of HIV in Blantyre. However there is At QECH, among 1196 women attending ANC bacterial vaginosis (BV) was significantly associated with HIV seroconversion. In several surveys at QECH BV is found to as common as 80% among women. HIV infection was found to be four times as likely among women with BV than those without. Among postpartum women, HIV seroconversion was about twice as much among those with BV compared to those without BV. An estimated 14% and 23% attributable risk for HIV infection due to BV was estimated among ANC and postnatal respectively.

Table 2 : Trends of Sexually transmitted Infections among women surveyed at Queen Elizabeth Central Hospital, Blantyre , Malawi

	1990	1993	1995
Total No women exam	6603	2161	808
HIV+positive	1502	694	107
HVI-negative	5101	1467	701
Sexually Transmitted Infection (STI) rate by HIV status (%)			
Syphilis	13.4	12.2	12.1
HIV+positive	18.4	16.0	13.0
HVI-negative	12.0	10.4	6.7
Trichomonas	32.5	28.6	23.8
HIV+positive	46.9	37.4	24.7
HVI-negative	28.2	24.4	17.1
Gonorrhea	4.9	2.5	2.5
HIV+positive	10.8	3.7	2.4
HVI-negative	3.2	1.9	2.9
Genital warts	4.8	3.1	2.5
HIV+positive	8.3	6.3	2.7
HIV-negative	2.2	1.7	1.0
Genital ulcers	6.8	6.7	3.4
HIV+positive	11.0	9.1	3.6
HIV-negative	5.5	5.7	2.1

Socio-economic Status (SES)

Socio-economic status can have a major influence on health status of individuals in a community. SES can be measure using income, education, access to certain facilities or social position. In Blantyre among women attending antenatal clinic, living in a house with electricity appears to be a strong SES indicator. In HIV studies among these women high SES is found to be strongly associated with HIV infection. However, low SES was found to be strongly associated with increased STIs.

Commercial sex

Commercial sex in many communities is a major factor in the epidemiology of STIs including HIV.

CWS and their clients constitutes core groups which facilitate the spread of sexually transmitted infection into the general population. Prostitution in Malawi is illegal which makes it difficult to determine the extent and the role of CSW in the HIV epidemic in Blantyre or Malawi.

There are many factors influencing the spread of HIV in Blantyre and these are not unique to Blantyre. However, some sexual behaviors such as having multiple sexual partners, extra marital sex appear to be quite common. The various sexual practices such as the use of intravaginal tightening agents, lack of condom use also are all quite very common. The high prevalence rate of HIV in Blantyre suggest an interplay of all these factors and despite not being well documented may be contributing factors for the wide spread of HIV infection. Commercial sex in this setting is strongly linked to socio-economic status. The argument is made that poverty is the main driving force why women enter the trade. However, other social or cultural reasons are also being cited such as the lack of women empowerment.

G. DISCLOSURE PRACTICES

Disclosure of HIV status affects both those infected and those affected. Because HIV testing is a confidential process, formal data on disclosure practices are difficult to access. However, it is generally understood that for those who are HIV infected disclosure of HIV status is related to the available social support from family and friends. Public disclosure of HIV status by individuals is limited. NAPHAM is one of the very few organizations representing those who have publicly disclosed their HIV status. The majority of those who are HIV infected normally will not disclose their status perhaps except to a few close family members or friends. It is also not uncommon that those who disclose their status do so due to illness or development of AIDS.

It also unlikely that members of the family for the patient who have an HIV infected patient can disclose the HIV status of the patient to others in the community. The major barrier to HIV status disclosure by those infected or affected is the fear of stigma and discrimination. This fear in the Malawi society is also manifested in the strong reluctance in acknowledging AIDS as cause of death at funeral ceremonies as is the case with other causes of death. In the majority of cases this lack of HIV status disclosure by family members is due to a strong prevailing sense of denial by the community.

The HIV status disclosure practice can affect home-based care efforts. Knowing HIV status is a major consideration in the recommendation for patient home based care. If HIV status cannot be disclosed to close family members because of denial or other factors proper home based care may be difficult to achieve. The national policy on disclosure is to promote voluntary disclosure of status by those who are infected and only exceptional cases can disclosure of individual HIV status can be done without their consent.

Knowledge

From the 2000 MDHS findings, awareness about HIV/AIDS in Malawi is high; 98.9% among women and 99.7% among men have heard about AIDS. Among women, 93.1% believe that there is a way to avoid getting AIDS; for men, this figure is 97.7 %. Knowledge of MTCT of HIV among women is about 60% and among men it is about 70.4% . Women and men in rural areas

are more likely to report that AIDS cannot be avoided than those in urban areas..

The MDHS data also indicated that knowledge of prevention methods in Malawi is high. Abstinence and condom use are the methods by far the most frequently cited for prevention against HIV. Among women, 67.1% and 54.6%, respectively, cited these methods. Among men, these figures were 77.3 and 71.4 %, respectively. Other methods cited include limiting number of sexual partners and avoiding sex with partners who have multiple partners. Despite high awareness of HIV/AIDS, some findings from the 2000 MDHS suggest that behavior change messages are not effectively highlighting key strategies for HIV prevention.

Among women 24% do not believe condoms are safe and among men it is about 16 %. This belief was highest among those who report never having had sex (women: 32.1 %; men: 22.8 %). These findings may be relevant to Blantyre as one of the main urban centers in Malawi. However, more data needs to be collected on knowledge in the population and how it can be translated into behavior change in response to the epidemic.

H. STIGMA AND DISCRIMINATION

Stigma is literally a mark or blemish upon someone or something. HIV infection is viewed negatively and social attitudes may be damaging to those infected or suspected of being infected. Stigma and discrimination occurs at all levels in the society and it has been the focus and theme during the World AIDS Day commemoration day in the past 2 years.

Discrimination is defined more along the lines of legal or human rights. When someone loses a job because of negative connotations or impressions of HIV, overt discrimination will have occurred.. According to MGFCC, health care workers consistently report reluctance by families and communities to care for members with chronic and terminal conditions. This is resulting in "dumping" of family members in hospitals, which are already overstretched. Both stigma and discrimination are a major concern in HIV/AIDS because they make life unbearable for those who live with the disease and they affect prevention, care and support efforts.

Community level - Among women, 72.2 % report that they personally know someone who has AIDS or has died because of AIDS (urban women: 78.0; rural women: 71.1%). Among men, this figure is 81.5 % (urban: 82.0 % vs. rural: 81.3 %). At household level among currently married women and men who have heard of AIDS, 72.3 and 85.8% , respectively, report that they discussed HIV prevention with their spouse. Data from MDHS indicated that for both men and women, educational level is strongly associated with having discussed HIV with one's spouse.

Work place - The 2000 MDHS found that 51.3 % of women and 46.9 % of men believe that a co-worker with HIV should not be allowed to continue working. This attitude was much greater among those with lower educational levels and among those living in rural areas. Perhaps discrimination in the work place is much more easily recognized than in informal settings. Work place discrimination may be in form of excluding HIV positive individuals from certain tasks or assignments, consideration for promotions and many other ways. It is also perhaps easier to put in place interventions through labor organizations or relevant sectors formulating regulations against discrimination.

The disclosure practices in Blantyre and Malawi are likely to have a great impact in determining the magnitude of this problem in Blantyre. Experts agree that like all forms of discriminations the most effective tool is awareness in the community. To fight stigma and discrimination in Blantyre it will require programs to raise awareness in the community at all levels. It requires the cooperation of the civil society and the government. The participation of organizations such as human rights, religious, non-governmental and people living with HIV is critical in efforts to raise awareness against stigma and discrimination in the community.

I. CARE AND SUPPORT

Care and support for HIV/AIDS is both a moral and humanitarian obligation. It can reduce suffering and improve quality of life. It also has a strong link toward prevention efforts. Care and support can strengthen prevention activities, stigmatization and discrimination can be countered. Inappropriate negative attitudes should be dispelled including the view that nothing can be done for those with HIV/AIDS. The National HIV/AIDS strategic framework recognized that HIV/AIDS care and support are central to the Government response against HIV/AIDS in Malawi.

In general care and support includes providing counseling and basic information, support groups and networks of people with HIV/AIDS, home based care, support for children orphaned by AIDS, improving access to essential drugs, specialist hospital-based care, palliative care etc

J. ECONOMY AND SOCIO-BEHAVIORAL CONTEXT

Many of the factors discussed in this section exist in countries that, unlike Malawi, have low HIV prevalence; these include poverty, gender inequality, history of colonialism, political and economic disenfranchisement. The relationship between HIV prevalence and socioeconomic factors is highly complex. Increasingly, risk of HIV infection is recognized as related to, inter alia, one's socioeconomic status as well as the socioeconomic profile of the community in which one is situated. We do not seek to demonstrate causality; rather, analyze key economic and socio-behavioral contextual elements to highlight the range of sectoral policies and interventions that may affect or be affected by HIV/AIDS.

Economy

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

Malawi began to experience relatively strong economic growth between 1988 and 1991. Real Gross Domestic Product (GDP) growth rose from 3.3 % in 1988 to 7.8 percent in 1991. However, the gains arising from this growth were short-lived as growth fluctuated through the 1990s, largely as a result of external shocks such as droughts and the reduction of donor financial support between 1992 and 1994. Growth has averaged 2.6% between 1997 and 2000 and 1.8 % in 2001. Malawi's economy has been adversely affected by severe drought in the 2001/02 agricultural season, and the country remains heavily dependent on foreign aid. In March 2000 the country started the process for obtaining debt relief under the HIPC initiative. In 1999 the World Bank and IMF replaced SAPs with new conditions for loans and debt relief: the Poverty Reduction Strategy Paper (PRSP).

Poverty

According to Malawi's 1998 Integrated Household Survey, 65.3 % of the population is now poor. (Poor is defined as those whose consumption of basic needs is below the minimum level, estimated at MK10.47 per day in 1998. Poverty is more prevalent in rural areas than in urban areas. It is estimated that 54.9 % of the poor live in urban areas. The Southern Region's poverty situation can partly be explained by high migration into it, including those seeking employment in its urban areas such as Blantyre. Although the relationship between poverty and HIV prevalence is highly complex HIV prevalence is highest in Southern Region (18 %), Central (11 %) and Northern (9 %) regions.

According to the National AIDS Commission, HIV/AIDS has undermined the country's efforts to reduce poverty. The U.N. notes that "HIV/AIDS is now an important part of structural poverty in Malawi, and its prevention and control are a central development concern." In its 2002 poverty reduction strategy paper, the government noted that "there are clear links between HIV/AIDS and poverty. Poverty is one of the major underlying factors driving the epidemic."

Population Mobility

Throughout southern Africa, high levels of movement between urban, rural, and mining areas facilitate HIV transmission. According to NACP, male migration is a common phenomenon. Migrant labor separates men from their families, places them in close proximity to "high-risk" sexual networks, and often results in their having an increased number of sexual contacts. Concurrently, it may also lead to women's reliance on sex to supplement their incomes while their male partners are away for long periods.

Both men and women are increasingly mobile as they pursue trading activities. Many female traders report exchanging sex for transport. They also report rape and sexual harassment. Other key mobile groups in Malawi include: truck drivers, CSWs, fishermen and fish traders, migrant and seasonal workers, military personnel, prisoners (in the sense that they often return to their families/communities upon release).

The study on male workers from the Nchalo sugar plantation found rate of acquisition of HIV followed a gradient based on distance from the Nchalo trading center (where most recreational activities and commercial sex occurs). Both HIV and syphilis prevalence were highest in communities closest to the trading center and lowest in communities furthest. There is substantial movement of family members from the surrounding rural areas and districts. Blantyre serves as a major trading center for cross-border trade.

Transactional Sex

According to the 2000 MDHS, among men who have ever had sex, 20.5 % report having paid for sex in the last 12 months. For unmarried men, this percentage was 21.0 %; for married men, 20.3 %. Among all men in urban areas, 24.9 % report having paid for sex compared to 19.6 % in rural areas. Married urban men were much more likely to have paid for sex (29.6 vs. 18.5%), whereas urban unmarried men were somewhat less likely to have paid for sex (17.1 vs. 22.1 %). Men who have been drunk in the last three months were more likely to have paid for sex (23.9 %) compared to men who did not become drunk (19.4 %). More data on the dynamics of transactional sex in Malawi are needed to determine its relative significance in the HIV epidemic. Economic difficulties and shortage of food due to famine may be increasing episodes of transactional sex.

Commercial Sex Workers (CSW)

Seroprevalence surveys found that HIV prevalence among CSWs attending Lilongwe's AIDS Counseling Center to about 70% to 86%. Although there are no data on the prevalence of CSW in Blantyre there is evidence of what may be considered as red districts. In Malawi prostitution is illegal, and CSW and prostitutes are terms used interchangeably. There have been frequent reports in the local press of prostitutes in BCA being arrested by authorities. In a report by BCA CSWs were identified as a high risk group. In order to have effective programs involving CSWs in BCA it will be important to provide an appropriate legal framework. Such approaches have been shown to be effective in other cities such as Dakar in Senegal where HIV prevalence among such groups have remained low for many years.

K. VULNERABLE POPULATIONS

In this section we examine data from BCA for population groups considered vulnerable due to HIV/AIDS. Vulnerability may be with respect to risk of acquiring HIV infection or suffering the impact or effects of HIV infection in the family such as losing economic support. Women and girls, widows and widowers, young people and orphans all constitute vulnerable population groups.

Women and Girls

Women are considered a vulnerable group both in terms of risk of acquiring HIV infection and its impact. In Malawi women become infected with HIV at younger ages than men. HIV prevalence data among women ages 15 to 24 ranges from 11.91 to 17.87%, whereas the comparable range for men in the same age cohort is 5.08 to 7.62 %. The cumulative AIDS cases reported to NACP show that among women is highest between 15 - 29 compared to > 30 among men. This suggests significant transmission among older males and younger females. Other factors that may make women vulnerable to HIV infection include use of hormonal contraceptives, traditional sexual practices during pregnancy, lack of socio-economic empowerment among many others. Food insecurity, may force women to trade sex for food or other necessities. This lack of empowerment and vulnerability is also reflected in the attitude of most women towards men's infidelity. In a the MDHS data 31.8 % of women reported that they did not believe that knowing that their husband had sex with other women justified refusing sex; 26.7 % did not believe that knowing one's husband had an STI was justification to refuse sex. In the following Figure 7 total reported new HIV infections among young people are shown. However, the figure shows the proportion of young women with new HIV infection is higher than among young men.

Widows and widowers

Those who loose their spouses particular women become vulnerable to exploitation at the time of their grief. Some communities in Malawi observe practices that promote casual and ritual sex after the death of a spouse. Initiation ceremonies, widow inheritance and death cleansing are among such practices. Widows may be particularly vulnerable to HIV infection because of sexual cleansing and wife inheritance. While the widow may be at risk of HIV infection, if already infected, they pass on the infection to the new partner.

Widows also become vulnerable as a result of losing the economic support from the deceased spouse. They are also vulnerable to losing their property to family members of the deceased. Although such cases are a common occurrence in Blantyre and other parts of the country, data are not available to quantify accurately the magnitude of this problem.

Children and Young people

Children and young people are culturally and socially vulnerable in many ways because their voices are not easily heard when exploited or abused. Youth, in and out school, have far much less incidence of HIV than other population groups but are extremely vulnerable. They are also a vulnerable population group due to desire to become sexually active, peer pressure lack of information on reproductive health, STI/HIV. With HIV epidemic they are also vulnerable to becoming orphaned from the death of parents.

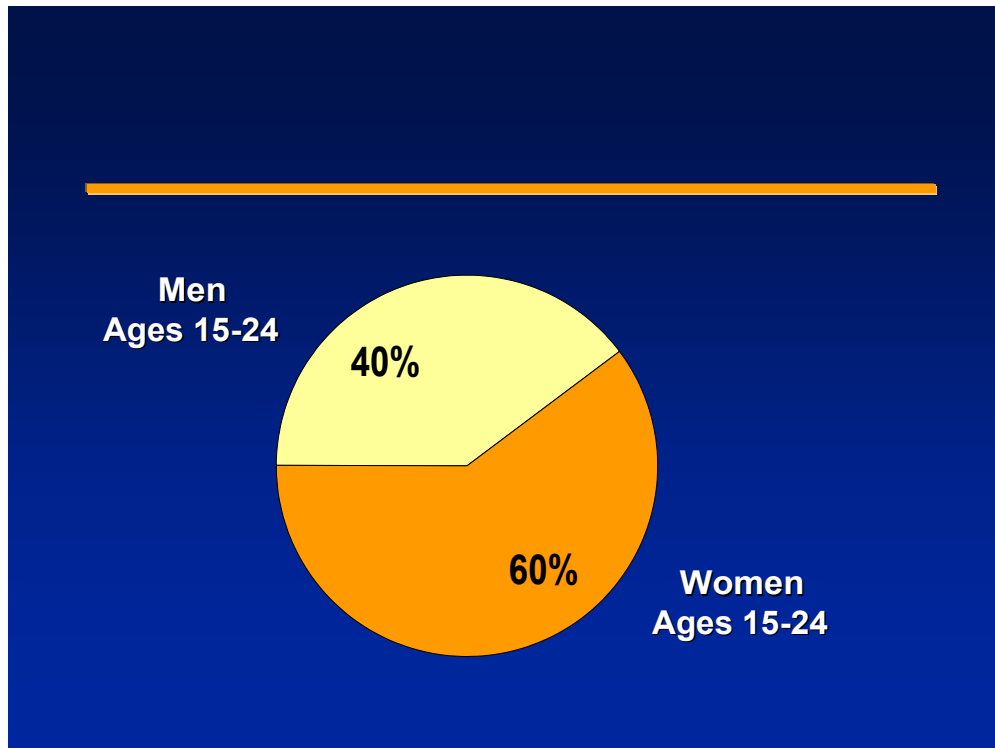


Fig . 7 : Proportion of new Infections among young men and women, 15-24 years. (Source: National AIDS Commission, 2002)

In a recent study among secondary school students in Thyolo indicate that about have the students may be sexually active. However, access to condoms in school is currently not accepted. Based on the 1998 population census there are about 70,000 and 90,000 people in the 5-17 age group. As the epidemic continues young people become one of the population groups at high risk. Data from sentinel surveillance show that between 1996 and 2001 the proportion of HIV infected among young women increased sharply.

Orphans

At the end of 2001, UNAIDS estimated that there were 470,000 orphans (ages 0 to 14) due to AIDS in Malawi. It is estimated that the proportion of Malawi's orphans due to AIDS rose from 5.7 % in 1990 to 49.9 % in 2001

In 1998, 1.5 % of those under the age of 20 had lost both their parents. Traditionally most orphans live with grandparents who in many cases are themselves single and resource-constrained. The census data in 1998, show that 0.6 % of households were headed by individuals under the age of 20, a reflection of the emergence of child-headed households. As a result there has been an emerging problem of street children in Malawi. The Ministry of Gender, Youth and Community Services estimates that 22,000 children are living on the streets of Malawi.

In Blantyre the exact number of orphans is not known. Sources of data on orphans is also limited as most orphans are not officially registered. However, there are reports indicating that in Blantyre district there are efforts to respond to the growing problem of orphan care. These reports indicate that in some villages orphan committees have been established to monitor the local situation and assist eligible children and families. There are two main established orphanages in Blantyre, The Open Arms and Kondanani both being run by NGOs.

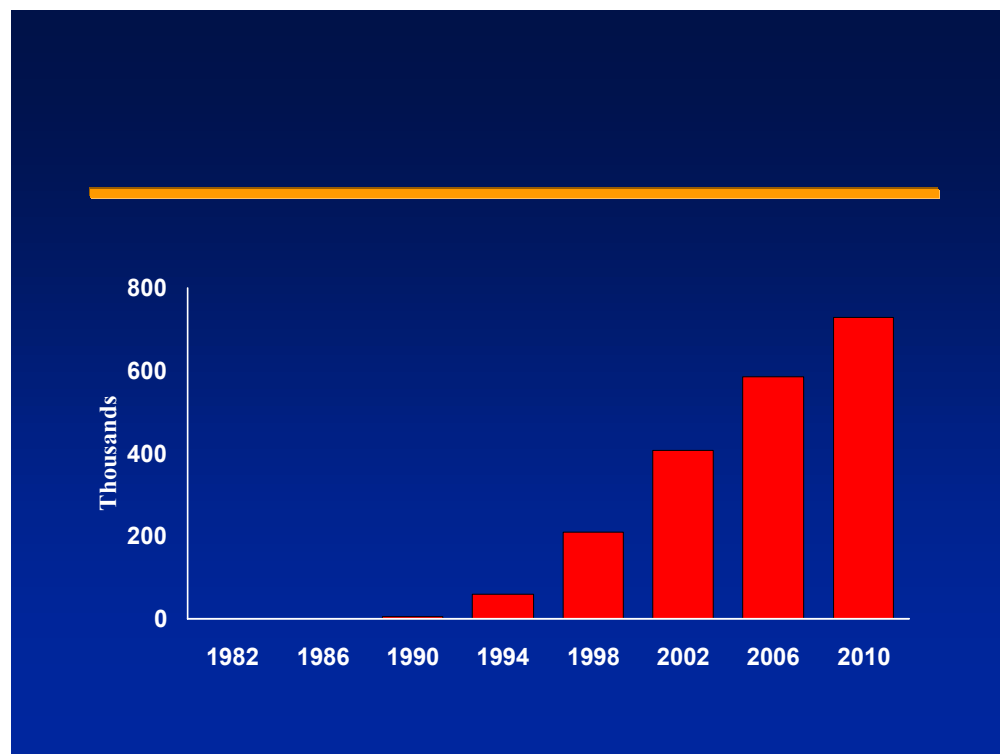


Fig. 8: Projected number orphans as a result of AIDS in Malawi. (Source: NAC, 2002)

Although established orphanages are few, a lot of data can easily be obtained from communities, relevant government departments and NGOs responsible for orphan support or care. Collection of these data is critical for any efforts to address the problem of orphans adequately.

In general orphans are underprivileged and orphans due to AIDS have additional burden of nursing a sick parent prior to death. As a result they may have been unable to attend school. In addition family resources may have been exhausted from medical and funeral bills. Due to the breakdown of traditional systems of caring of orphans through extended families the large and ever increasing number of orphans from the AIDS epidemic, most NGOs involved in care of orphans advocate supporting of foster homes to care for the orphans in community.

The Poor

The poor are also considered to be particularly vulnerable to HIV/AIDS. Although the majority of people living with HIV are poor this does not suggest that all people living with HIV are poor. However, poverty may force people into behavior that may put them at higher risk for HIV infection. Poverty often leads people to engage in survival strategies that are conducive to the spread of HIV such as migration commercial or noncommercial sex work. Furthermore, education and health care services that can reduce the risk of HIV infection such as STI treatment and use of condoms may not be accessible because they cannot afford.

L. THE IMPACT OF THE HIV/AIDS EPIDEMIC IN BLANTYRE

At global level, the HIV/AIDS pandemic is recognized as having a serious adverse impact on health, social and economic situation in many countries. Its impact on health is evident in the dramatic increase in morbidity and mortality especially in developing countries. In most sub-Saharan countries such as Malawi, life expectancy has drastically declined due to the impact of the epidemic. AIDS has become the leading cause of deaths among adults in many developing countries. Infant and child mortality have increased and all gains made in the past few decades through good immunization are being reversed. Its impact on the social and economic activities in the affected populations is being felt at all levels of society. In this section the aim is to provide information or data demonstrating the extent of the epidemic has affected residents in Blantyre.

The impact of HIV epidemic can be considered as direct or indirect. Its impact on morbidity and mortality is considered to be direct on health status, while its impact on social and economic activities of a community to be indirect. The distress of thousands of child-led households, the loss of large numbers of the country's workforce, and the increasing poverty that accompanies continued ill-health, the threat to the political stability of the country are all different levels of the indirect impact of the HIV epidemic.

Health Sector

At the national level the Ministry of Health and Population (MOHP) provides about 60% of health services while the Christian Health Association of Malawi (CHAM) about 37%. Other NGOs and private facilities provide about 3% of services. At community and health post levels, health surveillance assistants and community members are the main service providers.

Within southern Africa, only Mozambique spends less on health per capita (US\$8) than Malawi (US\$11). Access to care is limited; although 80 % of Malawians live in rural areas, most of the country's health resources are located in the major urban centers such as Blantyre. About 75 % of Malawians it takes more than 30 minutes to reach a health facility. The most cited reasons affecting access to health services are transport cost (60.0 %), money for treatment (56.2 %), time to reach a health facility (56.2 %), and availability of transport (52.3 %).

There is a critical shortage of medical personnel, particularly in rural areas. Most districts lack a doctor, and nurses are in extremely short supply resulting in extremely high ratios of population to medical personnel. HIV/AIDS is recognized by the official as a major factor for attrition of

qualified health workers. Health workers among other civil service sectors appear to have been disproportionately affected by the epidemic since it started. The human resource problem in the health sector exists at all levels in the country including other providers such as BCA. Mortality due to AIDS is seen as the major contributing factors to attrition of staff. The figure below indicates attrition of staff in the various sectors.

Morbidity

Data from the Health Information are the only major source in Malawi to determining morbidity rates. A few special surveys have been conducting a few hospitals to estimate the impact of HIV on morbidity. A study conducted at Queen Elizabeth Hospital about 3 years ago indicated that HIV/AIDS-related conditions accounted for over 40 % of all inpatient admissions and 70% in medical wards. In general, there is limited data on number of HIV/AIDS patients occupying hospital beds or cost of treating opportunistic infections.

In a study conducted at QECH in 1995, of the 1,020 postpartum women enrolled in a study investigating maternal morbidity in Blantyre, 26 %t were HIV-positive. Women with HIV had more health problems during pregnancy than HIV-negative women; these problems included herpes zoster (5.0% vs. 0.3%), abnormal vaginal discharge (7.3% vs. 3.6%), TB (1.9% vs. 0.3%), fevers (31.4 vs. 18.9%). Babies born to HIV seropositive mothers were, on average, 550 grams lighter, and there were more prenatal deaths among those with HIV infection (6.4% vs. 3.8%).

Tuberculosis (TB)

The HIV/AIDS epidemic has been associated with a rapid increase in the number of TB cases worldwide. A survey conducted by the National TB Control Program in 1999 showed HIV seroprevalence of 77% among TB patients. In 2000, more than 60% of hospitalized TB patients were found to have one or more other opportunistic infections. According to WHO, TB notification rates in Malawi increased from 77 per 100,000 population in 1980, 131 in 1990, 191 in 1995 and 209 in 2000. However, only 35 % of laboratories test samples for TB five days a week.

In general, the number of reported TB cases in Malawi increased threefold since the HIV/AIDS epidemic. The reported number of TB cases in Blantyre increased from 5,000 in 1985 to 23,000 in 1999. It is also reported that the greatest increase is among the extra-pulmonary TB cases. There has also been an increase in the rate of treatment failure and relapses among treated TB patients due to co-infection with HIV.

Malnutrition and other conditions: Another study at Queen Elizabeth Central Hospital examined the impact of HIV infection on clinical presentation and case fatality rate among 250 severely malnourished children over one year of age. HIV prevalence was 34.4 % and the overall mortality rate was 28 %. The in-hospital case fatality rate was significantly higher for HIV-infected children (38.4 %) than for children without HIV infection (22.7 %). The proportion of children with HIV/AIDS in the Umoyo house (NRU) at QECH is reported to have increased sharply over the past few years.

In general, the incidence of malignancies have increased since the start of the HIV AIDS

epidemic. In Malawi the Cancer Registry at QECH is main data collection center on cancers. Over the past 10 years these data indicate that incidence rate of Kaposi's sarcoma (KS) both in adults and children has increased. The data also reveals increase number of cervical cancer among young women and many others which normally are rare..

Demographic

In January 2002, Malawi's National AIDS Commission reported that HIV/AIDS is the leading cause of death in the age group 20-49 years which is the most economic productive age group. In July 2002, UNAIDS estimated that there were 80,000 adult and children's AIDS deaths in Malawi during 2001 compared to 70,000 in 1999. This increase in the HIV/AIDS specific mortality rate is having a major impact on the demographics in the country. According to estimates from the US Bureau of the Census, crude death rate in Malawi in 2002 was 22.3 per 1,000 population. In the absence of AIDS, this figure would be 12.0. Projections for 2010 indicate crude death rate of 23.1 per 1000 and 9.9 per 1000 without HIV/AIDS.

HIV/AIDS is also associated with increase in mortality rate due to other causes. The 2000 MDHS indicates that the maternal mortality ratio (MMR) was 1,120 deaths per 100,000 live births during the seven-year period prior to the survey while in 1992, MMR was 620 per 100,000. Thus, MMR increased by about 45 % from the late 1980s to 1990s. Although the AIDS specific MMR as well as the increase is not known, it is likely that AIDS is a main contributing factor.

Life expectancy at birth in Malawi was 38.5 years in 2002 compared to 56.3 years without the AIDS epidemic. By 2010, life expectancy is projected to fall to 36.9. According the US Census Bureau, Malawi's population growth rate in 2002 was 2.3 % (the highest in southern Africa) but would have been 3.3 % without AIDS. (Table3 and 4).

Table 3. Demographic Characteristics with and without AIDS, 2002

Indicator	With AIDS	Without AIDS
Crude Death Rate (deaths per 1000 population)	22.3	12.0
Infant mortality Rate (death per 1000 live births)	106.1	87.2
Underfive mortality rate (deaths per 1000 live births)	184.7	155

Source: K. A. Stanecki. The AIDS Pandemic in the 21st Century. Washington, DC: U.S. Bureau of the Census, July 2002. Draft report prepared for the XIV International AIDS Conference, Barcelona, July 7-12, 2002

Table 4. Demographic Characteristics with and without AIDS, 2010

Indicator	With	Without AIDS
Growth Rate (%)	1.9	3.2
Life expectancy	36.9	59.4
Crude Death Rate (deaths per 1000 population)	23.1	9.9
Infant mortality Rate (death per 1000 live births)	97.9	73.2
Under-five mortality rate (deaths per 1000 live births)	165.1	125.2

Source: K. A. Stanecki. *The AIDS Pandemic in the 21st Century*. Washington, DC: U.S. Bureau of the Census, July 2002. Draft report prepared for the XIV International AIDS Conference, Barcelona, July 7-12, 2002 .

Macroeconomic Impact

Haacker from the IMF has modeled the impact of HIV/AIDS on the economy in Malawi under several scenarios. According to the models Malawi would experience a 4.8% reduction in GDP per capita because of HIV/AIDS; of this percentage, 0.8 % due to total factor productivity, 1.4 % to the capital/labor ratio, and 2.5 % to "experience". The International Labor Organization projects that Malawi will lose 18.9 % of its labor force by 2020.

The declining economy, the social distress of thousands of child-led households, the loss of large numbers of the country's workforce, and the increasing poverty that accompanies continued ill-health may disrupt the political stability of the country. The availability and price of maize on the market is a major element in family food security for the majority of farmers. High levels of HIV/AIDS infection mean that the coping strategies of communities, already under major stress, are at breaking point.

Economic productivity

Increases in health worker illness and death rates have reduced personnel and increased stress and overwork. Lost time and labor rendering health care less accessible and more expensive for families and households. It is projected that if Malawi were to maintain its current numbers of doctors and nurses, training of doctors and nurses would have to increase by about 25-40 % between 2000-10. Concurrently, increasing workloads and concerns over HIV infection may undermine the quality of health care services for those most affected by HIV/AIDS. This scenario may provide incentive to emigration, which can exacerbate brain drain. All sectors of the economic production have been heavily affected.

The dependency ratio is defined as: (population ages 0 to 14 plus the population ages 50 and above/working age population (15-49). During the initial stages of the epidemic, dependency

ratios increase as most deaths occur among the working age population, which reduces economically productive population. This means that there are fewer working adults to support the non-working youngest and oldest members of the population. According a report by the U.S. Bureau of the Census Malawi's dependency ratio in 2000 was 116.5, which would have been 115.0 without AIDS.

Household level

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

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

Women head 25% of Malawi's households and these households have always been disproportionately poor, especially in the rural areas. The U.N. reports that the number of child-headed households is rising. Orphans fall to the care of grandparents or other relatives who are themselves facing economic hardship. Children who lose one parent suffer great disadvantage, whether in terms of loss of a breadwinner or of parental care.

Summary on Impact of HIV/AIDS

Based on the national HIV prevalence estimates nearly one in five adults in Blantyre live with HIV/AIDS. This proportion is very high. As described in this section the nature and impact of the epidemic is similar where heterosexual transmission is predominant. Certain social groups such as the poor, youths, women and children are disproportionately affected by the infection and its impact. While the impact of HIV /AIDS within BCA is recognized its exact magnitude on these population groups is not known. It is also recognized that the epidemic can erode capacity of the city to develop or responding the challenges of economic and political development of BCA. According the data more 50% of urban population in Blantyre lives below the poverty line. This suggests that the impact of HIV/AIDS in Blantyre may be much greater than is understood. It is recommended that data on the impact of HIV specific to Blantyre be obtained as such data will be critical in evaluation of intervention programs in the future.

N. THE NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

The goal of the National Response in Malawi is well summarized in the global fund application proposal. Its emphasis is on integration of care and support which is linked to the prevention strategies as outlined in National strategic Framework. The prevention strategy includes Behavior change and communication, Voluntary Counseling and testing, Control and management of STIs including use of condoms, Blood safety and prevention of mother-To-Child Transmission. The goal being to reduce the burden of HIV/AIDS related illnesses and deaths so that they no longer pose a threat to economic growth and political stability, thereby preserving the young democracy in Malawi. The response by Government has been systematic various policy have been developed and put in place.

The national response to HIV/AIDS is predicated on an effective, efficient health care system as well as strengthened capacity at all levels. However, given the impacts of the humanitarian crisis caused by the epidemic, the ability to mount a response to HIV/AIDS at all levels is adversely affected.

National HIV/AIDS Policy

In 1989, the government established the National AIDS Control Program (NACP) and the National AIDS Secretariat (NAS) to provide technical leadership. The National AIDS Committee (NAC) was established to provide NACP with policy guidance and technical support. A Cabinet Committee on HIV/AIDS Prevention and Care was formed to provide policy and political direction to the NACP. The cabinet committee is chaired by the Vice President, with the Minister of Health and Population as Vice Chair.

During the 1990s, two medium-term plans on HIV/AIDS (1989-93 and 1993-98) were developed. The second plan stressed multi-sectoral approach to dealing with the epidemic. During this period, NACP developed structures at central, regional, and district levels, including District AIDS coordinators and district AIDS coordination committees. As the institutional framework for HIV/AIDS prevention became more complex with the public and private sectors, NGOs, CBOs, PWHA, donors, and faith-based organizations becoming increasingly involved in HIV/AIDS prevention, support, and care. NACP became more diverse to include services in surveillance, counseling, home-based care, IEC, STI treatment and prevention, and research.

The process of developing a national AIDS policy in Malawi started in May 2000. Intervention-specific policies and guidelines are at different stages of preparation. Manuals to facilitate training and dissemination of information at district and local levels are also being developed. These among others, include travel, prisons, confidentiality, breast feeding, care givers, research & surveillance, and migrant populations. Malawi is developing a labor policy that explicitly integrates a human rights based approach to HIV/AIDS in the workplace. In the interim, lacking national guidance, several companies are working with NGOs to develop their own HIV/AIDS programs and policies.

National Strategic Framework for HIV/AIDS 2000-2004

In 1996, the government and its partners evaluated the response. They found that despite high awareness of HIV/AIDS, behavior change had been limited and HIV incidence continued to increase. They also cited weaknesses of NACP at central level and its inadequate representation at district and local levels as reasons for its inability to provide the required technical leadership in a deteriorating HIV/AIDS situation. The major recommendation was that Malawi should develop a comprehensive National Five-Year Strategic Plan to guide HIV/AIDS prevention and mitigation. In February 1998, the government established a Strategy Planning Unit (SPU) within NACP to manage the process.

The strategic framework was developed through a participatory approach, involving 60 communities in 20 districts, 57 public, private, non-governmental, community, and religious institutions. Its overarching goal is to "reduce incidence of HIV and other sexually transmitted infections and improve the quality of life of those infected and affected by HIV/AIDS." In the M&E section, it is indicated that "the overall target for the national response is to reduce the incidence of HIV in the age group 15-49 by about 50%. The annual incidence in this age group is currently estimated at 1.96% for 1999, and would be reduced to about 1.86% in the year 2004 even without any interventions. The national response aims at reducing this annual incidence rate to about 1.0% by the year 2004."

Non-Governmental and Community based organizations form the core of implementing agencies in response the HIV/AIDS epidemic. In chapter 14, government's role is defined as "to provide overall leadership and direction to the national response. The implementation is based on multi-sectoral approach which relies on the independent provision of a broad variety of interventions and service programs by many different actors. The government is expected to give implementing responsibility to civil society, recognizing the enormous and critical role they can play in HIV/AIDS prevention, care and support.

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

Budgets The strategic framework indicates that the Ministry of Finance would allocate adequate funds to line ministries, departments and organizations responsible for HIV/AIDS control and management activities. It was projected that the Government would contribute US\$14.5 million over the five-year implementation period of the strategic framework. Funds released through HIPC are supposed to benefit HIV/AIDS programs. However, on the whole budget allocation from Government remains relatively small.

Global Fund to Fight AIDS, Tuberculosis & Malaria (GFATM) There have been serious efforts to

identify external resources by government in response to the HIV/AIDS epidemic. In October 2000, the Malawi's GFATM proposal through an extensive process of consultations both nationally and internationally was submitted for funding. The Malawi Global Fund Country Coordinating Committee (MGFCC) was appointed in February 2002. It is chaired by the Principal Secretary in the Ministry of Health and Population with NAC acting as the Principal Recipient and secretariat. In August 2002, MGFCC received the final approval of US\$196 million funding for over five years. The global fund is major resource in addition to funds from other donors. The implementation of programs based on the response outline in the program is underway. Under HIV/AIDS there are 4 major components addressed in the proposal and these are VCT, PMTCT, Community home based care and treatment, management of opportunistic infections and ARVs.

In brief, the response to the HIV/AIDS at the national level is a fairly robust one. The political public acknowledgment of the seriousness of the epidemic is at the highest level. The leadership has also demonstrated its commitment to an effective response by developing relevant policies and guidelines. This commitment is also matched the government's pledge to provide funds for implementing programs on HIV/AIDS.

O. BLANTYRE CITY ASSEMBLY RESPONSE TO THE HIV/AIDS EPIDEMIC

There is strong evidence of a robust national response to HIV/AIDS in Malawi. However, the response at assembly level including Blantyre is extremely limited until now. BCA is among more than 20 Assembly areas in the country which were established under the Local Government Act 1998. The Act provides for many functions such as establishment and maintenance of health services within its area. Assemblies can also aid and support other institutions or organizations within its area providing charitable, educational and welfare services for the benefit of the public. The functions of the Assemblies are further elaborated in the Malawi Decentralization Policy approved by the government on January 26, 1996. The Local Government Act 1998 provides power and responsibility to Assemblies to draw up plans for social economic and environmental development of their areas. The Act requires that in the process of preparing the development plans, they should do so in conjunction with other agencies.

Policy and Funding level

The BCA leadership acknowledges and recognizes the importance of HIV/AIDS as a serious public health, social and economic problem. However, commitment in responding to the HIV/AIDS epidemic in terms of resource allocation to combat the problem is limited. The lack of policy at the assembly level may explain the inadequate or lack of resources for HIV programs provided by the Blantyre City Assembly.

In 2001, BCA developed an implementation plan on HIV/AIDS. Since then several workshops and consultation have taken place to determine a way forward in response to HIV/AIDS. The effectiveness and sustainability of the initiative will need a strong corresponding budgetary commitment by the Blantyre City Assembly. This report is part of BCA current initiative to respond to HIV/AIDS through collaboration with Municipal Development Partnership (MDP) with support from the Community Empowerment and social Inclusion (CESI) Program of the World Bank Institute, this initiative is being strengthened.

Infrastructure and Capacity

Currently, all health related activities including HIV/AIDS activities are under the BCA health department. However, BCA will need to integrate HIV/AIDS activities in all other departments in line with National Strategic Framework. In addition, Health Department has limited resources especially human resources. However, department will remain central to BCA HIV/AIDS initiatives to coordinate any activities or programs which may be established. In order for the department to effectively the response with BCA would require substantial inputs in terms of human resources and infrastructure to adequately manage any HIV/AIDS programs.

The Fig below shows the distribution of health facilities according provider within BCA. Of the nearly 20 health facilities in Blantyre 2 health centre are operated by BCA. This means most of the major core activities identified as core responses at national level through the global fund cannot be provided directly by the BCA because the facility based. BCA would therefore only have a minimal contribution in such programs as provision of ART, OIs, VCT or PMTCT. However, the BCA can provide leadership or coordination of the many stakeholders or partners within the BCA. Although BCA does not have an established HIV/AIDS epidemic response program there are many independent organization involved in HIV/AIDS activities in Blantyre. These activities

range from prevention to care and support services. Table 5 shows all organizations identified within BCA involved in HIV/AIDS programs. Some of the known specific programs include IEC, condom distribution, Antiretroviral therapy (ART), home based care, psychological support and prevention.

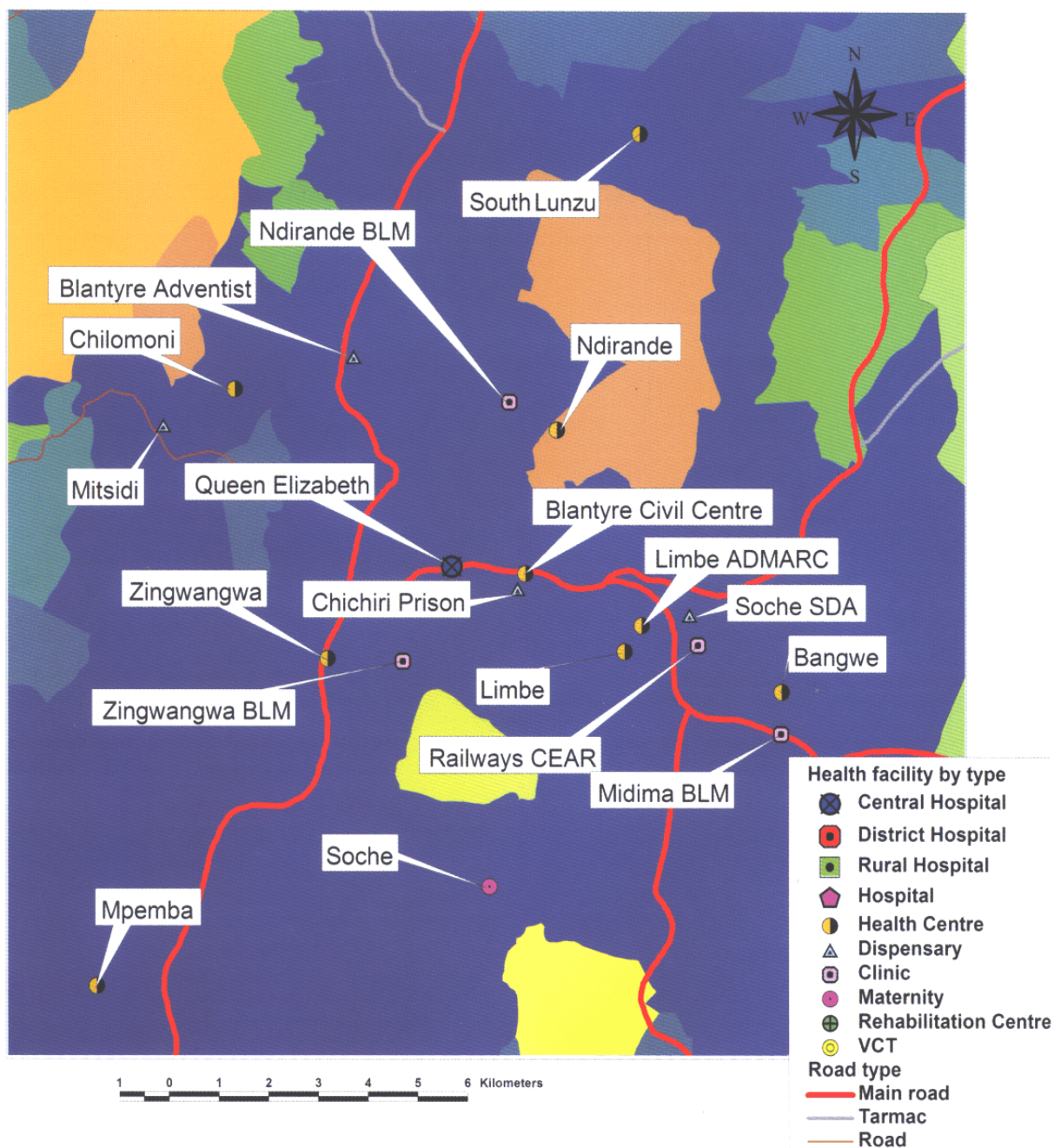


Fig : Blantyre District (Urban Area) Health facilities (Source: Ministry of Health 2003)

Although various organizations indicate the type of HIV activities or programs they are

conducting, no data is available to determine the effective of these programs. Below we discuss some the various HIV/AIDS activities in Blantyre.

Information Education and Communication (IEC)

According to the National Strategic Framework IEC is aimed at moving from general awareness which is found to be more than 98% to sustained behavior change. The emphasis is on messages encouraging adoption of low risk behavior such as abstinence, faithfulness, consistent condom use and reducing stigma.

Messages on HIV/AIDS are conspicuously visible on large billboards in Blantyre. They provide evidences of fairly intensive efforts by various organization involved in HIV prevention to disseminate HIV/AIDS information to the public. There are several radio stations in Blantyre including the national radio station. All carry various programs on HIV/AIDS. However, data on frequency, content or coverage of the HIV/AIDS program is not available. The print media is also fairly active in discussion issues on HIV/AIDS.

Many public places such as market, schools, hotels and hospitals have posters with HIV/AIDS prevention messages. Most posters are produced and distribution by the National AIDS Commission, the Ministry of Health and Population Services International.

Condom distribution

The Condom is a known effective method against sexual transmission of HIV and other STIs. However, in HIV/STI prevention programs many other factors determine their effectiveness. These include availability of policy on condoms, availability in appropriate places, quality and access for those who need them

PSI is a social marketing organization which promotes use of condoms to prevent HIV/STIs. Public health facilities and other large organizations in the private sector are known to provide free condoms. However, there is no data to determine, consistent availability and coverage in the distribution of condoms in Blantyre. Reports from PSI over the past 3 years indicate that sale of condoms in Blantyre and Malawi has steadily increased. However, apart from a few surveys conducted among child bearing age women at QECH data on condom use in Blantyre is limited. It is clear that in any program aimed at promoting condom use in Blantyre the role of PSI is critical. The private sector and health sector within Blantyre should be involved.

HIV Voluntary Counseling Testing

Malawi's strategic framework for HIV/AIDS is premised on informed consent and confidentiality. MACRO is the main provider of VCT services in Blantyre. According to World Health Organization, during 2001, 40,806 clients were seen at Malawi's 14 publicly funded/NGO VCT centers more than 50% of these were reported from the center in Blantyre. At national level the estimate from the 2000 MDHS is that only 10.5% of demand for HIV testing is being met. The demand among men was estimated at 87.4 %; with 15.2 % having been tested for HIV and 17.4 % of demand being met.

In addition to the VCT center at MACRO 2 other VCT centers have been opened at QECH and Ndirande Health Center. As ARVs become more available in Malawi the demand for VCT is

likely to increase and more such centers will be needed. However, this will also demand more qualified counselors. The main objective of the VCT in Blantyre would be to reach all individuals within the sexually active age group. The available VCT centers do not have the capacity to do so and therefore more centers are needed. BCA can play a major role in facilitating establishment of VCT centers to cover all geographical areas of the city.

Prevention of HIV MTCT

In Malawi the PMTC program was officially launched early 2003 by the government. The National Task Force on PMTCT with funding from GFATM has developed PMTCT guidelines. The MOHP through Boehringer Ingelheim (BI) agreement can access free Nevirapine for PMTCT. The free NVP can also be made available to any local organization involved in implementing PMTCT. Currently, there are about four established PMTCT pilot programs by MSF (France and Luxembourg), UNICEF and UNC. PMTCT services are also available in research settings through the as Johns Hopkins-College of Medicine Project and the University of North Carolina in Lilongwe.

There are no PMTCT programs in Blantyre despite the high HIV prevalence among pregnant women. Blantyre city assembly provides antenatal care services for pregnant women in all of its health facilities. As part of the response to HIV/AIDS these services can also easily be used to provide routine PMTCT services if free Nevirapine is made available. These facilities could also provide VCT services if test kits can be made available. However, more health personnel to provide counseling and HIV testing would be needed.

Home Based Care (HBC)

Home-based care is considered part of the continuum of care for those living with AIDS. It is identified a major component in the national response to HIV/AIDS. However, the skills, capacity, and financing are extremely inadequate to meet the increasing need at all levels. About 10 percent of AIDS patients receive HBC services, with great variance among districts. Several surveys on care of People with HIV/AIDS (PWHAs) in Malawi have identified food as the number-one unmet need of PWHAs which can be worsened by episodes of famine or poverty. Household's need for financial assistance is also frequently cited by patients and HBC providers. On a recent mission, Family Health International found that HBC programs with permanent professional staff (e.g., nurse, clinical officer, medical assistant, community health nurse, or health assistant) are more integrated and have better monitoring and supervisory mechanisms.

In responding to HIV/AIDS in Blantyre there will be need to establish more home based care services. Currently a few NGOs in Blantyre such as the Salvation Army and WordAlive Ministries International are involved in providing HBC. However, it is not clear how active these programs are within urban Blantyre. The BCA can act main coordinating institution for the various NGOs or agencies with interest in HBC in Blantyre.

Treatment of Opportunistic Infections (OI)

Treatment of opportunistic infections has been limited by lack of HIV/AIDS diagnostic facilities, unclear treatment guidelines, frequent stock-outs of drugs and inadequate training of health care personnel. However, this situation is changing, with the national response to HIV/AIDS (GFATM proposal) focusing on care and treatment. Treatment of OI is one of the major components to

benefit from the GFATM funding for Malawi.

According to WHO, 120 Malawian adults with HIV received Isoniazid (INH) prophylaxis during 2001, representing less than 1.0% of the population in need of such a services. Pnuemocyst carinii (PCP) prophylaxis using cotrimoxazole for children or adults is still under discussion.

The implementation of these activities is mainly through hospitals and clinics. There is no data on the current practices or level of OI treatment in the health facilities in Blantyre. Figure shows that there more than 10 health facilities which provide clinical services within BCA. These facilities are potential centers where OI services can be provided. The BCA can play a major role in establishing OI services within BCA as part of the response to HIV/AIDS.

Antiretroviral Therapy or Highy Active Antiretroviral Therapy (ART/HAART)

In Malawi, Antiretrovirals (ARVs) remain out of reach for the majority of HIV infected individuals. There is limited availability of drugs and the cost remains too high for the majority of people who need them. The Ministry of health and Population has developed guidelines for antiretroviral therapy. However, laboratory monitoring capacity to manage an effective ART program is still limited.

Blantyre as a major urban center has more options available accessing ART than many other places in the country. Both public and private specialist hospitals as well private pharmacies are available. Blantyre, through QECH, is one of the two main centers with Lilongwe to benefit first from a publicly funded ART program. The MOHP introduced the ART program in the year 2000 . The program started offering dual therapy (ZDV and 3TC) based on a cost sharing system (10,000 Malawi Kwacha per month). In 2002, the regimen was switched to a generic triple therapy product, Triomune. The introduction of Triomune reduced the cost to about 2,500 Malawi Kwacha per month. Since then up to 1000 individuals in Blantyre alone with HIV are estimated to have benefitted through this program. However, these costs exclude laboratory test costs for monitoring. As a result there has been a concern that the program may easily be providing sub-optimal service. The laboratory capacity for monitoring ART will remains a major challenge for a successful ART program for public institutions in Blantyre.

In January 2000, MOHP launched the lighthouse as a pilot HAART program at Lilongwe Central Hospital. Its partners include the University of North Carolina, Chapel Hill. Initial medication availability was limited to ZDV and 3TC combination therapy. In October 2001, Cipla's Triomune (D4T/3TC/NVP) was substituted due to cost. Demand for medications increased dramatically after this price reduction, although adherence remains a big problem. Médecins sans Frontières (MSF) has been providing HAART in Chiradzulu District Hospital for the past 2 years. After at least 3 drug counseling sessions, ARV triple regimen is offered to patients with AIDS. The ARVs are free. During the first months, patients return for drug resupply/counseling and clinical check-up at frequent intervals. A CD4+ -cell count is performed every 6 months. HIV viral load is not available in most settings.

In Blantyre, the private hospitals Mwaiwathu and Seventh Day Adventist were the first to start ART in Malawi. These health facilities remain the main providers of HAART in the country. As private facilities they also provide relatively better monitoring of patients. However, there is no

data on the number of patients who access ARVs through these facilities. Although, the government is developing a scaling up program for ART through the global fund and the World Bank support it is not likely the BCA health facilities can benefit from the initiative. These health facilities would require upgrading both physical and personnel.

Stigma and discriminations

According to the National Strategic framework there must be efforts to eliminate of all forms of discrimination against PLWAs, affected individuals and families. Issues raised by the HIV/AIDS epidemic with legal and human rights implications will be studied and laws and human rights codes of conduct be put in place. A labor policy that explicitly integrates a human rights based approach to HIV/AIDS in the workplace has been developed.

There are a number of non-Governmental Organizations/Community Based Organizations reported to have programs against stigma and discrimination working or based in Blantyre. The Malawi Government recognizes the role of such NGOs in protection of rights of those living with HIV/AIDS. The organizations include associations of PWHA and faith-based organizations. Some of the NGOs involved in such programs in Blantyre include Malawi Network of People Living with HIV/AIDS (MANET+), Malawi Network of AIDS Service Organizations (MANASO) and National Association of People with HIV/AIDS in Malawi (NAPHAM).

HIV/AIDS Programs at the work Place

In its new HIV/AIDS policy, the government is encouraging line ministries, public and private organizations to develop HIV/AIDS policies. Government has called upon all these organizations to include HIV/AIDS programs in their annual budget allocations. Some organizations such as the University of Malawi, Reserve Bank of Malawi and a few others already have HIV/AIDS programs especially on assisting HIV infected employees access ARVs.

There are a few NGOs who also are working with private organization on various HIV/AIDS programs. Umoyo Network and Family Health International have worked with Bowler Beverages Company Ltd. to develop an HIV prevention program for the workers, truck drivers, tavern owners, sex workers and their clients. Blantyre Christian Church has launched a program to provide HIV/AIDS services to police officers and their families. The project, funded by the Southern Africa AIDS Training Program, is deploying peer educators and is training HBC volunteers. Development Aid from People to People and Project Hope manage workplace HIV/AIDS education programs.

This represents some of the programs by partner and stakeholders to BCA directed against HIV at the work place. However, it is not clear how active or effective these programs are. There are some indications that many companies are expressing their interest to have HIV/AIDS programs at the work place. There is no data as to the coverage of such programs for the many organization in Blantyre to be effective.

P. SUMMARY

Blantyre city has one of the highest HIV prevalence rates in the country. From data among pregnant women and other population groups studied the estimated HIV prevalence is about 20% in the adult population. HIV transmission rate from mother to child is about 30% and among adults incidence of HIV is between 3.0 and 4%. These data indicate that the HIV/AIDS is major health and economic problem, and it continues to spread in the Blantyre.

There are many factors that appear to contribute or facilitate the spread of HIV/AIDS in Blantyre. It is worth to note that the fact the prevalence is high does not mean that people are not aware. According the MDHS 2000 more than 98% of those interviewed know and are aware about HIV. However, these data suggest that knowledge alone is not sufficient to influence sexual behavior. The continued high rate of new HIV infection also suggest that current prevention approaches are not showing any impact.

In the preceding discussion, it is clear that certain social groups are particularly vulnerable to HIV infection. These include women, youth and poor people. The groups are not mutually exclusive and overlap in many ways. In trying to determine vulnerability of these social groups age, gender, poverty or wealth are all highlighted as major factors.

There are many other factors that appear to facilitate the spread of HIV. The long natural history of HIV during which those infected may not be aware of their status. The political and social change in the country, the cultural beliefs, values and practices particularly those related sex or sexual behavior are all quite prevalent in Blantyre and are playing a major role in the spread of HIV.

The HIV/AIDS epidemic has a devastating impact at various levels from individuals, households communities and institutions. This impact seems so pronounced because it mostly affects young adults who are central to economic production as workers, breadwinners, parents, educators, health care providers and many others.

The level of the HIV epidemic in Blantyre requires a comprehensive response. A comprehensive approach must include all the core components as highlighted in the national response; VCT, PMTCT, HBC, ART and Os with the inherent emphasis on behavior change to reduce number of new HIV infections. The national response encompasses prevention and control as well as care and support. Although, many activities and programs in the national response are taking place in Blantyre by various organizations they are far too sparse and uncoordinated to have any meaningful impact. It should be recommended that a comprehensive response to HIV/AIDS in BCA will need to be well coordinated and must have substantial budgetary provision within BCA. It is also recommended that before any intervention programs are implemented appropriate indicators are identified and baseline surveys are conducted for purposes of evaluation those programs.

Q. REVIEWED DOCUMENTS

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9. Malawi AIDS Prevention Project June 1995 Family Health International
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14. UNDP. Malawi Government -The impact of HIV/AIDS on Human Resources in the public Sector
15. National HIV/AIDS Policy - A Call to renewed Action 2003. Government of Malawi
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APPENDIX I

WHO IS DOING WHAT IN BLANTYRE ON HIV/AIDS

ORGANIZATION	CARE	TREATMENT	TESTING & COUNSELING	PREVENTION
Banja La Mtsogolo	X			X
Blantyre Christian Centre				X
Catholic Commission for Justice and Peace	X			X
Catholic Development Commission of Malawi	X			X
Catholic Diocese of Malawi	X			X
Community-based Options for Protection & Empowerment	X			X
Council for NGOs in Malawi	X			X
Christian Health Association of Malawi	X	X	X	X
Episcopal Church of Malawi	X			X
Evangelical Association of Malawi				X
Family Planning Association of Malawi				X
Herbalist Association of Malawi	X			X
Malawi AIDS Counseling and Resource Organisation				X
Malawi Network of People Living with HIV/AIDS				X
Malawi Network of AIDS Service Organizations	X			X
Adventist Development Relief Agency	X			X
Civil Liberties Committee	X			X

ORGANIZATION	CARE	TREATMENT	TESTING & COUNSELING	PREVENTION
Blantyre C.C.A.P Synod				X
Malawi CARER				X
Development Aid from People to People	X			X
Save the Children USA	X			X
Scripture Union of Malawi				X
Youth Arm Organization				X
Action Aid	X			X
National Association of People Living with HIV	X			X
Catholic Relief Services				X
Story Workshop				X
Humana People to People	X			X
Salvation Army				X
World Council of Churches				X
World Medical Fund				X
World Vision International				X
St. Johns Ambulance	X			X

APPENDIX II

TERMS OF REFERENCE

METHODOLOGY

HIV AIDS IN BLANTYRE

- \$ Statistics and Trends in HIV/AIDS in the city
- \$ Context of HIV/AIDS in the city compared to other urban centers/rural district in Malawi
- \$ Major determinants of HIV/AIDS transmission in the city
- \$ Current disclosure practices in the city
- \$ Identification of vulnerable groups to HIV/AIDS infection in the city
- \$ Impact of HIV/AIDS in the city and the following levels: Individual, household, community, business, local government, the city as a whole.
- \$ Review of access to information about HIV/AIDS in schools, medical facilities and other places.
- \$ Review of access to care and treatment of people living with HIV/AIDS
- \$ Analysis of current attitudes including review of : are parents talking to their children about HIV/AIDS? Does a state of denial about HIV/AIDS exists? How important is stigma? Is there active discrimination against people living with HIV/AIDS?

WHO IS DOING WHAT IN BLANTYRE?

Summary review of activities by the following organizations in terms of care , treatment, testing, counseling and prevention (a table format could be used

- \$ Blantyre city Assembly both programs and policies that target HIV/AIDS
- \$ NGOs (include NAPHAM, CBOs, Religious organizations
- \$ The private sector - businesses and companies, informal sector vendors
- \$ National programs active in the city from National Ministries, Donor organizations, UN system.

ANALYSIS & ASSESSMENT OF THE RESPONSE TO DATE

- Are the responses to date effective in reaching the city population?
- Which are the most effective responses?
- What responses need to be developed?
- Where are their gaps in terms of providing information?



BLANTYRE CITY ASSEMBLY

HIV & AIDS

WORKPLACE POLICY

2006

DEFINITIONS.

There are several abbreviations that have been used in this document. These are explained below:

Affected Employee – an employee who is affected in some way by HIV and AIDS, e.g. an employee whose spouse has AIDS or is infected with HIV.

AIDS – the Acquired Immuno-Deficiency Syndrome, a group of diseases including some opportunistic infections and cancers that persons with HIV often suffer from.

ARVs – Anti-retroviral drugs used in HIV and AIDS patients.

BCA – Blantyre City Assembly.

CACC – City AIDS Coordinating Committee for City of Blantyre.

HAC – HIV/AIDS Coordinator for the City of Blantyre.

HBC – Home Based Care.

HIV – the Human Immuno-Deficiency Virus, a 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.

Infected Employee – an employee who has tested positive for HIV or has been diagnosed as having AIDS.

Informed Consent - a process of obtaining consent from a person that ensures that a person fully understands the nature and implications of the test before giving his or her agreement to it.

MANASO – Malawi Network of AIDS Service Organizations.

MDP – Municipal Development Partnership for Eastern and Southern Africa.

NAC – National AIDS Commission.

NAPHAM – National Association for People living with HIV/AIDS in Malawi.

PLWHA – People Living with HIV/AIDS.

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

SAfAIDS – Southern Africa AIDS Information Dissemination Service.

STIs – sexually transmitted infections.

Surveillance – anonymous unlinked testing or observation done to determine the incidence or prevalence of a disease condition in a particular population and helps to provide information on the control, prevention or management of the disease.

TB – tuberculosis.

TOT – Trainers of Trainers.

UMP – Urban Management Programme.

UNAIDS – United Nations AIDS Programme.

UNICEF – United Nations Children's Education Fund.

VCCT – Voluntary Confidential Counseling and Testing, a process by which a person gets counseled and gives consent to undergo a test for HIV infection.

1.0 INTRODUCTION.

Blantyre City Assembly is a local authority created by Government under the Local Government Act of 1998 and charged with responsibility to deliver infrastructure, local governance and social services to the residents of the area under its jurisdiction. The Assembly has a workforce of 1500 permanent employees, and engages between 300 and 500 temporary employees every year, especially during the wet season. With a workforce of this size, HIV and AIDS infections have not spared the organization. Approximately two (2) percent of the current permanent workforce is on antiretroviral treatment.

1.1 METHODOLOGY

The development of this policy has been guided through several consultation meetings with members of the senior management team and other members of staff of Blantyre City Assembly. Meetings were also held with our partners in the Blantyre City HIV/AIDS Initiative such as SFAIDS, MDP, UMP, etc. A Task Force, made up of ten (10) members of staff, led the process through consultations and drafting the policy. The members were representatives of various Assembly departments, the worker's union, junior members of staff with good gender representation, etc. Several documents were utilized in the process to guide the policy development; these included policies of other organizations, the Public Service draft HIV/AIDS policy, National AIDS Policy, the DFID and World Bank report on local government response to HIV/AIDS and International Labor Organization guidelines on policy development.

2.0 BACKGROUND

Malawi has a population of about 11,000,000. Out of this population, 85% lives in rural areas. Malawi is one of the countries that are adversely affected by the HIV and AIDS epidemic in Southern Africa, with an adult (15-49 years) prevalence rate of 14.4% according to National Aids Commission figures of 2003. The highest prevalence of HIV/AIDS is in urban areas (twice as high) as compared to the rural areas (urban 23% and rural 12.4%)

Blantyre City is the largest urban center and the main commercial and industrial center in Malawi with a population of about 600,000. About 60% of this population lives in unplanned or squatter areas that are characterized by congestion of houses and poor infrastructure and social services. The city has a young population hence a high dependency rate with about 60% of the total population being below 25 years. The population of Blantyre City is growing by 3.4% due to both natural growth and rural urban migration. The migrants are attracted to the city by economic activities, services and opportunities that are available in the city. Unemployment rate at the moment is 57%; illiteracy rate is at 27% while 82% are lacking formal skills. About 46% of all households in the city earn less than \$50 a month. Poverty is pervasive in the city with 65% of the total households in the city living below the poverty line.

According to National AIDS Commission (NAC), there were nearly 100,000 people living with HIV and AIDS in Blantyre city in 2003. At one time this represented the highest figure in the whole country but latest figures show that Blantyre City has been surpassed by Nsanje District.

2.1 SITUATIONAL ANALYSIS.

The impact of HIV and AIDS in the workplace is increasingly being felt. This is manifested in the following ways:

- Increased medical costs for organizations and individuals.
- Decrease in productivity by many employees due to absenteeism, funeral attendances and sickness.
- Organizational memory loss.
- Increased poverty and school drop outs due to lack of support.
- Premature payment of employee benefits and low workplace morale.
- A new development in some work places has been discrimination, dismissal and denial of some benefits to employees known or perceived to be HIV infected.

The Blantyre City Assembly as a Local Assembly is charged with the responsibility of performing and delivering various functions and services in the city, for the benefit of staff and residents. These include:

- Engineering services (civil, mechanical and electrical).
- Health, social and cleansing services.
- Leisure, culture and environmental services.
- Town planning and estates management services.
- Administrative and financial services.
- Local Governance.
- Local Policing.

Just like many other organizations, the Blantyre City Assembly is affected by the spread and impact of HIV and AIDS in one way or another.

Being a local authority and an employer, the Blantyre City Assembly is also expected to be exemplary to its citizens in the manner that it deals with its employees affected by HIV and AIDS, taking into consideration that the city has one of the highest prevalence rates in the country as earlier stated. With this background the Blantyre City Assembly undertakes to develop and implement an HIV and AIDS workplace policy and an HIV prevention, treatment, care and support programme targeting its employees and their families.

Blantyre City Assembly is already carrying out several activities in addressing HIV and AIDS. These programmes include condom distribution, clinical activities, access to ARVs by members of staff, workplace programmes on HIV/AIDS and the Mayors Cheer Fund (for those infected and affected by HIV). Programmes that also target surrounding communities include the HIV and AIDS education at workplaces, Blantyre City HIV and AIDS Initiative, public schools programme on Reproductive Health and HIV/AIDS, sexually transmitted infections (STIs) screening and treatment, and the operation of an HIV and AIDS Resource Centre (Library) at the Civic Centre.

3.0 IMPACT OF HIV AND AIDS IN THE WORKPLACE.

Blantyre City Assembly together with employees acknowledge and recognize that:

- (a) HIV and AIDS is a major threat to the health and welfare of all employees of the assembly.

- (b) The HIV and AIDS epidemic poses a great challenge to service delivery by the assembly.
- (c) Even though the number of HIV infected employees may not be very high, action on the epidemic is required now in order to prevent today's HIV epidemic from becoming tomorrow's AIDS epidemic. Thus the ultimate goal of the Assembly is to mainstream HIV and AIDS into all programme activities. Thus the Blantyre City Assembly HIV and AIDS Workplace Policy has been developed.
- (d) An HIV infected employee can lead a productive life for many years and contribute effectively to the development of this organization. Therefore, BCA will be supportive of and make reasonable accommodation for the employee who is medically fit to perform his or her duties.
- (e) Blantyre City Assembly is committed to providing a supportive work place for all its employees regardless of their HIV status. To accomplish this, Blantyre City Assembly will foster a work environment of openness, compassion and understanding, non-discrimination and lack of fear.
- (f) Blantyre City Assembly employment practices will comply with local laws and regulations. BCA will not discriminate against a qualified individual with regard to job applications, hiring, advancement, discharge, compensation, training, or other terms, conditions or privileges of employment based on their HIV status.
- (g) BCA recognizes the fact that discrimination and stigmatization of people living with HIV or AIDS, whether real or perceived, retards efforts aimed at promoting HIV prevention.
- (h) Blantyre City Assembly does not and will not require HIV screening as part of pre-employment or general workplace physical examination.
- (i) Blantyre City Assembly will provide employees with risk reduction and prevention methods for the transmission of HIV and other STIs.
- (j) Blantyre City Assembly will actively seek to reduce and address the stigma associated with HIV and AIDS by addressing knowledge and attitude levels among staff and working partners. This will include, *inter alia*, workplace education addressing prevention, care and support, training and periodic gathering of information on employees' knowledge, attitudes and practices on HIV and AIDS.
- (k) BCA recognizes that women are at greater risk of infection than men, and carry a great burden in caring for the sick, special consideration will be provided for prevention and impact mitigation services targeting women.
- (l) Subject to financial and medical feasibility, BCA will seek to provide access to care and support services for the staff and their families infected and affected by HIV and AIDS. This will also include care and support following occupational exposure to the virus for members of staff such as nurses, medical and laboratory staff and refuse collectors.
- (m) BCA shall promote sporting activities at its work places in order to keep its workforce fit and healthy, but also to assist in dissemination of important messages on HIV/AIDS, STIs and other related subjects, just as it does with football and sanitation.

4.0 GUIDING PRINCIPLES

The policy is based upon and shall be guided by the following principles:

- 4.1 Non-Discrimination:** The Assembly shall ensure that the workplace is free of discrimination based on HIV status (perceived or real). HIV positive employees shall continue working under normal conditions in their current employment for as long as

they are medically fit to do so. Members of staff that test HIV+ or have AIDS shall not be denied benefits given to other employees. No person shall be denied employment solely on the basis of their HIV sero status.

4.2 Confidentiality: Members of staff will be under no obligation to disclose their sero status. Confidentiality will be upheld where such disclosure is made. Employees shall be encouraged to undergo voluntary testing and counseling.

4.3 Management and Care: Employees who undergo VCT and are found to be HIV positive and are eligible for treatment according to WHO's guidelines on HIV treatment, shall be put on the ARV programme once they have disclosed their sero-status to the Medical Officer of Health.

5.0 OVERALL OBJECTIVE.

The overall objective of this policy is to strengthen and guide the implementation of the HIV and AIDS programmes at the workplace for the benefit of the employer and employees.

5.1 SPECIFIC OBJECTIVES:

- (a) To ensure that all Blantyre City Assembly employees are treated equitably, whether or not they are affected in some way by HIV and /or AIDS.
- (a) To provide all Blantyre City Assembly staff with information necessary to increase their awareness of the issues related to HIV infection and AIDS.
- (b) To ensure that HIV and AIDS does not lead to discrimination and stigma against those employees affected and infected.
- (c) To ensure that Blantyre City Assembly provides the same services on HIV and AIDS in terms of prevention, care and support to its staff.

6.0 COMMITMENT OF THE BLANTYRE CITY ASSEMBLY

HIV and AIDS is weakening institutions and destroying institutional memory and capacity to implement development programmes and deliver services. Due to this, Blantyre City Assembly is committed to implement and sustain an HIV and AIDS at the work place programme. The commitment is evidenced by the following factors:

- Workplace activities on HIV and AIDS are already being implemented/undertaken through the Department of Health and Social Services.
- The Assembly has a budget line for implementation of the policy and HIV and AIDS activities. This has been in place since the 2001 budget season.
- Interest shown by the Assembly and its collaborating partners locally and internationally e.g. NAC, Municipal Development Partnerships (MDP), Urban Management Programme (UMP), Southern Africa AIDS Information Dissemination Services (SAfAIDS), Alliance of Mayors Initiative for Community Action Against AIDS at the Local Level (AMICAAL) and Malawi Local Government Association (MALGA) in implementation of the Blantyre City Assembly HIV and AIDS Initiative.
- Creation of an HIV/AIDS Officer position on the organizational chart for the Department of Health and Social Services.

7.0 PREVENTION.

Blantyre City Assembly is fully aware that:

- The major form of transmission of HIV is through unprotected sex with an infected person. Increasingly, HIV is also being transmitted from infected pregnant women to their unborn babies or after birth through breast milk. To a lesser extent some people can get infected through blood contamination.
- Some sexually transmitted infections such as syphilis, can facilitate the transmission of HIV from one person to another. Therefore, early treatment of these diseases is one of the effective responses to the HIV/AIDS epidemic.
- There is currently no vaccination against HIV or drugs to cure AIDS. The ARV drugs currently being administered to some individuals can reduce the amount of the virus in ones body and prolong lives of people with HIV and AIDS when taken regularly.
- People can control the spread of HIV by making *personal changes in their sexual behavior*, such as abstinence, being faithful to ones sexual partner and correct and consistent use of condoms.

As a result of this, the Assembly will embark on the following activities:

Information, Education and Communication: The HIV and AIDS Officer shall in collaboration with partners initiate a variety of HIV and AIDS information dissemination and education processes tailored to specific employee groups and their families. These would be done through; drama, leaflets, posters, workshops, lectures, focus group discussions. Materials shall be sourced from our partners and other reputable institutions.

Peer Education: The Assembly shall endeavor to train peer educators (TOT) who will carry out HIV and AIDS education in the Assembly. The Assembly shall support this education with the relevant materials. This would be supported by formation of HIV and AIDS clubs at the workplace.

Condom Distribution: The Assembly shall make condoms available freely in all work depots and workstations of the Assembly for members of staff. The Assembly shall include the purchase of condoms in the budget for drugs and other medical supplies.

HIV testing and counseling: HIV testing shall be on voluntary basis. Counseling services, both pre and post testing, shall be provided.

STI management: The Assembly shall provide treatment for sexually transmitted infections to members of staff and their spouses at the staff clinic and the satellite centers in the City. Dependants of members of staff shall be encouraged to visit their nearest Health Centers for medical attention and review

Occupational Exposure: The Assembly shall endeavor to provide protective wear for all employees who are at risk of being exposed to contaminated blood or other occupational exposure to HIV.

Resource Centre: In collaboration with our local and international partners the Assembly has opened a Resource Centre on HIV and AIDS at the Civic Centre to cater for its employees, community and youth groups, pupils, researchers and the general public who would like to learn more about HIV/AIDS and other related topics.

8.0 CARE AND SUPPORT

Health Care: The Assembly shall provide health education to its employees on HIV and AIDS, STIs and other related opportunistic diseases such as TB and dietary information. The Assembly shall provide affordable intervention through a medical scheme and support an ARV programme for members of staff.

Counseling: The Assembly shall facilitate accessibility to counseling facilities for members of staff. Quality training shall be provided to the counselors to offer pre and post testing counseling.

Disclosure: Employees shall be encouraged to inform their supervisors if they are unable to perform their duties due to their HIV status with the advice of the Medical Officer of Health. Such information shall only be kept on medical files. However voluntary disclosure to the supervisor would help the supervisors to allocate them tasks/work that would be suitable to their condition. The Medical Officer Health shall make recommendations as to the type of work that is suitable for a member of staff e.g. light duties.

9.0 PROGRAMMES

9.1 Prevention programmes These shall be conducted through:

- Awareness-raising campaigns such as the World AIDS Day campaigns.
- Education programmes.
- Gender specific programmes such as training and sensitization on gender issues with reference to HIV, AIDS and STIs.
- Support for behavioral change activities.
- Staff outreach programmes using Community Workers to visit affected and infected employees and offer them psycho-social support, train patients and care givers on nutrition, infection prevention, etc.
- Dissemination of I.E.C materials to employees and other stakeholders in the City.

9.2 HIV and AIDS Training. A training programme shall be put in place to train various sections and levels of employees in the Assembly on issues related to HIV and AIDS. Those to be trained shall be, but not limited to, the following cadres:

- Managers and supervisors.
- Peer educators.
- Health and Safety officers.

9.3 Voluntary Counseling and Testing. In order to encourage VCT and make the service more accessible, the Assembly shall provide:

- Training for counselors.
- Setting up a testing center at the Civic Center's public health laboratory.

9.4 Managing the Impacts of HIV and AIDS. In order to reduce and manage the impact of HIV and AIDS, the Assembly shall support the following programmes:

- Encouraging all members of staff to enroll in the Medical Scheme supported by the Assembly.
- Provision of Anti Retroviral Drugs.

- Nutritional education programmes.
- Treatment of opportunistic infections.
- Provision of prophylaxis against opportunistic infections.
- Timely processing of retirement and death benefits.
- Whenever possible, provide emergency loans to members of staff to settle medical bills, procure necessary medical drugs and food items.

10.0 CO-ORDINATION AND MANAGEMENT.

As a Local Authority, Blantyre City Assembly is responsible for co-ordination and management of HIV and AIDS activities in the City. In order to do this, the Blantyre City Assembly shall provide in its annual budget an allocation for HIV and AIDS activities and an office for an HIV and AIDS Officer.

The HIV and AIDS Officer shall be responsible for the facilitation and implementation of the HIV and AIDS activities in the City Assembly as well as being the coordinator of the local response including building partnerships and networks with other stakeholders, both local and international.

- The Coordinator will be expected to plan, design, monitor and evaluate HIV and AIDS activities in the Assembly. S/He will be responsible for the coordination of the activities with other stakeholders.
- Each Department in the Assembly shall nominate one representative to be a member of and HIV and AIDS Task Team for a one-year term (renewable). The local trade union office shall nominate one representative for one-year term to be a member of the HIV and AIDS Task Team. At least three members of the Task Team shall have to be female members in order to take gender issues into consideration.
- The HIV and AIDS Task Team shall regularly monitor and review the anti HIV/AIDS programmes and activities at the workplace. The data collected shall be analyzed to monitor trends of new HIV and STI infections amongst members of staff.
- Blantyre City Assembly shall set up a Coordinating Committee (CACC) that will be responsible for coordinating all HIV/AIDS activities in the City of Blantyre.
- The Assembly shall set up a Standing Committee on HIV/AIDS to oversee the activities of CACC and approve for funding all proposals submitted to the Assembly.

Management of BCA shall demonstrate full support of the workplace HIV and AIDS programme by e.g. funding activities, attending meetings, opening workshops and any other issues on HIV and AIDS that require Management Team's attention and decision.

Implementation of the workplace HIV and AIDS policy shall be reviewed regularly to accommodate changing needs in the work environment and new information gathered through research. The Assembly shall make an annual assessment of the impact of the epidemic in the Assembly for planning purposes e.g. by analyzing medical bills, absenteeism and death records, productive time lost etc.

Employee benefits, such as medical treatment shall be regularly reviewed in the context of HIV and AIDS. The Assembly shall be obliged to put in place a skills succession plan and improve recruitment and training of staff in the context of HIV and AIDS so that services are not adversely affected when an employee is too ill to work, retires or dies.