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GLOBAL HEALTH POLICY CENTER

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THE GLOBAL HEALTH INITIATIVE IN MALAWI NEW APPROACHES AND CHALLENGES TO REACHING WOMEN AND GIRLS

*Janet Fleischman*¹

Introduction

The Obama administration designated Malawi as a GHI Plus country in June 2010, one of the first eight countries selected to implement the Global Health Initiative's (GHI) more comprehensive approach to global health and serve as learning labs for other GHI country programs.² The GHI team in Malawi has identified the health of women and girls, including HIV and family planning (FP)/reproductive health (RH) services, as critical, promising areas for GHI success. Though still in early stages of implementation, new approaches are emerging in Malawi that leverage resources from the President's Emergency Plan for AIDS Relief (PEPFAR) to develop greater program synergies for women and girls. Yet Malawi's weak health system, combined with ever more serious concerns about governance and human rights issues that are undermining donor support, present challenges that may threaten GHI's ability to achieve sustainable results.

Although over half of U.S. funding to Malawi is focused on HIV/AIDS, Malawi was not one of the original PEPFAR focus countries.³ The U.S. government has relatively balanced health and development funding in Malawi, which gives the GHI comparatively greater potential for impact than in neighboring countries where U.S. flexibility is limited because funding is effectively tied to

¹ Janet Fleischman is a senior associate with the CSIS Global Health Policy Center. This report was supported by a grant from the David and Lucille Packard Foundation.

² The Obama administration's Global Health Initiative (GHI) was announced in May 2009 as a six-year, \$63-billion program. The GHI Plus countries are: Bangladesh, Ethiopia, Guatemala, Kenya, Malawi, Mali, Nepal, and Rwanda. The purpose is to help partner countries improve health outcomes, guided by seven core principles: focus on women, girls, and gender equality; encourage country ownership and invest in country-led plans; build sustainability through health systems strengthening; strengthen and leverage key multilaterals and other partnerships; increase impact through strategic coordination and integration; improve metrics, monitoring, and evaluation; promote research and innovation. See GHI, "U.S. Global Health Initiative," <http://www.ghi.gov/newsroom/factsheets/2011/161412.htm>.

³ The 15 focus countries were: Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Uganda, Tanzania, Vietnam, and Zambia.

PEPFAR.⁴ Granted, many questions remain about how GHI will add value, deliver results, and create space for innovative approaches, especially without new money.⁵ Nevertheless, GHI has encouraged an attitude of active collaboration within the U.S. government interagency team in Malawi and has introduced new expectations about the importance of program synergies to guide U.S. programs. The value and impact of GHI's new business model may ultimately be evaluated based on its outcomes for women and girls, given the prominence of the women, girls, and gender equality principle in GHI and the importance of cross-sectoral approaches to address their health and non-health needs.

This will not be an easy task, since women and girls face serious health challenges in Malawi. The HIV-prevalence rate in Malawi is almost 12 percent, with women disproportionately affected, accounting for some 60 percent of those living with HIV. Malawi also has extremely high levels of maternal mortality, reported to be somewhere between 510/100,000 and 1,100/100,000, which is related to poor access to health services.⁶ According to the preliminary results from the 2010 Demographic and Health Survey in Malawi, the modern contraceptive prevalence rate is 42 percent, and the total fertility rate is 5.7. In addition, the realities of violence against women and other abuses of women's rights, limited access to education and productive resources for women and girls, and harmful gender norms, all serve to perpetuate poor health outcomes for women and girls and broader gender inequalities.

Policy Options

This is a critical yet perilous time for GHI in Malawi. Because Malawi is a GHI Plus country, U.S. supported programs will be subject to considerable scrutiny by U.S. government agencies and others evaluating GHI about whether they deliver results for the health of women and girls. At this same time, the national government has engaged in violent, repressive actions that threaten the willingness of donor governments to continue their investments in health and other arenas, prompting several to suspend assistance. The United States can use this opportunity to demonstrate that the program synergies inherent in GHI represent a useful and strategic way to achieve improved health outcomes for women and girls, and that such investments can be carefully managed while addressing the ongoing concerns about governance and respect for

⁴ In FY 2010, the U.S. government provided \$145 million in development assistance to Malawi, and in April 2011, the Millennium Challenge Corporation (MCC) signed a \$350-million compact with Malawi, focusing on the energy sector. However, the MCC agreement was put on hold in July 2011, due to governance concerns.

⁵ GHI does not include new money; rather, it is a compilation of other U.S. global health and development funding streams, including PEPFAR, the President's Malaria Initiative (PMI), maternal, newborn and child health (MNCH), nutrition, and family planning/reproductive health.

⁶ Global Health Initiative, "Malawi Global Health Initiative Strategy Document," <http://www.ghi.gov/documents/organization/158919.pdf>.

human rights. To accomplish this, the U.S. government in Washington and Malawi should consider the following policy options:

1. Demonstrate progress by enhancing coordination of women's health programming under GHI:

- Create technical working groups under GHI as well as with other external donors, focusing on issues such as maternal child health (MCH)-FP/RH linkages, and HIV-PMTCT (prevention of mother-to-child-transmission) and FP/RH linkages.
- Facilitate ease of integrating U.S. government funding streams in integrated programs, so that the program planning, implementation, and reporting processes can be more efficient and effective, less burdensome to partners, and have greater impact.
- Promote enhanced linkages between U.S. government programming and other development partner programs in Malawi, especially those focusing on family planning and reproductive health.

2. Address human resource constraints, health system challenges, and the policy environment to meet the needs of women and girls:

- Use PEPFAR funds to train and supervise health care workers on providing integrated HIV-PMTCT and FP/RH services.
- Provide management support to increase accountability for cost-effective and quality programs on women and girls, and support the development of policy guidelines for integration.
- Enhance opportunities for cooperation and collaboration between the U.S. and other partners—the national government, multilateral organizations, nongovernmental organizations (NGOs), and faith-based organizations (FBOs)—to support programs focusing on increasing access to comprehensive health services for women and girls and to build the capacity of government health services to address the issues faced by women and girls.

3. To optimize investments, leverage PEPFAR resources to strengthen comprehensive services for women and girls, including linkages between PMTCT and FP/RH services.

- Support multi-sectoral programs linked to PEPFAR that target adolescent girls, enabling them to access HIV, PMTCT, and FP/RH services, while also increasing their participation in education, economic empowerment, legal assistance, and nutrition programs.
- Enhance and promote more effective integration of family planning/reproductive health with HIV and PMTCT services, and clarify how this will be operationalized under GHI and PEPFAR. Working with the U.S. Agency for International Development (USAID), UN Population Fund (UNFPA), and UK Department for International Development

(DFID), ensure that family planning and HIV-testing commodities are available for HIV-positive women to ensure continuous access.

4. Maintain a strong U.S. focus on human rights and governance issues through health diplomacy and other high-level interventions:

- Continue high-level leadership from the Obama administration and the U.S. embassy in Malawi to ensure the centrality of women and girls in U.S. global health policy and programs under GHI and PEPFAR.
- Support civil society groups—including networks of women living with HIV, human rights and women’s rights organizations, and women’s health advocates—to provide information, education, and help create demand for quality health services.
- Ensure that populations at risk of HIV infection—including men who have sex with men (MSM), sex workers, and young women—have access to quality health and HIV services, without fear of stigma and discrimination.

U.S. Health Program in Malawi

The United States is the largest funder for health in Malawi—contributing about \$100 million per year—but it is not the only donor. Since Malawi was not an original PEPFAR focus country, the United States never set up a separate, siloed system for HIV/AIDS services as it did in some of the focus countries. Integration of HIV/AIDS and FP/RH in Malawi with U.S. funding began by providing one implementing partner with funding from the two different funding streams (PEPFAR and FP/RH). In this way, the U.S. government was able to support “one-stop shopping” to increase access to services for women and girls in public-sector services, where feasible and appropriate.

By the time Malawi was named a GHI-plus country in June 2010, U.S.-funded programs had already been pursuing greater integration in its health programs for several years and were therefore in the forefront of these efforts. According to the deputy chief of mission (DCM), “We were practicing GHI long before it had an acronym.”⁷ U.S. health and development programs in Malawi reflect an internal recognition within the U.S. mission of the importance of addressing the broader health challenges faced by women and girls in Malawi. For example, the 2011 PEPFAR Country Operational Plan for Malawi specifically refers to the importance of implementing a women, girl, and gender equality approach as part of the GHI as being “critical to sustaining the gains we made under PEPFAR.”

The U.S. global health program in Malawi is a relatively balanced portfolio, more so than in many other partner countries, with 52 percent devoted to HIV/AIDS (\$51.9 million), 27 percent (\$27 million) to malaria, 11 percent (\$10.7 million) to family planning/reproductive health, 6 percent

⁷ Interview in Lilongwe, Malawi, July 12, 2011.

(\$6 million) to MCH, and 3 percent (\$3 million) to nutrition.⁸ This spectrum of funding streams provides a favorable framework to pursue greater linkages and integration between health programs, since U.S. government resources can draw on funding streams beyond just PEPFAR. This is particularly important for bi-directional linkages between HIV and FP/RH programs; in countries where the U.S. government has little or no funding for FP/RH, it becomes difficult to create effective and sustainable linkages.

In fact, the U.S. health program in Malawi was already pushing to integrate its programming as early as 2007, when the first integrated FP project came on line. According to a USAID official in Malawi, “When GHI came, it presented a big opportunity to expand what we had started. With the human resources and financial constraints we had, it made more sense to integrate.”⁹ Since PEPFAR was still the largest funding source, the integrated programs were built on the PEPFAR platform of services. In this way, the requests for applications (RFAs) were developed with different U.S. government funding streams, with the majority of funding from PEPFAR.

The U.S. official went on to describe how the advent of GHI gave the health program “impetus for innovation” and “performance-based incentives” for quality of care. Given the high rates of maternal mortality, GHI in Malawi is dedicating resources to better understanding the causes and the links with infant mortality. Saying there’s a “bright future” for GHI programs in Malawi, the official said that: “the opportunities are great under GHI for an efficient model of service delivery. We need to go into full force to implement.” The same official noted that the challenges will involve addressing the policy issues related to integration, since Malawi has not yet developed a national policy on or guidance about HIV-FP/RH integration, and the question of resources, since new money will be needed for the health sector. Other U.S. government officials emphasized the importance of going beyond a focus on U.S. resources alone, emphasizing the importance of engaging the private sector, encouraging public/private partnerships, and seeking greater donor coordination to increase overall aid effectiveness.

PEPFAR-Malawi has also moved toward greater integrated support for service delivery. A new procurement in 2011 bundles services for HIV, malaria, FP/RH, MNCH, nutrition, and TB, which covers 5 zones and 15 districts—8 million people—offering a one-stop shop for these health services, meaning that people can receive a range of services in one place rather than having to travel to different sites for different services. Other initiatives are planned to integrate child survival, family planning, malaria, safe motherhood, nutrition, TB, and HIV. In some of the primary health care clinics, PEPFAR will also support RH services such as cervical cancer screening, while FP commodities will be provided by the Ministry of Health.¹⁰ In addition,

⁸ Kaiser Family Foundation, “Malawi: GHI Funding by Sector, FY 2010,” <http://facts.kff.org/chart.aspx?ch=1998>.

⁹ Interview in Lilongwe, July 11, 2011.

¹⁰ “Malawi FY 2011 Country Operational Plan,” <http://www.pepfar.gov/documents/organization/170276.pdf>.

PEPFAR provided Malawi with an additional \$10 million in PMTCT plus up funds, much of which has supported the development and implementation of “test and treat” (see below), at the request of the government of Malawi. PEPFAR funds are also supporting the development of guidelines, curriculum development, technical assistance, training, and supervision support.

Importantly, PEPFAR in Malawi is invoking the GHI principle on women, girls, and gender equality to explicitly link with other health and development areas to address the needs of women and girls more comprehensively. According to the 2011 Country Operating Plan (COP), PEPFAR intends to ensure linkages between PMTCT and the government’s infant feeding program and economic empowerment for women through Title II Food for Peace; integrate HIV services with antenatal care (ANC) and FP/RH services; strengthen gender-based violence (GBV) screening in HIV testing and counseling sites and refers to victim support units and post exposure prophylaxis (PEP) services; increase access to FP commodities and counseling through youth-friendly HIV health services; prioritize changing harmful gender norms and practices as part of behavior change interventions; and reduce maternal and child mortality by improving infrastructure and quality of care.

That said, U.S. officials acknowledge the challenges that lie ahead for implementing GHI in Malawi, especially related to how specifically PEPFAR funds will be used to contribute to GHI goals, as well as lack of clarity about how GHI will be funded and implemented.

Test and Treat for HIV-positive Pregnant Women

In 2010, the Malawian government announced plans to launch a “test and treat” program in which all HIV-infected pregnant women will immediately be put on antiretroviral treatment (ART) drugs for life. The program aims to prevent mother-to-child-transmission as well as providing essential treatment for the mothers.

This is an ambitious approach to HIV/AIDS treatment, and presents an alternative response (known locally as “Option B+”) to the World Health Organization’s (WHO) guidelines, which call for beginning antiretrovirals (ARVs) when the patient’s CD4 count falls below 350. In countries with weak health systems such as Malawi, waiting until CD4 testing is widely available throughout the country results in delayed access to treatment, since health care providers are largely using only clinical staging for determining ART eligibility. Given Malawi’s severe resource constraints and the limited availability of machines to count patients’ numbers of CD4 blood cells, the government decided not to make a CD4 count a prerequisite to treatment for HIV-positive pregnant women, but rather to pursue a public health approach—a simplified treatment regimen and associated training for health care providers to allow a significant scale-up in HIV/AIDS treatment. The argument for this strategy was outlined in an article in *The Lancet* in July 2011: “[Malawi’s] approach offers a real opportunity to integrate HIV treatment into mother and child health services and make tangible progress towards achieving the relevant Millennium Development Goals. Option B+ favors women rather than men in terms of ART accessibility,

although we feel this inequality is acceptable in view of the policy's potential contribution to the elimination of paediatric HIV infection.”¹¹

This plan has required retraining approximately two-thirds of Malawi's nurses, clinical officers, and data clerks between June and October 2011, and more than doubling the number of ART sites from less than 300 to 740. Given Malawi's very limited resources, this strategy creates a more feasible way to decrease mother-to-child transmission through significantly increasing HIV-infected women's access to treatment. Criticism of this approach has focused largely on the high cost, which Malawi does not have the national or international resources to support.

The implementation of Malawi's new strategy faces many challenges, particularly related to how the country will finance the new and expanded ART program without new resources and what type of counseling and social support will be provided to the women who are being placed on ART for life. Yet the new approach also presents opportunities to address HIV/AIDS in Malawi, including expanding access to HIV treatment throughout the country and enhancing effective integration of FP and RH services into HIV/AIDS care for these HIV-infected women.

As one U.S. government health program analyst in Malawi put it, “Using this approach will in effect bypass the system challenges and allow HIV-positive pregnant women in even the most remote clinics to be provided with the best option for preventing transmission to her baby; that's the genius and the controversy of test and treat.” Overcoming such system challenges is difficult under even the best of circumstances, and it remains to be seen whether Malawi will be successful in achieving its ambitious treatment goals.

Integrated Government Guidelines on HIV

In 2011, the Malawian government issued guidelines for the clinical management of HIV in children and adults. The guidelines promote a comprehensive approach to HIV prevention, care, and treatment and form a promising foundation for expanding services around the country.

The government's integrated guidelines include antenatal care, maternity care, clinics for children under five years old, family planning clinics, exposed infant/pre-ART clinics, and ART clinics.¹² The guidelines note that “clinical HIV services are an integral part of the essential health package.” Phase I of the implementation plan, beginning in July 2011, includes provider-initiated family planning (PIFP), focusing on the provision of Depo-Provera (injectables) and condoms as part of the package of prevention services provided in pre-ART and ART clinics. Similarly, the PMTCT strategy includes all four prongs of PMTCT recommended by WHO, including prong two—prevention of unintended pregnancies among HIV-positive women. The package aims,

¹¹ Eric J. Schouten et al., “Prevention of mother-to-child transmission of HIV and the health-related Millennium Development Goals: time for a public health approach,” *The Lancet* 378, issue 9787 (July 16, 2011): 284.

¹² Malawi Ministry of Health, “Clinical Management of HIV in Children and Adults,” 2011.

among other things, to reduce HIV transmission to sexual partners and to reduce HIV transmission from mother to child by preventing unwanted pregnancies.

The section of the guidelines focusing on preventive services for HIV patients discusses FP, underscoring the importance of avoiding unwanted pregnancies, regardless of HIV status, as well as the risks of unprotected sex for discordant and concordant HIV-infected couples and therefore the importance of using dual protection. The guidance emphasizes that health care providers should “encourage HIV-positive women to make an informed choice about pregnancy.” In terms of implementation, the guidance advises providers to assume that all patients over 15 years old are sexually active and that they should therefore offer condoms to all men and condoms and depo to all women, and refer clients to FP clinics for further counseling or other FP methods.¹³

Community-based Distribution Agents (CBDAs)

An innovative program begun in Malawi in 2007, led by Management Sciences for Health (MSH) with Population Services International and Futures Group International, involved using community-based distribution agents (CBDAs) to provide family planning commodities, as well as HIV/AIDS information and testing, to rural, underserved communities in four districts. Given that almost 85 percent of Malawi’s population live in rural areas, access to health facilities is often very limited, and this project worked to create demand for these health services, develop the capacity of CBDAs to deliver them and to advocate for supportive policies to implement integrated FP and HIV/AIDS services.¹⁴ Despite challenges of transportation, inadequate numbers of CBDAs and health surveillance agents (HSAs), and shortages of commodity supplies, the project showed that non-health professionals can effectively provide certain FP methods, that integrated FP-HIV services can reduce stigma, and that creating demand improves service uptake. However, it remains to be seen if the Malawian government will be able to sustain this approach.

In the past, family planning commodities were provided only by clinicians, which meant that many rural women had difficulty accessing FP information and services. The idea of this program is to provide a “one-stop shop” that integrates some FP and HIV services as a way to reduce stigma and travel time, and thereby increase uptake in services. As one program manager put it: “With the CBDAs, it’s a concept of integration beyond the clinic.”¹⁵

The program provided different levels of training for different services. The CBDAs are volunteers who live in the communities, identified by the community and local health workers, and receive training to provide some FP commodities (condoms, oral contraceptives), HIV information, and HIV counseling and testing. The next level is the health surveillance agents (HSAs), who provide a link between the community and the formal health system, and have been

¹³ Ibid, pp. 30–31.

¹⁴ USAID/Malawi, “Community-Based Family Planning and HIV/AIDS Services in Malawi,” Quarterly Report No. 14, January-March 2011.

¹⁵ Interview in Lilongwe, July 10, 2011.

given additional FP training to provide injectables (depo). MSH has trained over 1,000 CBDAs and has also trained supervisors and HSAs in the communities where they work, who in turn are supervised by a nurse or health care provider in the local clinic. In the project, over 1,000 HSAs received training. Other HSAs have been trained by UNFPA and WHO in the districts they support. Mexon Nyirongo of MSH described the program's unexpected success: "The country wasn't prepared when we started, many were pessimistic. When we trained and mobilized communities, it was a bush fire—nobody was prepared for it."¹⁶

The design of the project relied more on FP funding than HIV funding, but the idea was that more HIV funds could be accessed if necessary. "The CBDAs can have a huge role in the linkages between family planning and the PEPFAR pillar—there's a huge gap," according to Rudi Thetard, the country director of MSH.¹⁷ Still, the U.S. funding streams for HIV and FP have to remain separate, but MSH channeled those funds into one person to provide services. The U.S. government allows HIV funds to train some CBDAs, a practice that pre-dated GHI, but with the advent of GHI, there seems to be a greater understanding of the importance of creating such synergies. A significant problem, however, has been the shortages of HIV test kits. "We mobilize people to come, and then there are no kits," a nurse in Salima district explained in frustration.¹⁸

Once a client gets an HIV test from a CBDA, he/she is referred to the local health center, or eventually sent to the district hospital for further testing and treatment. Some health centers are now providing ARVs but don't have CD4 machines. Stock-outs are a "perpetual" problem around the country and present barriers to service provision. HIV test kits, CD4 reagents, family planning commodities, male and female condoms, pregnancy tests, syphilis tests, and emergency contraception are among the supplies that are often unavailable. This is why donors have focused attention on the central medical system (CMS), which is being transformed into an independent trust to improve controls and safeguards and to strengthen forecasting, procurement, distribution, and inventory. However after a decade of attempts at strengthening CMS, the stakes are extremely high for the government of Malawi to make good on its pledges and win back donor support.

In the village of Mndola in Salima district, a CBDA named Amon Chimphebo described the results of his work in the community. He began doing HIV counseling and testing in April 2009 for his population of 1,319: he has 159 family planning clients for basic methods, but he refers others to health centers or clinics for depo and other methods. On HIV, he goes door to door to offer HIV counseling and testing. He has conducted 439 tests and referred 12 clients for ARVs (6 of the 12 are women, and 2 have died, so now 6 of his 10 HIV-positive clients are women). At first, the community was wary of him, and women were reluctant to take family planning methods, so he came with his supervisor and was introduced to the community by the village

¹⁶ Interview in Lilongwe, July 10, 2011.

¹⁷ Interview in Lilongwe, July 12, 2011.

¹⁸ Interview in Salima district, July 11, 2011.

headman. He then started going door to door, bringing his materials on a bicycle, and telling them the importance of knowing their HIV status. The villagers then choose if they want to be tested or if they want FP services. “They discuss family planning as a family; I give them time,” he explained. But he went on to describe some of the challenges his clients face: “Sometimes, women are afraid of their husbands at home.” In those cases, women can come to see him to get information on FP. “Little by little, they come with questions, then they come for condoms.”

The Lighthouse Trust

An example of how the PEPFAR platform can be leveraged to include FP/RH services is the Lighthouse Trust, an innovative ART program in Malawi and longtime implementing partner of the U.S. government. The Lighthouse has begun integrating FP into its ART clinics in two sites in Lilongwe: the Lighthouse Center at Kamuzu Central Hospital, where FP counseling and services have been integrated into routine patient visits, and Martin Pruess Center at Bwaila Hospital, where patients are referred for FP services in an adjacent wing. In this program, U.S. government funding from FP and PEPFAR are both used to support different aspects of the program—PEPFAR funding through the Center for Disease Control and Prevention (CDC) supports the HIV work, and USAID provides the family planning contraceptives with population/FP funding. It is important to note that USAID provides the commodities directly—not money to purchase commodities—due to challenges and costs associated with providing funding through the government system.

The Lighthouse Trust is a public trust that is part of the central hospital. It provides service delivery, model interventions and interventions research, and capacity building and training to support the Ministry of Health at several urban and rural sites around the country. The program provides ART to some 15,000 people, and provides care for some 22,000 HIV-infected patients, many of whom are not yet eligible for ART. In August 2010, the Lighthouse Center at Kamuzu Central Hospital started offering FP services beyond condoms—pills, depo, and intrauterine contraceptive devices (IUDs). This change stemmed from the realization that the women in their HIV program were coming back with sexually transmitted infections (STIs) or pregnant, indicating that they were engaging in unprotected sex. They now have 410 women registered in their FP clinic.¹⁹ The Lighthouse intends to move toward integrating other RH services, including cervical cancer screening and strengthening STI and FP services, in the pre-ART and ART clinics at their facilities. On-site integrated services are expected to be made available at the Martin Pruess Center in the coming year.

The Lighthouse program has shown that FP services can be successfully integrated into an ART clinic using minimal additional resources and that clients appear interested in receiving these services in an integrated setting.

¹⁹ Interviews at the Lighthouse in Lilongwe, July 12, 2011.

Donor Climate

Significant tensions are growing between the Malawian government and its international donors due to concerns about corruption, human rights, and governance. This could put the government's ambitious HIV program at risk. Some 40 percent of Malawi's budget comes from foreign donors, the largest donor being the United Kingdom with \$121 million in 2010–2011, followed by the United States. For the HIV program, the donors provide some 90 percent.

Tensions were heightened in July 2011, when government security forces killed 19 people who were participating in a peaceful demonstration over deteriorating economic conditions and political repression.²⁰ But problems between Malawi and the donor community had been escalating for several months. In May, the UK DFID suspended funding, after Malawi ordered the expulsion of the British ambassador due to a leaked cable that referred to the Malawian president as “autocratic and intolerant of criticism,” and in July 2011, DFID suspended new funding due to corruption concerns. Germany suspended \$16.5 million in funding because of Malawi's anti-gay laws.²¹

In 2010, the Global Fund to fight AIDS, TB and Malaria rejected Malawi's application, which amounted to some \$565 million,²² due in part to concerns about Malawi's capacity to implement the programs and its management of commodities. The Global Fund support to Malawi covers the cost of most of the ARV drugs. Accordingly, the country's ability to sustain the “test and treat” program was going to depend on the success of its round 11 application to the Global Fund, given the expectation that its new application would be more focused and have a better chance to be funded. In November 2011, however, due to huge shortfalls in contributions and ongoing uncertainties about future financing, the Global Fund announced that round 11 would not go forward as planned, and that no new grants would be made until at least 2014. At this writing, it is unclear what this new situation will mean for Malawi, and whether it will be eligible for funding under the Global Fund's transitional funding mechanism. At a minimum, it seems unlikely that any significant expansion of Malawi's HIV program will be supported by the Global Fund at this stage.

²⁰ Human Rights Watch, “Malawi: Promptly Investigate Killing of Peaceful Protesters,” July 22, 2011, <http://www.hrw.org/news/2011/07/22/malawi-promptly-investigate-killings-peaceful-protesters>.

²¹ Malawi's criminal code prohibits same sex practices between males under Section 153, which prohibits “unnatural offences” and Section 156 on “public decency.” In 2010, Malawi's first openly gay couple to get married, Tiwonge Chimbalanga and Steve Monjeza, was prosecuted and convicted of “indecent practices” and sentenced to 14 years of imprisonment. After considerable international pressure, the men received a presidential pardon on humanitarian grounds. Nevertheless, homosexuality is still a crime, and a new law criminalizes same sex practices between females.

²² John Donnelly, “Maternal death stalks Malawi's rural poor: Politics disrupts international aid,” *Global Post*, June 26, 2011, <http://www.globalpost.com/dispatch/news/health/110622/maternal-death-stalks-malawi-s-rural-poor>.

In June, the International Monetary Fund (IMF) declared Malawi “off-track,” relating to exchange rate imbalances and disagreements about devaluing Malawi’s currency, the Kwacha, as well as assumptions and targets in the 2011/2012 budget, among other monetary and policy issues. This “off-track” designation means that most other donors will no longer provide the government with direct budget support, and it led the World Bank to hold back \$40 million in budget support in May. In August, Malawi devalued its currency in an effort to revive the stalled program with the IMF.

In July, the Millennium Challenge Corporation (MCC) put a hold on its \$350-million program for the energy sector, which had just been signed in April, indicating that governance concerns are critical to the terms of its compact with Malawi.²³ The rest of U.S. programming remains on track, although further deterioration of the human rights situation and governance concerns could imperil those programs as well.

These tensions between Malawi and its international donors starkly illustrate the challenging context in which the GHI strategy is being rolled out. For GHI to have a meaningful impact on the health of women and girls in Malawi, the United States and its implementing partners will have to ensure that the program synergies promised by GHI can be delivered and that PEPFAR platforms can be leveraged to provide more comprehensive, integrated services for women and girls and their communities. For all these reasons, Malawi will be an important test case for the GHI approach—it presents a complicated set of health, development, governance, and human rights issues, and addressing them will require a new approach to global health that supports a multifaceted response.

²³ Center for Global Development, “MCC Puts Hold on Compact with Malawi,” July 26, 2011, <http://blogs.cgdev.org/mca-monitor/2011/07/mcc-puts-hold-on-compact-in-malawi.php>.



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