

## Chapter 5

### Malawi case-study

#### Chapter overview

This chapter provides a case study of the collaborative situation in Malawi. Firstly, it provides a brief overview of the religious-health landscape in this country in the context of the HIV and AIDS epidemic. It then presents the country-specific findings, followed by recommendations arising from the research.

#### 5.1 Malawi country context

##### Country Information<sup>183</sup>

**Geography:** Located in Southern Africa, landlocked Malawi shares borders with Mozambique, Tanzania and Zambia, is 118,480km<sup>2</sup> in total.

**Capital:** Lilongwe

**Language:** Chichewa 57.2% (official), Chinyanja 12.8%, Chiyao 10.1%, Chitumbuka 9.5%, Chisena 2.7%, Chilomwe 2.4%, Chitonga 1.7%, other 3.6%.

**Politics:** Established in 1891, the British protectorate of Nyasaland became the independent nation of Malawi in 1964. After three decades of one-party rule the country held multiparty elections in 1994, under a provisional constitution which came into full effect the following year. President Mutharika, elected in May 2004, struggled to assert his authority against his predecessor, culminating in Mutharika starting his own party, the Democratic Progressive Party (DPP). Reported corruption, population growth, increasing pressure on agricultural lands, and the spread of HIV and AIDS pose major problems for the country.

**Administration:** 27 administrative districts. These districts all have traditional authorities, or former chieftains, who serve as the local government throughout the country.<sup>184</sup>

**Urban Rural Split:** The economy is predominately agricultural, with about 85% of the population living in rural areas.

##### Religion in Malawi<sup>185</sup>

~80% Christian; 13% Muslim; 5% traditional African religions; and 2% Hindu or other faiths.<sup>186</sup> Major Christian denominations are Catholics(25%), Protestants(20%), and AICs(17%); groups like Evangelicals and Pentecostals are rapidly growing in Malawi, particularly in urban areas, and together account for about 32% of the country's Christians. Muslims comprise the majority in the South and Protestants dominant in the North.



<sup>183</sup> WHO-Afro 2006.

<sup>184</sup> UNFPA 2004

<sup>185</sup> Trinitapoli & Regnerus 2005

<sup>186</sup> UNFPA 2004

WHO Mortality Summary <sup>187</sup>	Year	Males	Females	Both Sexes	Top ten causes of death all ages - Malawi 2002	Death (000)	Years Life Lost %
Population (millions)	2005	6.4	6.5	12.9	All causes	252	100
Life expectancy (years)	2004	41	41	41	HIV/AIDS	86	35
Under-5 mortality (per 1000 live births)	2004	179	172	175	Lower respiratory infections	29	13
Adult mortality (per 1000)	2004	663	638		Malaria	20	10
Maternal mortality (per 100000 live births)	2000		1800		Diarrhoeal diseases	19	9
<b>Other Health Information</b>				<b>Year</b>	<b>%</b>		
HIV prevalence among adults (15 - 49) Both sexes				2003	14.2		
Total expenditure on health as % of GDP				2003	9.3		
Per capita expenditure on health at ave exchange rate \$US				2003	13		

### 5.1.1 Religious-health landscape in Malawi<sup>188</sup>

#### A. The history of religious involvement in health

The arrival of Arab merchants and the British in Malawi brought with them Islam and Christianity respectively. Missionary David Livingstone is one of the pioneers of Christianity in Malawi. The early Christian missionaries not only spread their religion but also provided social services such as schools and hospitals. Christian churches grew quickly and, in some cases, were looked upon as vehicles for modernization.

To this day, religion in Malawi, especially Christianity, has a strong service and development dimension. Christian churches and organizations in Malawi boast over 159 health facilities, 200 schools, numerous successful businesses, farms, recreational facilities and a myriad of churches. The clergy are respected and highly esteemed members of society.<sup>189</sup>

Churches in Malawi play a vocal role in matters ranging from politics and policy to health and development.

Collectively, they have an infrastructure that is even more vast than that of the government, covering every district, town and village in the country, and functioning as a source of education, health, agricultural and financial information and service delivery.<sup>190</sup>

The HIV and AIDS epidemic has also spurred on religious involvement in health. Religious entities have been involved in the epidemic since its early stages, with religious leaders taking a vocal position (although not unmarred by controversy and failures in understanding the complicated nature of the epidemic and thus fuelling stigma and discrimination). However, as the 2004 UNFPA report notes,

Faith-based organizations have come a long way since 1985 in helping to care for the spiritual, material and physical needs of those affected by HIV and AIDS. Moreover, this support is growing. In the last five years alone, at least 40 religious institutions have begun responding to the HIV and AIDS epidemic on a national and local level.

<sup>187</sup> WHO-Afro 2006

<sup>188</sup> Unless indicated otherwise, this summary is from Schmid et al 2008

<sup>189</sup> UNFPA 2004

<sup>190</sup> UNFPA 2004

The potential to expand this support through carefully formed partnerships is enormous.”<sup>191</sup>

It is, however, interesting to note that the UNFPA report continues to recognize that despite having a vast coverage and immense *potential*, the majority of ‘FBOs’ are concentrated in the South and Central regions “making HIV and AIDS-related efforts in the northern part of the country scarce.”

There is little comprehensive information about the precise location of the AIDS-related work of religious entities, particularly the more community-based or non-facility based efforts that are not tracked through networks such as CHAM. A 2007 survey by CADRE suggests that in general civil society AIDS activities in Malawi are located mainly in rural areas.<sup>192</sup> However, an earlier UNFPA report states that the work of AIDS-engaged ‘religious organizations’ is said to be concentrated in urban centres, “in part because funds for HIV and AIDS projects are more readily available there.”<sup>193</sup> Without comparative typologies or data, this issue cannot be resolved here. However, see 5.2.1 below for further participant discussion on this issue.

As an additional note, several reports have recently used Malawi as the example of a country where religious entities have been partially (yet significantly) responsible for positive behaviour change by promoting AIDS prevention through a variety of methods ranging from the relatively passive (such as inviting or allowing AIDS educators to address congregations), to the more active (such as using the prestige and moral authority of the religion to advocate behaviour such as fidelity or abstinence).<sup>194</sup>

## B. Religious entities in the Malawian health sector (or system)

Malawi ranks among the world's least developed countries. It shares many of the same challenges as its neighboring states do. This includes a weakened health system and a variety of public health and development challenges ranging from a rampant HIV and AIDS epidemic, to the technical problems of a medical workforce crisis. The extremely high maternal mortality rate in Malawi can be seen as evidence of the lack of trained midwives and access to care by pregnant women.<sup>195</sup> Health service providers in Malawi can also be separated into the traditional and modern sectors, with a large number of people using the two systems simultaneously or consecutively.

TABLE 3.1 DISTRIBUTION OF HEALTH FACILITIES IN MALAWI, BY OWNERSHIP, 1998

	MOHP	Local Govt.	Other Govt.	CHAM	Firms	Private*	Total
Central hospitals	3	0	0	0	0	0	3
District hospitals	22	0	0	0**	0	0	22
Hospitals	1	0	0	22**	7	3	33
Mental hospitals	1	0	0	0	0	0	1
Rural Hospital	16	0	0	18	0	0	34
Urban Health Centers	8	0	0	0	0	0	8
Health Centers	193	11	33	88	36	10	371
Maternity Units	0	12		4	0	11	27
Dispensaries	45	3	5	13	83	76	225
Closed	2	0		0	0	0	2
Total	291	26	40	146	126	100	729
Percentage share (%)	39.9	3.6	5.5	20.0	17.3	13.7	100

Figure 5.1: Government of Malawi 2001

<sup>191</sup> UNFPA 2004

<sup>192</sup> Birdsell & Kelly 2007

<sup>193</sup> UNFPA 2004

<sup>194</sup> See Green 2003, Liebowitz 2002, Chand & Patterson 2007

<sup>195</sup> Dimmock 2008.

There are two main categories of *traditional health providers*: traditional healers dealing with diseases/spirits, and traditional birth attendants (TBAs). TBAs have more established links with the modern health sector, having been trained to support primary health care since 1992.<sup>196</sup>

Within the *modern health sector* there are three main health service providers namely; the public sector, non-profit private sector and the private-for-profit sector. The Ministry of Health and Population (MOHP) is the largest provider of public health services. The non-profit private sector comprises the mission sector grouped mainly under the *Christian Health Association of Malawi* (CHAM).<sup>197</sup> Secondary literature states that faith-based organizations and networks currently provide between 35-40% of health services in Lesotho.<sup>198</sup>

As can be seen in the table insert (figure 5.1 above), the MOHP has the largest number of facilities (39.9% of the total health facilities), followed by CHAM (20%).<sup>199</sup> Two specialist hospitals have been added to the CHAM membership since this table was produced: St John of God Mental Hospital and Cure Children's Orthopedic Hospital.<sup>200</sup>

### 5.1.2 The HIV and AIDS epidemic in Malawi<sup>201</sup>

HIV and AIDS Estimates <sup>202</sup>	Estimate
Number of people living with HIV and AIDS	900 000
National HIV prevalence among adults (ages 15-49) <sup>203</sup>	(2003) 14.2 (2005) 14.1
Adults aged 15 and up living with HIV	850 000
Women aged 15 and up living with HIV	500 000
Deaths due to AIDS	78 000
Children aged 0 to 14 living with HIV	91 000
Orphans aged 0 to 17 due to AIDS	550 000

#### A. State of the epidemic<sup>204</sup>

Malawi's HIV and AIDS epidemic is said to have *stabilized* with declines in some local areas.<sup>205</sup> Several urban areas, such as the capital Lilongwe, have witnessed a decline in HIV prevalence, although some rural areas have seen prevalence increase.<sup>206</sup> In 2005, approximately 14.1 percent of the adult population aged 15 to 49 in Malawi was living with HIV and AIDS - almost twice that of the overall rate for sub-Saharan Africa.<sup>207</sup> New estimates in Malawi place HIV prevalence for the 15-49 age group at 12.0%. "This implies that the universal access target of 14% HIV prevalence rate by 2010 as set in 2006 has since been achieved."<sup>208</sup> Nevertheless, with one of the highest adult prevalence rates in the world, the epidemic has

<sup>196</sup> GoM 2001

<sup>197</sup> GoM 2001

<sup>198</sup> Green et al 2002, UNFPA 2007, UNFPA 2004

<sup>199</sup> GoM 2001

<sup>200</sup> Dimmock 2008

<sup>201</sup> This report emerged as international epidemiological fact sheets were being updated. New figures are expected by August 2008

<sup>202</sup> Unless otherwise stated, these come from UNAIDS 2006a

<sup>203</sup> These surveillance stats from GoM 2007 M&E report

<sup>204</sup> This section acts as an introduction to the case-study to follow, and therefore not all HIV and AIDS statistics and issues are presented. See GoM 2007 for a more complete update of the Kenyan epidemic and national response

<sup>205</sup> UNAIDS 2007

<sup>206</sup> Avert 2008

<sup>207</sup> PEPFAR 2008, UNAIDS 2006a

<sup>208</sup> GoM 2007

exacerbated social problems. There is, however, some evidence of behavioural changes that could have reduced the risk of acquiring HIV infection.<sup>209</sup> Reports on the Malawian HIV and AIDS epidemic highlight a numbers of themes. These include the following:

**The Malawian HIV and AIDS epidemic is multi-faceted:** The AIDS crisis is one of a multitude of problems currently faced by Malawi. Other challenges that coexist are poverty, food insecurity and other diseases such as malaria. "Equally, efforts to strengthen the country's economy need to be coordinated with the fight against AIDS, as one of the most significant economic problems faced is the lack of human resources caused by AIDS deaths."<sup>210</sup> Malawi is one of the poorest countries in the world and is currently facing the triple threats of HIV and AIDS, food insecurity and poor infrastructure. The economy relies on agriculture and is highly vulnerable to weather conditions.<sup>211</sup>

It has been stressed that Malawi faces a **human resource crisis**, which is exacerbated by a high staff mortality rate caused by HIV and AIDS. This has created a lack of capacity to deliver health services, especially in rural areas, where primary health care has been compromised.<sup>212</sup>

Of increasing concern is the way the HIV and AIDS epidemic affects other health issues. For example, the high levels of HIV infection have resulted in an unprecedented increase in the number of tuberculosis cases, "which rose to over 27,000 cases annually in recent years. The disease burden is also exacerbated by endemic malaria, which affects up to four million people annually, the majority of whom are women and children."<sup>213</sup>

**Location:** HIV prevalence in Malawi is significantly higher in urban areas than in semi-urban and rural areas. However, there is evidence that while infection rates are slowing in urban areas, HIV prevalence continues to increase in rural areas. The southern region of Malawi is the most densely populated and has the highest prevalence rate among pregnant women.<sup>214</sup>

**A gendered epidemic:** In Malawi, women are disproportionately affected by the epidemic. In 2005, approximately 500,000 women 15 years and older were living with HIV/AIDS.<sup>215</sup> "The epidemic is increasingly developing a woman's face in Malawi, accelerated by inequitable power relations between men and women, young girls in particular."<sup>216</sup>

**Government commitment:** Several sources speak of the current Malawian government's high level of commitment to addressing HIV and AIDS.<sup>217</sup> However, others still place high-level commitment as one of the major challenges, saying there has been limited engagement of high-level political leaders in driving the response, compounded by a lack of clear accountability of roles for HIV prevention.<sup>218</sup>

**High risk groups:** "HIV prevalence among the high-risk groups namely teachers, female cross border traders, estate workers, the police officers, fishermen, truck drivers and female

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<sup>209</sup> UNAIDS EU 2007

<sup>210</sup> Avert 2008

<sup>211</sup> WHO 2006b, Kaiser 2005

<sup>212</sup> WHO 2006b, PEPFAR 2008

<sup>213</sup> PEPFAR 2008

<sup>214</sup> PEPFAR 2008

<sup>215</sup> PEPFAR 2008

<sup>216</sup> NAC 2003

<sup>217</sup> See WHO 2005, Avert 2008, GoM 2007

<sup>218</sup> See UNAIDS 2006a

sex workers is above the national HIV prevalence with an exception of male vendors, among whom prevalence was found to be 7.0%.”<sup>219</sup>

**The ART programme** has grown significantly over the years. “In 2003 only 3,000 persons with advanced HIV infection were receiving ART and in 2004 this figure rose to 13,183 when, with support from the Global Fund, Malawi started providing free ART. As of June 2007, a total of 114,375 persons with advanced HIV infection had ever started on ART.”<sup>220</sup>

**OVC:** The National Plan of Action (NPA) on orphans and other vulnerable children (OVC) estimates that there are more than 1 million orphans and other vulnerable children in Malawi and half of these are due to HIV and AIDS. It has been observed that there are more orphans in urban areas than there are in rural areas, which is seen as a result of the high HIV and AIDS prevalence within urban areas as compared to rural areas. According to NAC, 14% of OVCs were supported with impact mitigation interventions in 2003/2004, 38% in 2005/2006 and 53% in 2006/2007. “This demonstrates that a lot of effort has been made by the Government of Malawi with support from civil society and development partners to provide support to OVCs.”<sup>221</sup>

This provides only a brief snapshot of a broad and complex epidemic. We will now consider a listing of some of the significant events in Malawi’s epidemic history.

## **B. Timeline of significant events in Malawi’s AIDS epidemic**

This timeline does not depict every AIDS-significant event in Malawi, but rather is an amalgam of events important to the participants, those listed in government documentation, and responses of participants in the questionnaire. It, therefore, contains events also important to the religious entities.<sup>222</sup>

1900s	Missionaries came to Malawi
1964	Malawian independence
1985	The first case of AIDS was diagnosed at Kamuzu Central Hospital in Lilongwe after which HIV prevalence grew quite rapidly
1985	The Government implemented a short-term AIDS strategy
1988	The Government created the National AIDS Control Programme (NACP) to co-ordinate the country’s AIDS education and HIV prevention efforts
1989	Five-year AIDS plan was announced
1992	Political riots
1992	Pastoral letter on AIDS by Catholic bishops recognised as significant by participants
1993	Between 1985 and 1993, HIV prevalence amongst women tested at urban antenatal clinics increased from 2% to 30.5%
1994	Following protests and international condemnation, President Banda agreed to relinquish power and Malawi became a multi-party democracy. Freedom of speech was re-established creating a more liberal climate in which AIDS education could be carried out. New President Bakili Muluzi took office, making a speech in which he publicly acknowledged that the country was undergoing a severe AIDS epidemic and emphasized the need for a unified response.

<sup>219</sup> GoM 2007

<sup>220</sup> GoM 2007

<sup>221</sup> GoM 2007

<sup>222</sup> Sources: Avert 2008, GoM 2007, UNAIDS 2006a, WHO 2005, participant workshops

- 1996 First public celebration of World AIDS Day by Christian religious entities
- 1999 Formulation of the National Health Policy, 1999-2004
- 2000 The Government develops a National HIV/AIDS Strategic Framework (2000-2004) to coordinate the country's response to the epidemic.
- 2001 The Government forms the National AIDS Commission (NAC) which replaces the National AIDS Control Programme
- 2001 Malawi commits itself in the Abuja Declaration and Framework for Action for the Fight against HIV/AIDS, Tuberculosis and other Related Infectious Diseases in Africa, of 27 April 2001 and the United Nations General Assembly Special Session Declaration of Commitment on HIV/AIDS, of 27 June 2001
- 2002 Malawi suffered its worst food crisis for over fifty years, with HIV recognised as one of the factors that contributed most significantly to the famine<sup>223</sup>
- 2002 A report suggested that 70% of hospital deaths at the time were AIDS related<sup>224</sup>
- 2002 Interfaith Prayer event on AIDS recognised as significant by participants
- 2002 Malawi Poverty Reduction Strategy Paper (MPRSP) and HIV/AIDS, April 2002
- 2003 NAC led by the Minister of State Responsible for HIV/AIDS Programmes
- 2003 Establishment of Malawi Interfaith AIDS Association (MIAA)
- 2003 National HIV/AIDS Policy: A Call For Renewed Action. Office of the President and Cabinet, National AIDS Commission. October 2003
- 2003 National Policy on Orphans and Vulnerable Children
- 2004 Newly elected President Bingu Wa Mutharika launches Malawi's first National AIDS Policy. This policy set the goal of improving the provision of prevention, treatment, care and support services, and called for a multisectoral response to the epidemic.
- 2004 A Principal Secretary for HIV and AIDS was appointed within the Government.
- 2004 World AIDS Day recognised as significant by participants
- 2004 World Global Prayer Day on HIV and AIDS recognised as significant by participants
- 2005 The National HIV and AIDS Action Framework for 2005-2009 developed, which guided the national response for the period 2005-2009.
- 2005 Malawi finalizes frameworks to guide the scale-up of antiretroviral therapy. These include, a national HIV and AIDS policy, the Two-year Plan to Scale Up Antiretroviral Therapy for 2004-2005, a six-year human resource relief programme for the health sector, antiretroviral therapy guidelines and training materials.
- 2005 Formulation of OVC policy and national plan
- 2006 In 2000, Malawi was approved to receive relief under the World Bank programme for Heavily Indebted Poor Countries (HIPC). It reached the HIPC completion point during 2006.
- 2006 HIV and AIDS commemoration day recognised as significant by participants
- 2007 The development of the 2007 National Monitoring and Evaluation report
- 2008 World Health Day - call for more HIV and AIDS drugs

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<sup>223</sup> Avert 2008

<sup>224</sup> Avert. 2008

### C. Malawi's HIV and AIDS national policy:<sup>225</sup>

In the timeline above, it can be seen that several important AIDS-related government policy documents have emerged in recent years. These include policies and guidelines for community and home-based care, voluntary counseling and testing, prevention of mother-to-child transmission, antiretroviral therapy and treatment of sexually transmitted infections, and the care of OVCs. In the following section, which provides a brief outline of Malawi's HIV and AIDS policy, we focus on two documents, namely: the 2003 National HIV and AIDS policy, and the more recent National HIV and AIDS Action Framework 2005-2009.<sup>226</sup> (See box 5.1 below).

#### Box 5.1: Key elements of the Malawian national HIV and AIDS policies

**NAC, 2003. National HIV/AIDS policy: A call for renewed action. Office of the President and Cabinet, National AIDS Commission. October 2003.**

**The goal** is to prevent HIV infections, to reduce vulnerability to HIV, to improve the provision of treatment, care and support for people living with HIV/AIDS and to mitigate the socioeconomic impact of HIV/AIDS on individuals, families, communities and the nation.

#### **The objectives**

- Prevent HIV infections Improve delivery of prevention, treatment, care and support services.
- Mitigate the impact of HIV/AIDS on individuals, the family and communities.
- Reduce individual and societal vulnerability to HIV/AIDS through the creation of an enabling environment.
- Strengthen the multisectoral and multi-disciplinary institutional framework for co-ordination and implementation of HIV/AIDS programmes in the country.

#### **Guiding Principles**

- Political leadership and commitment
- Multisectoral approach and partnerships
- Public health approach
- Promotion and protection of human rights
- The greater involvement of PLWAs
- Good governance, transparency and accountability
- Scientific and evidence-based research

**NAC, 2005. National HIV/AIDS Action Framework. Lilongwe: National AIDS Commission, Office of the President and Cabinet.**

#### **Eight priority areas defined in the NAF for the period 2005-2009**

- prevention and behaviour change
- treatment, care and support
- impact mitigation
- mainstreaming, partnerships and capacity building
- research and development
- monitoring and evaluation
- resource mobilization and utilization
- policy coordination and programme planning

Also included as important are: high-level government commitment and leadership, the 'three ones' principle, multisectoral and multi-stakeholder partnerships, greater involvement of PLHIV, gender considerations and evidence-based interventions.

<sup>225</sup> Unless stated otherwise, all quotations in this section C come from the NAC 2003 and NAC 2005 policy documents under discussion.

<sup>226</sup> Participants did also mention the importance of the newer 2005 National AIDS Action Framework.

Some of the key issues emerging from these documents that are important to this research are:

**Commitment to a multisectoral approach:** The Malawian government's commitment to a multisectoral approach seems to have begun in 2000 and 2001, and reaffirmed in the 2003 and 2005 policies.

Malawi has committed itself to the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that are resourced to the extent possible from national budgets without excluding other sources, inter alia, international cooperation ... strengthen partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people...<sup>227</sup>

**A participatory process:** Both the 2003 national policy, and the 2005 Action Framework were said to have been developed through a wide consultative process including "all the major stakeholders including civil society organizations, the public and private sectors, the media and people living with HIV and AIDS were all involved."<sup>228</sup>

The government (through the National AIDS Commission) designed a policy development process that would be both participatory and consultative. It realized for the policy to be comprehensive, forward thinking, and widely supported throughout the country, multisectoral, multi-level participation from governmental, non-governmental, and civil society partners was essential. This would require providing sufficient opportunities for meaningful stakeholder orientation to and dialogue on a wide range of HIV/AIDS policy issues ... Meaningful stakeholder participation has resulted in a comprehensive policy that has wide support and greater prospects for successful implementation.<sup>229</sup>

Furthermore, the UNGASS 2008 report, and the 2007 national monitoring and evaluation report for Malawi state that there was "highly consultative and involved the participation of civil society, the public and private sectors and development partners."<sup>230</sup>

**The Three Ones:** Because these principles were only documented fairly recently, the concept of the Three Ones is only evident in the later 2005 National Action Framework. "In terms of operating structures, Malawi has fully subscribed to the UNAIDS principle of the Three Ones with the National AIDS Commission (NAC) as the national coordination body for the national HIV and AIDS response. Donors and implementing partners have accepted this and they also subscribe to one national monitoring and evaluation framework. There is also only one national action framework that provides a basis for coordinating with all partners."<sup>231</sup>

**Existence of a national M&E plan:** In line with the concept of the Three Ones, Malawi has instigated one national M&E plan. In the 2007 NAC evaluation, some challenges are noted:

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<sup>227</sup> NAC 2003. See NAC 2008

<sup>228</sup> See Sanje et al 2004

<sup>229</sup> Sanje et al 2004

<sup>230</sup> GoM 2007

<sup>231</sup> GoM 2007

... because of under reporting among stakeholders and differences in data requirements. For example, some donors and development partners include additional indicators for purposes of decision-making for their respective agencies and organizations and often such data is not available in the National M&E reports. The National M & E Plan however, encourages these diversities in order that those who collect data should find it relevant in decision-making and planning and hence improve delivery of quality services.<sup>232</sup>

Training in M & E was conducted last year mainly for those working in Government Departments and Ministries. This was conducted at district level and did not include civil society personnel.<sup>233</sup>

**Religious and cultural awareness:** The 2003 National Policy makes a strong statement on recognizing the importance of culture and religion.

Cultural and religious practices further influence HIV/AIDS, governance and poverty. The population of Malawi is diverse in terms of language, religion and ethnicity. There are about nine indigenous ethnic groups, in addition to Asian and Caucasian groups. Moreover, the majority of the African population is Christian, while the Asian population is predominantly Muslim, resulting in a wide range of practices, some of which are detrimental both to development and to an effective HIV/AIDS prevention programme. For instance, certain traditional norms limit access of women to education, thereby increasing illiteracy, decreasing participation in governance and lowering their socioeconomic status.

The policy shows an awareness of Malawian cultural and religious contexts, recognizing that culture and religion have a strong influence on lifestyle and choices of its citizens.

**The coordinating structures in Malawi:**<sup>234</sup> The HIV/AIDS Unit within the Ministry of Health is responsible for implementing the health sector response to the epidemic. **The National AIDS Commission** was established in July 2001 to coordinate multisectoral implementation of the national response. The National AIDS Commission Statutory body falls under the office of the President and Cabinet. The Cabinet Committee on HIV/AIDS Prevention and Care provides policy and political direction to the National AIDS Commission.

- NAC is led by a multisectoral Board of Commissioners and assisted by a secretariat of over 70 staff.
- Other coordination structures include: (a) Principal Secretaries of the HIV and AIDS committee; (b) Multisectoral District AIDS Committees; (c) Civil Society Forums for International and Local organizations; (d) Umbrella Organizations for community-based organizations and small non governmental organizations at District level; (e) Interfaith Umbrella Organizations; (f) Country Coordination Mechanism; (g) Malawi Business Coalition Against AIDS. All coordination structures are represented in the National Partnership Forum.
- Donor coordination takes place through the HIV and AIDS Development Group.

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<sup>232</sup> GoM 2007

<sup>233</sup> GoM 2007

<sup>234</sup> See UNAIDS-RSTESA 2006, WHO 2005, Birdsell & Kelly 2007

The recent evaluation by NAC states that the formation of the *National HIV and AIDS Partnership Forum* is key as it brings together “all stakeholders including international NGOs, L-NGOs, Government, private sector, CSOs, development partners (both bilateral and UN organizations) and organizations of PLHIV is another important development for Malawi as it ensures policy discussions at the highest level of collaboration.”<sup>235</sup> With that in mind, we will now consider further themes around multisectoral collaboration that emerges from the literature.

### **5.1.3 A brief survey of the state of collaboration in Malawi**

We will briefly consider some of the key issues emerging from secondary literature on the state of multisectoral collaboration in Malawi, that are most relevant to this research.

#### **A. Collaboration with government<sup>236</sup>**

As in Kenya, there appear to be different levels of collaboration between health-providing facility-based CREs such as those represented by CHAM, and those CREs who are grouped as part of ‘civil society’ and whose relationship is therefore managed mainly through NAC and its umbrella stakeholders structures.

Considering the former group, there are some indications that collaboration between CREs (such as CHAM) and the Malawian government is not as strong as it is in neighboring countries such as Zambia. There is, however, an memorandum of understanding (MOU) between the Government of the Republic of Malawi and CHAM, revised in 2002. This MOU is structured on the understanding that it is the Malawian Government's primary responsibility “to provide health services to the nation and CHAM's role is to complement Government efforts in line with Government policy.”<sup>237</sup> Towards this end, the government undertakes to provide financial assistance to CHAM units.

Less is known of the level of collaboration between the other CREs and the Government of Malawi (hence this study), but a 2004 UNFPA study notes (in the context of HIV and AIDS),

... most faith-based organizations and religious institutions involved in HIV and AIDS prevention and care feel that they have been marginalized to a large extent by the government and NGOs ... (hindering) the formation of long-term partnerships. The result is that many faith-based organizations have carried out their work without due attention and recognition.<sup>238</sup>

We will engage with all these matters in the participant discussion below, see section 5.2.

#### **B. Interfaith and ecumenical collaboration**

Again, not enough is said in secondary literature of the state of interfaith and ecumenical collaboration around HIV and AIDS in Malawi. However, it is possible that the above feeling of marginalization from government and other civil society organizations has resulted in an interesting situation in Malawi where CREs engaged in HIV and AIDS are *primarily* working in partnership with other CREs. As the same UNFPA study says,

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<sup>235</sup> GoM 2007

<sup>236</sup> This section is from the Schmid et al 2008 landscaping study

<sup>237</sup> GoM 2002

<sup>238</sup> UNFPA 2004

... this has limited the funding that is available to them and kept their efforts out of international view. Some religious institutions have been able to tap funding from sister organizations abroad, usually within the same denomination. Those without international connections have been forced to raise funds from the meagre resources available within Malawi.<sup>239</sup>

Secondary literature also points towards limited *interfaith* relations around HIV and AIDS in Malawi - most evident in the lack of collaboration between CREs and the traditional health sector. For example, in 2004, only one CRE was noted as having activities which involved and targeted cultural leaders and traditional healers.<sup>240</sup> However, anecdotally, there has been improved interfaith collaboration, *driven* by the HIV and AIDS epidemic, and managed through bodies such as MIAA:

... Christian and Muslim leaders in the Southern Africa country of Malawi have come together to address the problem of (the HIV and AIDS) pandemic ... MIAA coordinates religious organizations dealing with HIV/AIDS issues and programs across the country. It currently groups 172 members from both the Islamic and Christian faiths ... Malawi's history of inter-faith relations indicates there was hardly stable relationship when it came to working together on religious matters.... Some donors have been impressed by the Muslim-Christian collaboration ... "(says an OXFAM representative) this kind of collaboration between Christian and Muslim organizations is rare" ... this according to MIAA ... (is based on an increased) common understanding among various religious institutions...<sup>241</sup>

Not enough is yet known of the extent of representation in such interfaith initiatives, or how such collaboration translates into action.

### **C. Collaboration between funders**

There is not sufficient information publicly available on the level of collaboration between donors or funding partners in Malawi around HIV and AIDS. This becomes especially complex in light of the variety and range of organizations providing support in Malawi (see list in section 5.1.5 below). What is known is that at a government level, donor coordination takes place through the *HIV and AIDS Development Group*,<sup>242</sup> which has been termed 'fully functional' by UNAIDS.

#### **5.1.4 A brief survey of the state of funding in Malawi**

*Malawi's efforts to overcome poverty, AIDS and famine are heavily dependent on international donors, with international development assistance totaling around \$400 million a year. In the past there have been concerns about political corruption and the mismanagement of funds in Malawi, problems that caused a number of donors to suspend support for the country in 2001. Since President Mutharika took office in 2004, vowing to take a zero-tolerance approach to corruption, these difficulties seem to have been reduced and international support for Malawi has increased.*<sup>243</sup>

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<sup>239</sup> UNFPA 2004

<sup>240</sup> See UNFPA 2004. See below for an updated discussion on this

<sup>241</sup> Mnela 2007

<sup>242</sup> See Birdsell & Kelly 2007, GoM 2007

<sup>243</sup> Avert 2008

This research did not set out to provide a full funding breakdown for Malawi or for CREs in Malawi; however, in the surveyed literature, some themes emerge. Malawi is supported through a range of bilateral and multilateral funding agencies, as well as foundations, and other private donors. Such funds are either pooled in what is termed a ‘functional basket’ managed by NAC or termed as ‘discreet’.

- Funds pooled in the functional basket coordinated by NAC (e.g. The Global Fund, CIDA, DfID). NAC disburses grants to NGOs, ‘FBOs’, private and public sectors.<sup>244</sup>
- Discreet funds (some still to the Government of Malawi, but outside of NAC): e.g. UNDP, CDC, USAID, NORAD, Clinton and Hunter Foundation etc (see 5.1.5 below).

According to a UNAIDS regional report, Malawi has greatly improved donor harmonization.<sup>245</sup>

Although there are continued efforts towards drawing the national HIV and AIDS response together under the Three Ones (see above), NAC is not yet able to track all ‘discreet’ funding that happens in Malawi.<sup>246</sup> It is possible that this is particularly the case for CREs who frequently have historical funding partnerships with individuals and other religious entities.<sup>247</sup>

*Official development assistance for AIDS, 2000-2004<sup>61</sup>*

US\$ millions	Total bilateral ODA commitments for AIDS (2000-2004)	Total multilateral ODA commitments for AIDS (2000-2004)	Total ODA for AIDS (2000-2004)	Rank, overall ODA for AIDS (within sub-Saharan Africa)	ODA for AIDS per capita (US\$)	Rank per capita ODA for AIDS (within sub-Saharan Africa)
Lesotho	5,370	18,840	24,210	31	13.49	12
Malawi	101,590	79,070	180,660	9	14.02	11
Mozambique	166,450	94,010	260,920	8	13.18	13
Namibia	59,030	35,820	94,830	14	46.70	1
Swaziland	4,340	33,080	37,420	29	33.09	4
Zambia	236,370	116,540	352,910	5	30.25	5
Total	573,150	377,820	950,970			

Figure 5.2: Source Birdsell & Kelly 2007

... all external development partners have endorsed the NAF... However, in terms of external development partners aligning and harmonizing HIV and AIDS programmes to the NAF, 60% have done so and effort is being made to achieve 100% alignment and harmonization... What seems to be preventing full alignment and harmonization by some external development partners are some of the requirements of funding and reporting to their respective governments and funding agencies.<sup>248</sup>

What is unclear is whether ‘development partners’ include the array of funding sources that CREs traditionally tap, such as funding which may not be *directly* classified as aimed at HIV and AIDS response, yet has that effect. Large-scale funding addresses the full spectrum of treatment, prevention, care and support. For example:<sup>249</sup>

<sup>244</sup> See UNAIDS 2006b, WHO 2005

<sup>245</sup> UNAIDS-RSTESA 2006

<sup>246</sup> See UNAIDS 2006a, GoM 2007

<sup>247</sup> See Chapter 3

<sup>248</sup> GoM 2007

<sup>249</sup> GoM 2007, PEPFAR 2008, UNAID 2006b, World Bank 2008 - see list in section 5.1.5 below for more funding partners.

- *The Global Fund to Fight AIDS, Tuberculosis and Malaria*: has so far approved grants of around \$228 million to Malawi (since 2003). Among other things this funding has allowed the Malawian Government to implement its ARV treatment programme.
- *The President's Emergency Plan for AIDS Relief (PEPFAR)*: provides Malawi with around \$15 million dollars annually. It has funded VCT, condom distribution and mother-to-child prevention programmes, amongst other initiatives.
- *The World Bank's Multi-Country HIV/AIDS Program*: Funding for HIV prevention and care activities includes a commitment of \$35 million from 2004 through 2008 (including capacity building, education, and increased support for orphans and vulnerable children.)

This is only a small indication of some of the focus of funding partners. The WHO identifies three main areas of challenge: weak government capacity to coordinate increasing number of partners; lack of clarity of the role of partners and need for better coordination during decentralization and SWAp implementation; need to align multiple initiatives that require coordinated implementation amidst under-financing and critical human resource shortages.<sup>250</sup>

The following extract (Box 5.2) depicts some of the challenges felt by CREs within this funding context.

**Box 5.2: MALAWI: Accounting for AIDS funding no small matter**

*LILONGWE, 14 May 2007*: Smaller AIDS organizations in Malawi are in the spotlight after a recent move by the National AIDS Commission (NAC) to suspend their financial aid because many cannot account for the funds allocated to them. But community-based organizations (CBOs) have warned that the NAC's decision could jeopardise their efforts to curb the spread of the epidemic in a country with one of the highest HIV infection rates in the world. Over 30 CBOs have failed to account for money from the Global Fund to Fight AIDS, Tuberculosis and Malaria, distributed by the NAC.

Many CBOs who start local HIV/AIDS interventions have no experience of running an organization, and struggle to write funding proposals or report to donors. Organizations such as the Malawi Interfaith AIDS Association (MIAA), an umbrella body of faith-based organizations (FBOs), are calling on the NAC to assist them in managing their financial resources. Rev Francis Mkandawire, chairman of the MIAA's board of trustees, told IRIN/PlusNews: "We are aware that a number of organizations fail to account for NAC funds, but most of them do not really know how to properly write how the money was spent because they do not have receipts; but this does not mean that they have misused the money."

The donor community and bodies such as NAC, also had a responsibility to build the capacity of CBOs, pointed out Donald Makwakwa, programme officer for the Malawi National Association of People Living with HIV/AIDS (MANASO). "The organizations that are giving the money to the CBOs ... are not training them on how to manage the funds properly ... some of the people managing the funds have no knowledge of how they can account for them," he said ... "I would like to call upon NAC to review their funding procedures. Most of our FBOs fail to access funds from NAC because their process takes too long. We cannot wait over five months to have the money from NAC even after the proposal for funding has met all the criteria. People are dying and we need to be on the ground to do the work," said Kettie Gondwe, an MIAA programme officer ...

*Source: PlusNews 2007*

### **5.1.5 The key players in the Malawian HIV and AIDS context**

We provide here a listing of some of the key organizations that secondary literature shows are working in the Malawian multisectoral context. This is in no way a comprehensive listing.

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<sup>250</sup> WHO 2006b

**Collaborative networks or networking organizations:**<sup>251</sup> Council for Non-Governmental Organization in Malawi (CONGOMA), Malawi Business Coalition Against HIV and AIDS (MBCA), Malawi Interfaith AIDS Association (MIAA), Malawi National Association of AIDS Support Organizations (MANASO), Malawi Network of People Living with HIV (MANET+), National Association of People Living with HIV and in Malawi (NAPHAM), National Association of People Living with HIV in Malawi (NAPHAM), Society of Women Against AIDS in Malawi (SWAM), Youth HIV and AIDS Network ...

**Multilaterals, bilaterals and major donors providing support to address Malawi's HIV and AIDS epidemic:** <sup>252</sup> African Development Bank, British Council, Department for International Development (DfID), Canadian International Development Agency (CIDA), Caritas Internationalis, Clinton & Hunter Foundation, Danish Church AID, European Union, German Agency for Technical Cooperation (GTZ), Global Fund to fight AIDS, TB, and Malaria (GFATM), Japan International Cooperation Agency (JICA), Joint United Nations Programme on HIV/AIDS (UNAIDS), NORAD, Norwegian Church AID (NCA), Norwegian foreign ministry, President's Emergency Plan for AIDS Relief (PEPFAR), SWAP, Swedish Development Assistance (SIDA), U.S. Agency for International Development (USAID), Umovo Network (a consortium of Save the Children US, ADRA, Plan International, CARE international and PATH), United Nations (UN) agencies (FAO, UNAIDS, UNDP, UNFPA, UNICEF, WFP and WHO) through the UN Development Assistance Framework (UNDAF) and the World Bank, United States Centers for Disease Control and Prevention (CDC), World Council of Churches.

**Christian religious entities engaged in HIV and AIDS:** secondary literature does not provide a comprehensive mapping of CREs engaged in HIV and AIDS in Malawi. The work undertaken via desk review, as well as in the snowballing sampling process, helped to identify a wide range of CREs that are responding to health generally, and the HIV and AIDS epidemic in particular. A full listing is provided in Appendix 6.2. Please note, this listing is limited and does not capture every organization working in HIV and AIDS in Malawi. Several named here are networks or umbrella bodies that incorporate a number of individual religious entities or programs. Furthermore, some international organizations have local offices and therefore make categorisation difficult. It is our hope that this listing highlights the scope and range of AIDS-engaged religious entities in Malawi, and is a working document that can be utilized and developed further.

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<sup>251</sup> NAC 2007, UNAIDS 2006a

<sup>252</sup> Kaiser 2005, GoM 2007, WHO 2006b, WHO 2005, World Bank 2008



*Figure 5.3: Malawi CRE workshop - 2008*

## **5.2 The findings of the research in Malawi**

The participatory research process was designed to identify findings in four key areas:

1. Concerning the context in which Christian religious entities (CREs) are working
2. Concerning the work of CREs in the promotion of Universal Access
3. Concerning the strengths and weaknesses of collaborative partnerships between CREs and other stakeholders
4. Concerning the challenges and potential of collaborative partnerships between CREs and other stakeholders

Within these four areas, the participatory research process produced the following six findings in Malawi:

1. CREs in Malawi are proud of the role played by religious leadership in the social life of the country, but recognise that they have only recently begun to respond to the HIV and AIDS epidemic.
2. CREs in Malawi are committed to and involved in promoting Universal Access to Prevention, Treatment, Care and Support including education around abstinence and behaviour change, the provision of ART, home-based care groups and work with orphans and vulnerable children, and psycho-social support services. While the work is aimed at a wide range of beneficiaries, young people, women and rural citizens form the key target groups.
3. CREs in Malawi are acknowledged by collaborative stakeholders as having key strengths, namely, their reach to the grassroots, the resources they have at their disposal, and the

capacity of offer psycho-social support. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.

4. CREs in Malawi are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. (1) The main strengths are perceived to be the wide range of funders supporting work in Malawi, the willingness expressed in the national policy to engage with the religious sector, and good working relationships at local and district level. (2) The main weaknesses are perceived to be the lack of engagement by CREs at a national level with NAC and MIAA, competition and conditionalities around funding, and the lack of a common agreement on the efficacy of 'spiritual healing'.
5. Both the CREs and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges include differing belief and value systems, difficulties with adhering to monitoring and evaluation standards, the dissemination of information, adequate representation, funding conditionalities, and inter-faith collaboration. These challenges are balanced by an awareness of the potential for these partnerships amongst both CREs and collaborative stakeholders, given the commitment to the Three Ones policy.
6. There is a desire for stronger multisectoral collaboration in Malawi, without a further proliferation of initiatives. CREs desire a greater focus on local and district level initiatives. Collaborative stakeholders desire a greater commitment to collaborative planning, monitoring and evaluation. All parties hope for a greater focus on cultural and gender aspects of the epidemic.

### **5.2.1 Findings concerning the context in which Christian religious entities are working**

**Finding 1: Christian religious entities in Malawi are proud of the role played by religious leadership in the social life of the country, but recognise that they have only recently begun to respond to the HIV and AIDS epidemic.**

In the participatory workshop with CREs, participants were asked to contribute to a communal time line that helped to map the history of their engagement in social life, and specifically in responding to the epidemic. The following information emerged from the timeline.

Clearly, the advent of multi-party democracy in the country in 1992 is a significant event in the lives of most of the participants. There is a strong recognition of, and appreciation for, the role played by the Roman Catholic Church in the emergence of multi-party democracy.

It really affected us, we were in a broken situation, in a one party system...since 1964...so we remember it was one of the key moments, a turn of events, this relationship with religious events, the church united against political system...the pastoral letter of 1992 had an effect, for us the issue of transformation and change of events is a religious and political event.

For a long time the nation was crippled by fear, everyone knew what was going wrong, and we were let loose by the courageous pastoral letter.

What is also evident is that the Catholic church continues to play a significant religious and political role in responding to the epidemic.

The movement from a one-party state to multi-party democracy created an environment where there was a greater visibility of NGOs, religious entities, and involvement of civil society in social issues. This environment also enabled the formation of organizations responding to HIV and AIDS.

CREs have emerged over a broad historical period in Malawi. While missionary activity began over a hundred years ago, it was during the 1960s that health-related CREs, such as Christian Health Association of Malawi (CHAM), were established. Most of the organizations responding to the HIV and AIDS epidemic were formed after 1999. Examples include: Kosi, Episcopal Conference of Malawi, Catholic Health Commission (ECM CHC), Private Schools Association of Malawi (PRISM), African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS (Anerela+), and Partners in Hope (PIH).

The presence of funding from global institutions such as PEPFAR and Global Fund has also had an impact on the formation of these organizations. However, participants were adamant that the response by CREs to the epidemic had already begun prior to the formation of these organizations and the availability of funding.

... the response was already there...but the organization of the response took longer ... facilities and programs were already there, but the organization took longer.

One participant felt funding played little part in their response, specifically because their work was not being recognised by international agencies.

... most of the local organizations have been struggling for funds, even if they are doing a lot of work on the ground, there is no credibility, their methods are questioned, in fact, there has been a response to need, but this has not been backed up by resources. After the government change, most of the civil society organizations are very local, and these local ones are really struggling, after surviving a decade on the ground.

However, another participant felt that the reason for the formation of organizations varied, and in some instances they were formed directly as a result of funding.

It is a mixed bag. Some organizations have been formed because of resources ... now everyone thinks they can form their own NGO.

There was some consensus that, generally, CREs were slow in responding to the epidemic. The first public reporting of a case of HIV infection was in 1985 while the first public celebration of World AIDS Day by CREs took place only in 1996. "It is only really in the 2000s that things started to happen". Most participants admitted that their organizations were only beginning to think through their HIV and AIDS policy in relation to the National AIDS Policy. The exception was the Catholic Church which is in the process of ratifying its 2008 policy. This policy supports and extends the National AIDS Policy.

In summary then, CREs in Malawi perceive themselves to have a well established role in national and social life, and recognise that this must now include responding to the HIV and AIDS epidemic. They acknowledge that a concerted response has only been forthcoming in recent years.

## 5.2.2. Findings concerning the work of Christian religious entities in the promotion of Universal Access

**Finding 2:** Christian religious entities in Malawi are committed to and involved in promoting Universal Access to Prevention, Treatment, Care and Support including education around abstinence and behaviour change, the provision of ART, home-based care groups and work with orphans and vulnerable children, and psycho-social support services. While the work is aimed at a wide range of beneficiaries, young people, women and rural citizens form the key target groups.

The work undertaken via desk review, as well as in the snowballing sampling process helped to identify a wide range of CREs that are responding to the HIV and AIDS epidemic (see Appendix 6.2).

Whilst not each and every entity noted here is equally involved in all aspects of Universal Access, it is clear that taken as a whole CREs in Malawi perceive themselves to be involved in Prevention, Treatment, Care and Support, as well as some 'Other' tasks. Asking the Christian Entity participants to depict and describe the three 'main' areas they were each involved in HIV and AIDS work, the following basic table was derived:<sup>253</sup>

Prevention	Treatment	Care	Support	Other
ECM	ECM	ECM	SUM	ECM
KOSI	SDA	CHAM	KOSI	PIH
ELDS	PIH	ELDS	ELDS	ANERELA
WRM	CHAM	WRM	WVM	CHAM
PIH	<i>Word Alive</i>	WVM	CHAM	EAM
LISAP		SDA	TSA	SDA
WVM		EAM	ANERELA	ECC
EAM		LISAP	WRM	<i>Word Alive</i>
ANERELA		TSA	LISAP	
CHAM		CRWC		
TSA				
SCOM				

Figure 5.4: Depiction of participatory exercise, Malawi 2008

### A. Prevention

The most predominant activity is education and awareness work, particularly amongst the youth. Messages seem to focus on abstinence and behaviour change, although World Vision and Scripture Union also include life-skills training in their prevention programme. The Salvation Army has notably specifically targeted Traditional Healers in its prevention programmes. All are expected to promote the ABC (abstinence, be faith, correct and consistent condom use) approach. But an agreement was made in 2005 through the state-faith dialogue that Government would not force the faith community to distribute condoms. Conversely the faith community was expected not to condemn condom use for HIV prevention. Responses by some participants indicated that they would encourage condom use in the case of discordant couples. ANERELA seemed to be the only exception given that their broad message included the use of condoms.

We use the SAVE message ... enhancing the ABC... [Our approach is that] not all condom use is immoral; many who abstained are now positive because they did not know the status of their partner; not all who are faithful are negative because their

<sup>253</sup> See Appendix 1 for acronyms. Those in italics in the table above did not have representatives at the workshop, but were added by fellow participants.

partner is unfaithful. The SAVE message of ANERELA: Safer sexual practices; Access to medication: Voluntary testing and Counselling; Empowerment education.

It was noted that a 'Mutual Faithfulness' (MF) national plan of action is in place which seeks to address one of the key drivers of HIV in the country, which is multiple sexual partners-vs-partner reduction.

## **B. Treatment**

CREs in Malawi play a crucial role in the provision of anti-retroviral treatment (ART). Three organizations are particularly significant in this regard namely, CHAM, Seventh Day Adventist (SDA, and ECM. CHAM's network provides up to 40% of healthcare in Malawi, and about 20% of the provision of ART.

## **C. Care**

Almost all the participants present at the workshop indicated that they were involved in two activities involving care:

- The home-based care networks which provide opportunities for assisting PLWHA.
- Care for orphans and vulnerable children.

Of note is World Vision which has established 'Community Care Coalitions' that are involved in training and mobilising communities to be involved with care of those living positively with HIV.

## **D. Support**

CREs are involved in a range of 'support' activities for people living with HIV and AIDS, and particularly for OVCs and grandmothers caring for children. These activities include:

- Ensuring food security through the establishment of gardens
- Material support in the form of food
- Micro-credit support
- Income generating activities
- Psycho-social support

## **E. Other**

The key other aspects that CREs are involved in are:

- Radio Programmes that broadcast HIV and AIDS prevention messages
- Advocacy work through organizing forums to which CREs are invited
- Capacity building and resource mobilisation

## **F. Beneficiaries**

In promoting Universal Access to Prevention Treatment Care and Support, CREs work with a wide range of beneficiaries.

Participants felt that they worked with beneficiaries across all **age** groups but probably predominantly with young people in the 15-24 age group. In terms of **gender**, they recognise that it is crucial to work with men but acknowledge that most of their work is with women. In terms of **location**, participants felt strongly that most of their work was carried out in rural areas and that government recognised this aspect as a key contribution they were making to mitigating the epidemic.

The participants were asked for their response to the findings of a 2004 UNFPA report that stated that in Malawi, the majority of 'religious institutions' are concentrated in the South and Central regions, that HIV and AIDS efforts in the northern part of the country are scarce, and that the work of these religious organizations are concentrated in urban centers where funds are more readily available.<sup>254</sup> All participants rejected these findings and indicated that they might apply to Christian NGOs, but not to churches as local communities of faith. In fact, some argued that,

... there has been an outcry that the urban is being neglected, so a deliberate movement to get into the urban areas ... from program assessment people.

Nonetheless, it was recognised that in Malawi, the poorest of the poor live in rural areas and still have difficulty accessing services. This could be related to a poor road and transport system, but was also seen partly as related to cultural taboo and traditional practices.

It also has something to do with literacy levels, in very rural areas where the poorest of the poor live, when the sick comes, they still run away ... around VCTs they run away ... they say blood suckers have come.

CREs that are not local churches felt that in some instances people rejected their services in favour of 'denominational interests'.

Some suggested that CREs in Malawi are to a large extent not engaged in inter-faith interventions even though the Malawi Interfaith AIDS Association (MIAA) was established for this purpose. Others felt that this was happening at grass roots level, more than at national level.

When probed about their relationship with the traditional health sector, it became clear that there are few established initiatives that actively seek to work with traditional health practitioners. .

We try to work with traditional healers and leaders, consciously and purposively...in reality it doesn't work out that good.

We distinguish between traditional healers, traditional leaders, and traditional religious leaders - traditional leaders, no problem ... traditional healers, there is resistance from FBOs because their practice is not altogether Christ-like ... traditional indigenous religious leaders, the mainline churches are not making a deliberate effort to work with them (although I stand to be corrected) ... because that would compromise their faith ... the only point of working with those people is with the traditional leaders.

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<sup>254</sup> UNFPA 2004

Indigenous religious leaders - traditional ones - are not as influential in society as they used to be, so when you are working with traditional leaders, you are working with someone who still has influence ... so we work with them ... our target is children and youth, but they come from villages and parents, so we still meet with traditional leaders ... so these people who are custodians to tradition, know who we are. When we sit down and talk about these issues, it works very well. The religious leaders are very scarce now, there are places where you can't even find traditional religious leaders ... they shy away.

As was noted earlier, the one evident exception was the Seventh Day Adventist Church,

For example in our programme in areas like Nsanje where acknowledged cultural practices are driving the epidemic, there is a deliberate approach to get traditional leaders to influence their culture and influence the other two groups and their subjects.

It was noted by the facilitators and is obvious from the above discussion that participants held strong negative convictions concerning inter-faith work.

In summary then, CREs in Malawi are committed to and involved in promoting Universal Access to Prevention, Treatment, Care and Support. Prevention activities focus on education around abstinence and behaviour change. In terms of treatment, CHAM provides 20% of the ART delivery in the country. In terms of care, the focus is on home-based care groups and work with orphans and vulnerable children. There is a range of support services including food security, micro-credit and psycho-social support services.

While the work is aimed at a wide range of beneficiaries, it seems clear that young people, women and rural citizens form the key target groups. There is quite a bit of uncertainty around inter-religious cooperation.

**Finding 3: In their contribution to Universal Access Christian religious entities in Malawi are acknowledged by collaborative stakeholders as having three key strengths, namely, their reach to the grassroots, the resources they have at their disposal, and the capacity of offer psycho-social support. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.**

As discussed in chapter 3, religious entities are seen to have key strengths that can be leveraged in the HIV and AIDS epidemic. In the introduction above, we further presented some of the assets religious entities are said to hold in the Malawian health system. While this particular study did not focus on identifying the specific assets of CREs that can be leveraged towards providing Universal Access (for example, the number of facilities held or patients served), this was nevertheless clearly demonstrated throughout the discussion, in the organizational documentation collected through the desk review and through the questionnaire response.

#### **A. Perceptions of collaborative partners with regards to the work of Christian religious entities**

When representatives of other stakeholders such as government, donors and other religions were asked to reflect on the work of CREs they identified three major areas of strength.

(1) The first related to the **reach** of CREs, particularly in the rural areas. It was felt that they were one of the few organs of civil society that were accessible to and trusted by 'grassroots people'. Their leadership is hardworking and committed and furthermore, they were in contact with large numbers of people within close proximity to their sphere of influence.

(2) The second area of major strength lay in their **resources**, both human and material which are plentiful through their large national and international networks.

(3) The third area of strength lay in their **capacity to offer psycho-social support** through counselling, home-based care, and their work with OVCs.

CREs in Malawi are acknowledged by collaborative stakeholders as having these three key strengths. They represent vital assets that are essential to strengthening multisectoral collaboration in the promotion of Universal Access.

### **5.2.3 Findings concerning the strengths and weaknesses of current collaboration between Christian religious entities and other stakeholders**

**Finding 4: Christian religious entities in Malawi are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. (1) The main strengths are perceived to be the wide range of funders supporting work in Malawi, the willingness expressed in the national policy to engage with the religious sector, and good working relationships at local and district level. (2) The main weaknesses are perceived to be the lack of engagement by Christian religious entities at a national level with NAC and MIAA, competition and conditionalities around funding, and the lack of a common agreement on the efficacy of 'spiritual healing'.**

Through the desk review and the snowballing approach to the identification of participants for the workshop it was clear that CREs are involved in a range of collaborative partnerships. (See section 5.1.5, Appendix 6.2 and Appendix 5.3 for the selection of key collaborative stakeholders identified by advisors in Malawi).

In a rough typology, these included: government bodies and structures, national AIDS coordinating mechanisms, international donors (a full range from large internationals to individuals), interfaith bodies or networks, national faith-based health networks (NFBHNs), denominational bodies, other NGOs, other CREs.<sup>255</sup>

This was confirmed in an exercise carried out with CRE participants during which they had to draw a 'spidergram' showing their relationships with one another, other faith-based organizations, government, and with donors. This exercise sparked much animated discussion and was embraced enthusiastically. Participants engaged in critical dialogue with one another. The exercise uncovered a number of key issues.<sup>256</sup>

- There are an enormous numbers of diverse funders (at least 22 were noted) within such a geographically small country.

<sup>255</sup> As noted in chapter 2, one of the limitations of this study, and this exercise in particular was the lack of focus on relationships with other NGOs

<sup>256</sup> Note that this only speaks of the relationships between the participants and a few other key partners they choose to include in the exercise. Furthermore, unlike Kenya, the MIAA representative attended the collaborative stakeholder workshop, so was not present to represent MIAA in this exercise.

- There were few funding relationships *between* the local CREs present at the workshop.
- CHAM was the only organization present at the workshop that raises funds on behalf of others.
- CHAM was the only organization present that was in relationship with many of the other organizations.
- All CREs relate to NAC, but few have formal relationships with one another.
- All funding from NAC is channelled through MIAA to the participant organizations. MIAA does not receive funds for dispersal at the moment, as this role has been suspended. MIAA recommends to NAC for funding of organizations.
- CREs did not report a strong relationship with MIAA.

In discussion, the participants identified the large number of donors as a problem both for their relationships with one another and for the long term sustainability of their projects.

... we have a problem ... if the Christian organizations don't fund other Christian organization. ... What if the donors get tired of us? ... 5 years back the red circles [i.e. those representing donor relationships] would have been more. These have stopped, got tired and left us ... so what would happen if the others stopped too?

The majority of these FBOs are not indigenous ... they have links to the first world, and the first world dictates, if you indicate such things your proposal is stopped. We wanted to become a member of CHAM, but CHAM wanted us to be a church ... and we are not ... the criteria limits how you can collaborate or join. NAC will tell you, you have to operate along these lines and you have to do what they tell you to do.

There was also a general feeling that funding was not reaching projects at the grassroots level because NAC was the centralised conduit and this structure was not accessible to this group. Adding to this problem was the lack of strong relationship with MIAA who receives the funding for dispersal from NAC. Despite their recognition that as a group they had a large funding base, financial constraints still dominated their agendas.

While engaging in the exercise enthusiastically, there were no clear strategies as to the way forward in improving collaboration amongst each other.

While the facilitators noted that there was no opportunity to map their relationships with non-governmental organizations, it was pointed out by the participants that many were in relationships with universities carrying out research projects. These relationships were often fairly long-term and imbued with large financial grants. There was general agreement that this often created unnecessary competition amongst each other, particularly in relation to staffing issues.

## **A. Perceptions of Christian religious entities about collaboration**

In seeking to explore the perceptions of CREs about collaboration, time was spent exploring their understanding of government policy, government practice, and collaborative relationships with funders.

### **Interaction with Government Policy**

The 2003 Malawi National AIDS Policy was used as the basis for discussion on views relating to government policy. Most were aware of the document, but few seemed to have read it or

were familiar with its contents. There was a resistance to discuss the policy document without having been alerted before the workshop giving sufficient time to prepare a response. There was great sensitivity to this matter and it was finally agreed to discuss only the section on Religious and Traditional practices and services (see box 5.3 below).

**Box 5.3: Excerpt from Malawi National AIDS Policy utilised in Christian Entity workshop**

**Religious and Cultural Practices and Services**

*Rationale:* Religious groups have an important role to play in promoting behaviours that reduce the risk of HIV infection, such as abstinence before and faithfulness within marriage, and the use of VCT prior to marriage and during marriage reconciliations (after divorce or separation). These groups can also provide care and support for PLWAs. However, certain religious practices, such as refusal to seek medical care and treatment or belief in miracle cures, increase vulnerability to HIV infection.

*Policy Statements:* Government, through the NAC, undertakes to do the following:

- work closely with religious leaders to facilitate the provision of accurate HIV-related prevention information and education, as well as care and support for PLWAs.
- sensitize religious leaders to HIV/AIDS and discourage them from making false claims of miracle HIV/AIDS cures.

*NAC 2003*

The discussion indicated that CREs were supportive of the contents of this section of the policy document and felt that the facilitator was interpreting it in a way that cast religious leaders in a negative light.

My response is VERY positive ... I have problems that you read it in a critical way ... of course there are differences ... but it is a positive approach ... we won't fight each other, we work in partnership.

Despite the earlier discussion which indicated that CREs were not working with traditional healers, but only with traditional leaders, participants indicated that they were positive about the recognition of cultural practices in the document. One participant stressed the importance of this recognition,

We've been writing the HIV and AIDS policy of ECM ... we've acknowledged that Catholics ... everyone is double-faced ... they are coming to church, but have roots in culture ... we need to relate to that in our fight against HIV and AIDS ... we can't leave that separate in our fight against HIV and AIDS.

The discussion on healing and 'miracle cures' proved controversial.<sup>257</sup> Many participants felt that it was important to acknowledge that God could heal people from HIV infection, and in fact had done so. This was tempered by another participant who confessed his positive status and argued that healing is more than physical; it included spiritual and emotional healing.

There is all sorts of healing ... I have been emotionally and spiritually healed, but am still HIV/AIDS positive ... I do not have to doubt God even though I am taking ARVs ... should not say that those who are HIV positive are not believers.

Yet another declared,

We have realized, in our policy ... there are still taboo ... in our marriage counselling we still leave out HIV/AIDS sometimes ... we have not been able to talk about it ... we

<sup>257</sup> See chapter 3 for more on this discussion

have not been able as a church, to co-ordinate ... to discuss what are our standards, in some cases there were some churches who say that if you pray you will be cured - some have spoken of miracle cures ... the policy should state clearly otherwise.

Furthermore, it was felt by some that they, as religious leaders, were not seen by government to be key stakeholders in mitigating the epidemic.

That's where the policy lacks - it takes the religious leaders or FBOs as an annex to the solution of the problem, but if you look at ABC, that is a Christian principle ... to be solidly founded on Christian principles would be a good thing.

### **Interaction with Government Practice**

Overall, Christian Entity participants felt positive about the political will of government in dealing with the epidemic as expressed through the National AIDS Policy. Furthermore, they were seen to be seriously engaged in the roll-out of ART and offering technical support when necessary.

However, responses in this session seemed to contradict what participants had indicated earlier with regard to their collaborative relationship with government. Many felt that this partnership is strong and there is recognition of CREs in mitigating the epidemic. This partnership included the sharing of resources and information and collaborative consultations. In the previous two exercises participants were suggesting otherwise, particularly in relation to access to funding and with regard to how they were perceived by government stakeholders. One way of understanding the contradictory response is that perceptions vary at different levels of government. At a District level in rural areas, CREs do enjoy a good relationship with government and in many instances their leaders are members of district committees. In addition, as was argued by participants earlier, local communities of faith are often the only organized structure in rural areas through which government can facilitate programmes.

The initiative of the government to dialogue with the church is very positive, their initiative ... but that needs to grow, and not just using the church ... there needs to be a mutual partnership...

But the dialogue does indicate that the issue of values and belief systems was seen as a stumbling block.

Although there are big efforts to sit down together, we have not yet appreciated each other's values ... and so that is why we still have the negatives ... what we need is that mutual understanding where we as the faith-based can be [clear] about our values and standards ... so we can be complementary to each other.

The issue of condoms has clearly been a bone of contention and continues to colour how CREs experience their collaborative relationship with government.

... if we say we are very strong in A & B, we should not be forced to go and do C ... when they come and do their C part, we should say they are complementing our A and B part, especially when it comes to youth, children and married people.

As was the case in the discussion about work with traditional healers, the conversation turned to a conservative theological position that sets CREs apart from other collaborative stakeholders, including government.

The pandemic, HIV and AIDS, is more of a spiritual problem, not a scientific problem ... NAC has a scientific focus ... but in fact everything has a spiritual aspect ... we think of HIV/AIDS as a virus, but everything that man is encountering has a spiritual side to it. The condom is a spiritual issue, abstinence is a moral issue.

Furthermore, the participants felt that it was unhelpful for government stakeholders to make blanket statements about CREs. This was particularly so because they felt 'used' by the ad hoc way in which CREs were drawn into government programmes.

A particular concern with regard to government practice related to their bureaucratic structures which implemented stringent conditionalities in accessing funding. Government's focus on "managing funds" detracted from what they saw as government's prime role, namely "to manage the epidemic". Because of their structures and conditions, resources were not reaching the grassroots speedily as there were long procedures and delays in responding to urgent needs.

What is there practically, while the system is supposed to be that way, centralization, the experience is that it is not as effective as it is supposed to be [general agreement] ... there are many, many issues such as capacity in the FBOs, capacity at a district level, DAC, it is overwhelming for many of the districts. One of the meetings NAC was saying we want to coordinate with you ... if the centralization was working very well, they would not have to send us a form to fill in every quarter.

### **Interaction with donors**

CREs were appreciative of their partnership with donors because of their willingness to assist and fund programmes and for the fact that this relationship was flexible. This flexibility enabled a more timely response to urgent needs. In addition to financial resources, participants valued the capacity building opportunities offered by these partnerships as well as the technical expertise they gain.

Having said this, participants once again reiterated their frustration that donors always set the agenda for action. CREs often feel 'dictated to' and feel at times there is an inability to appreciate 'local realities'.

... when the developed world gathers to decide what happens ... they are so rigid ... developed by the brains of the developed world, they have put one goal for themselves, and seven for the developing world, I am just expressing a frustration.

Conditions and expectations from donors are in some instances seen as a burden. The participants highlighted the need for greater coordination between donors themselves which would ease the differing expectations placed upon CREs.

... the donors should move out of this way of doing things ... they are not networking at the donor level ... and this is trickling down and creating competition and fighting, and one organization is saving one community and funded by one donor ... and this lack of networking, this fighting is beginning to create problems.

Intensive discussion amongst the participants at both workshops suggests that CREs in Malawi are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. Furthermore, these partnerships are perceived to

have a number of strengths and weaknesses. The main strengths are perceived to be the wide range of funders supporting work in Malawi, the willingness expressed in the national policy to engage with the religious sector, and good working relationships at local and district level.

The main weaknesses are perceived to be the lack of engagement by CREs at a national level with NAC and MIAA, competition and conditionalities around funding, and the lack of a common agreement on the efficacy of 'spiritual healing'.

#### **5.2.4 Findings concerning the challenges and potential of collaborative partnerships between Christian religious entities and other stakeholders**

**Finding 5: Both the Christian religious entities and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges include differing belief and value systems, difficulties with adhering to monitoring and evaluation standards, the dissemination of information, adequate representation, funding conditionalities, and inter-faith collaboration. These challenges are balanced by an awareness of the potential for these partnerships amongst both Christian religious entities and collaborative stakeholders, given the commitment to the Three Ones policy.**

The discussions in both participatory workshops highlighted the following concerns around the challenges to partnerships.

(1) While discussion in both workshops highlighted the general lack of meaningful collaboration, all participants seemed to agree that it worked best at district level. It is at this level that government stakeholders acknowledge the significant contribution of CREs. Likewise, it is at this level that CREs feel most positive about government practice.

However, there are clearly ongoing overt tensions between CREs and government stakeholders in areas such as condom promotion and monitoring and evaluation procedures. As was noted in finding 4, CREs reject government assumptions concerning their promotion of 'miracle cures' as well as their emphasis on condom use. On the other hand, collaborative stakeholders identified 'conservatism' as one weakness of collaborative relationships with CREs. This is expressed as differing belief systems and values by both parties.

We have different backgrounds with different beliefs ... and sometimes not easy to come together.

Collaborative stakeholders also experience their conservatism as expressed by a resistance to change and an unwillingness to adopt new approaches. They perceive that CREs tend to be inflexible in their attitudes, and this hinders collaboration.

The church is not running with the time, the government has decentralized, but the church has not.

(2) Furthermore, collaborative stakeholders acknowledge with concern that there is limited female representation of CREs at collaborative forums. In the discussion with CREs about who benefits from their services from a gender perspective, they acknowledged that most of their programmes were created by men for a largely female audience. This poses a further challenge to collaboration.

(3) While collaborative relationships between government and CREs seem to operate best at a district level, both groups also acknowledge that there are problems at this level. Government stakeholders feel that CREs lack capacity at this level which is one reason why monitoring and evaluation procedures are not adhered to. On the other hand, CREs have indicated the inadequacy of communication filtering down to the grassroots. This reality was acknowledged by government stakeholders who suggested that this could be remedied by strengthening the district implementation plans (DIP) and ensuring that report back sessions of the findings of Annual Reviews take place at a district level.

(4) A further challenge relates to representation. Government stakeholders and CREs both acknowledge that representation at the collaborating forums is often not balanced and representative of all stakeholders. Government stakeholders see this as a result of a lack of clear guidelines on representation.

Sometimes representation is haphazard...with inconsistent representation.

On the other hand, CREs feel that because MIAA was set up with government funds as a coordinating and representative body without adequate consultation, problems exist in collaborative efforts. Many are at best in an informal relationship with MIAA and at worst have no relationship at all. Clearly several CREs feel resentful or at least disinterested in the fact that this body is seen to be their representative and yet they had little say in its inception.

(5) Funding continues to evoke strong feelings in both parties. However, there seems to be little sympathy for one another in the particular challenges each face with regard to funding.

Government stakeholders pointed out that there is an unpredictability of funding levels and timing from international donors which makes planning collaboration difficult. They further find it difficult that certain CREs receive funding directly from their own national and international networks. This often means that their outcomes are not reflected in the national reporting mechanism, as they do not feel any obligation to report to this body because they are not being funded through the national funding mechanism.

They feel they don't have to [feed into the national M&E framework].

CREs, on the other hand, experience a great deal of pressure from their donors with regard to reporting procedures which often differ from donor to donor. They often find themselves in the position of having to spend so much time in monitoring and evaluation procedures that they have little to time "to get on and do the necessary work".

(6) A further challenge relates to inter-faith collaboration. It was noted by collaborative stakeholders that CREs isolate themselves from other faiths. This was evidenced in the discussion with CREs on which other religious communities benefit from their services. Their collaborative stakeholders felt that the different religions had different approaches in their programs and because there was poor communication between religious entities, this hindered a collaborative approach to planning. Collaborative stakeholders raised a concern about a lack of engagement with Traditional Healers by all stakeholders, including themselves. This was confirmed by the CREs' views on this matter as recorded earlier in the report.

There is no official representation of indigenous churches at a national level...there are so many faith groups not represented at a national level ... such as Pentecostals and indigenous churches ... and they are the ones not wanting ARVs.

Despite these challenges to meaningful collaborative relationships, the workshops also pointed to the potential for the future collaboration of all stakeholders. Given that there are a number of existing structures and forums for evaluation, collaborative stakeholders felt that there is enormous potential for strengthening multisectoral collaboration in Malawi.

Those noted by participants included the fact that:

- They have a commitment to the Three Ones principles.
- There are national, regional, and district structures in place to foster collaboration.
- There is a delegated coordination strategy in place that enables various stakeholders to participate, including the faith-based sector.
- Regular National Reviews are conducted.
- Technical working groups are in place.
- Local NGO forums exist, such as the Malawi Partnership Forum.

It is clear then, that both the CREs and their collaborative stakeholders see challenges and potential in such partnerships. Specific challenges include differing belief and value systems, difficulties with adhering to monitoring and evaluation standards, the dissemination of information, adequate representation, funding conditionalities, and inter-faith collaboration. These challenges are balanced by an awareness of the potential for these partnerships amongst both CREs and collaborative stakeholders, given the commitment to the Three Ones policy.

**Finding 6: There is a desire for stronger multisectoral collaboration in Malawi, without a further proliferation of initiatives. Christian religious entities desire a greater focus on local and district level initiatives. Collaborative stakeholders desire a greater commitment to collaborative planning, monitoring and evaluation. All parties hope for a greater focus on cultural and gender aspects of the epidemic.**

Despite an expressed desire for the stronger multisectoral collaboration, researchers felt there was a certain level of saturation in the number of collaborative initiatives and efforts that had already been put in place.

#### **A. Hopes for stronger collaboration: Christian religious entities**

CREs were able to reflect on their hopes for stronger collaboration in two areas, namely, government practice, and with donors.

In terms of **government practice**, the following were identified as key issues:

- Decentralization should be encouraged with less weight placed on national structures.
- There is a need to focus on strengthening district level structures so that they are able to cope with the demands of decentralization.
- There is a need to strengthen district level capacity and collaborating mechanisms enabling them to access funds more readily.
- Build capacity within the grassroots so that they are more accountable to the district structures in terms of M&E frameworks.

In terms of **donors** the following was identified as a way forward for the future:

- Donors should form their own collaborative forums, particularly at district level. Better monitoring of donors commitment to signed MOUs by government.

In addition to the above two key areas, the issue of gender and cultural issues were recognised as a stumbling block to collaboration (as was indicated by their collaborative stakeholders in the previous section). Some discussion took place as to how this matter could be addressed in order to improve future collaboration and at the same time acknowledge the feminized nature of the epidemic. Christian Entity participants indicated that there is existing legislation within a number of their structures that ensures gender equity in all committees. This legislation needed to be implemented more rigorously in the future. They felt that Government needed to ensure that gender and cultural issues were discussed within primary education. In addition, all Collaborative-stakeholders needed to strengthen existing NGOs that address gender and cultural issues.

### **B. Hopes for stronger collaboration: Collaborative stakeholders**

Collaborative stakeholders also reflected on ways forward in strengthening multisectoral collaboration. The following suggestions were made:

- Stakeholder meetings should be conducted at all levels of government.
- Ensure better communication and information sharing, particularly at a district level
- Strengthen joint planning and M&E structures.
- Ensure more user-friendly M&E frameworks
- Strengthen umbrella organizations such as MIAA.
- Undertake to conduct more research at a grassroots level in order to better understand their needs.
- Conduct a bi-annual conference on collaboration between the religious entities and government.

Donor stakeholders were not that forthcoming in suggesting ways forward in terms of their role in multisectoral collaboration.

It is clear then that there is a desire for stronger multisectoral collaboration in Malawi, without a further proliferation of initiatives. CREs desire a greater focus on local and district level initiatives. Collaborative stakeholders desire a greater commitment to collaborative planning, monitoring and evaluation. All parties hope for a greater focus on cultural and gender aspects of the epidemic.

## **5.3 Recommendations arising from the research findings in Malawi**

### **5.3.1. For the attention of the Christian religious entities**

- Assess effectiveness of the Malawi Inter-faith AIDS Association and restructure ensuring appropriate representation.
- Strengthen relationships with one another through establishing regular forums for dialogue and information sharing.
- Recognise culpability in hindering relationships with government stakeholders through conservative and dogmatic beliefs, particularly in relation to the condom issue, and be willing to compromise in certain instances.

### **5.3.2. For the attention of government**

- Communicate the principles of the Three Ones more deliberately and effectively, particularly at a district level.
- Ensure better representation within their coordinating structures.
- Involve CREs in ensuring that HIV and AIDS information is reaching the grassroots communities

### **5.3.3. For the attention of donors**

- Establish a forum of representatives of all funding partners as a matter of urgency.
- Develop one set of reporting and M&E procedures
- Recognise the importance of long-term relationships with their collaborative stakeholders

### **5.3.4. For the attention of all**

- Prioritise the principles of the Three Ones as a way forward for collaborative efforts.
- Ensure adequate representation in all co-ordinating bodies
- Establish regular regional forums for all collaborative stakeholders that enables ongoing dialogue, information sharing, and evaluation of strategic interventions.