



# CHANGING LIVES

A Portrait of Children in Malawi

## CONTENTS

1	Foreword
3	Malawi Country Profile
4	Children and Women in Malawi
8	UNICEF in Malawi
<b>9</b>	<b>THE HEALTH AND NUTRITION PROGRAMME</b>
10	A tale of two pregnancies and two different outcomes
14	Treating severely malnourished children at home
18	The people's doctor
23	Pain for a purpose
<b>25</b>	<b>THE WATER, SANITATION AND HYGIENE PROMOTION (WASH) PROGRAMME</b>
26	The first drop of water
28	Community says "No" to eating faecal matter
<b>32</b>	<b>THE BASIC EDUCATION AND YOUTH DEVELOPMENT PROGRAMME</b>
33	Girls return to "friendly" school, yet not without sacrifices
36	Reaching for the skies: the dreams of a young Malawian
40	Young people lead the response to HIV and AIDS
<b>44</b>	<b>THE ORPHANS AND OTHER VULNERABLE CHILDREN AND CHILD PROTECTION PROGRAMME</b>
45	Getting ready for school and life
48	How to deal with domestic violence: the 'dilemma' for poor women
50	Healing deep emotional wounds with play therapy
<b>53</b>	<b>SOCIAL POLICY, ADVOCACY AND COMMUNICATION</b>
54	Alone and grieving, two orphans are thrown a lifeline
57	Women find their voice through radio



## FOREWORD

Grandmother Sonia, who does not know her age, but I guess is about seventy years old, made a huge impression on me. She lost her own child, probably to AIDS, and now has to bring up her three grandchildren alone.

Yet her attitude is positive and she is wisely spending the little money she receives from a cash transfer programme, carving out a life full of promise for her grandchildren.

With the money from the cash transfer scheme, the grandmother was able to buy government-subsidized fertiliser and seeds, farming tools and hire labour to cultivate her small plot. She told me with a beaming smile that it was the first time in her life that she was not worried about having enough food for her family. She can now send her grandchildren to school with food in their stomachs and shoes on their feet. Her eldest grandchild is even at secondary school, a feat she regards as major.

Sonia is not the only one

with a story to tell. There are hundreds of other Malawians, many of them extremely poor, whose lives are being transformed as much-needed services reach their communities and doorsteps. Whether it is cash transfers, immunization or a borehole, their stories are the same: communities can do wonders with just a little bit of help.

In this country kit, you will read about these transformations through the stories of children and women. The stories are uplifting, even the most desperate ones, for they not only demonstrate the extraordinary resilience of those who live through such miseries but they also point to the generosity of those who have given their lives, time and money to helping the poor.

Today in Malawi, fewer babies are dying from preventable and treatable diseases than ever before, and are surviving to celebrate their landmark first and fifth birthdays. The infant and under-five child mortality rates are coming down, representing tangible progress towards reaching the Millennium Development Goals. Credit for this must go to the amazing efforts of the government and its partners to reduce malaria through mass distribution of long-lasting insecticide-treated nets. Vitamin A supplements have also been important, boosting natural immunity and reducing susceptibility to disease, as well as protecting eyesight. And the 11,000 or so Health Surveillance Assistants, who educate families about how to better care

for themselves and their children and who treat children in village clinics with affordable, easy-to-use remedies like oral rehydration salts, have contributed to this success.

A lot more work needs to be done. Too many women in Malawi still die from largely avoidable pregnancy-related complications, and many babies die in the first weeks of life from neonatal diseases and conditions. Even here though, we have seen progress. Little by little, tragic deaths are being avoided with intensified educational campaigns, community outreach, and the provision of motorcycle ambulances which have significantly eased transport challenges faced by expectant women.

Chronic malnutrition remains a challenge, with half of under-five children stunted. Efforts to prevent moderate malnutrition have been stepped up through the school feeding programme, which we jointly support with the World Food Programme, and the community therapeutic care programme ensures that malnourished children can be treated at home.

Undoubtedly, one of the most encouraging developments in Malawi has been the dramatic difference that free anti-retroviral (ARV) treatment has made to the lives of everyone, not just those who are living with the virus. Today, Malawians living with HIV are not only able to carry on caring for their families, but they are also able to contribute to the development of their country. ARVs have prolonged lives and enabled children who might have been orphans by now to continue enjoying life with their parents. More children are on ARV treatment now than was the case in 2005 when the Unite Against AIDS campaign was launched.

You will also read about how HIV-positive pregnant women are successfully preventing the transmission of the virus to their babies and how young people are taking the lead in HIV prevention both in school and in their communities. Girls have taken centre stage as peer educators, talking to other young girls - who are the most vulnerable to HIV infection - about avoiding behaviour that exposes them to HIV.

Orphans continue to need more assistance. About one in every six children is an orphan in Malawi, half of whom have been orphaned by AIDS. Community-based childcare centres, or CBCCs as they are commonly known, are offering invaluable help to orphans and other vulnerable children. More than 400,000 children attend these centres, receiving psychosocial counselling, a nutritious meal, and basic life skills training for the older ones. Those aged below five engage in early learning activities that make them better prepared for school. We continue to work tirelessly with the government to improve

the quality of services offered in these centres.

We are also proud of our ongoing work with the Malawi Police to provide protection to vulnerable children through "Victim Support Units". The units offer a safe place to children and women who have survived domestic violence, and the police officers manning them provide counselling and ensure that perpetrators have their day in a court of law.

Following the government's decision to abolish schools fees in 1994, many more children are now able to attend school, with gross enrolment in standard 1 exceeding 100%. Keeping the children in school, however, remains a huge challenge as only a third of children manage to complete primary school. Among the reasons are overcrowded classrooms (on average there are more than 100 pupils per class), inadequately trained teachers, socio-cultural practices such as early marriage, and a lack of water and sanitation facilities.

Another visit that stands



out in my mind is one I made to a village that had declared itself "Open Defecation Free." The village had witnessed a remarkable drop in diarrhoea and for me, it showed that lasting change only comes about when communities realise they have a problem and decide to do something about. This is part of an innovative approach called Community-Led Total Sanitation based on mobilizing communities to take a stand against open defecation.

There are numerous stories in this kit which show how children and women in Malawi, with a little help, are gradually turning their lives around for the better. I hope you can join us in creating a better Malawi for all children.

Carrie Auer  
UNICEF Representative  
Malawi

## MALAWI COUNTRY PROFILE

### Country

- Official name: Republic of Malawi
- Capital: Lilongwe
- Size: 118,484 sq km
- Coastline: none
- Climate: sub-tropical; rainy (November - April); cold and dry (May-July) hot and dry (August - October)
- GNI per capita: US \$250
- Major exports: tobacco, tea, cotton

### People

- Population: 13 million
- Population growth rate: 2.8%
- Total fertility rate: 5.2
- Children aged 18 years and below: 6 million
- Children aged 5 years and below: 2.8 million
- Average household size: 4.6
- Household poverty: 40% of the population lives on less than 44 Malawian kwacha (about US \$0.28) per day

### Health and Nutrition

- Neonatal mortality rate: 33 per 1,000 live births
- Infant mortality rate: 72 per 1,000 live births
- Under-five mortality rate: 100 per 1,000 live births
- Maternal mortality rate: 807 per 100,000 births
- Skilled attendant at birth: 54%
- Life expectancy at birth: 48 years
- Under-fives who are moderately or severely underweight: 21%
- Under-fives who are moderately or severely stunted: 46%
- Children who are exclusively breastfed for six months: 57%
- One-year-olds immunized against DPT3: 87%
- One-year-olds immunized against measles: 83%
- Under-fives sleeping under an insecticide-treated net: 25%

### HIV/AIDS

- Adult HIV prevalence: 12%
- Estimated number living with HIV: 1 million
- Children living with HIV: 102,000
- Orphans: 1.1 million
- Children orphaned by AIDS: 550,000

### Water and Sanitation

- Population with access to improved water source: 75%
- Population with access to improved sanitation (including pit latrine): 88%
- Population with access to improved sanitation (excluding pit latrine): 20%
- Households with soap/washing powder or liquid: 67%

### Basic Education

- Net primary school enrolment ratio: 91%
- Children reaching standard 5: 86%
- Children reaching standard 8: 71%
- Total number of primary schools: 5,460
- Adult literacy rate: 72%
- Average teacher to pupil ratio: 1:107
- Schools with a protected water source: 82%
- Schools with sanitary facilities: 23%

### Child Protection

- Children engaged in child labour: 26%
- Children married before age eighteen: 50%
- Young women aged 15-19 currently married or in a union: 33%

Malawi is blessed with an array of wonders - mountain ranges, forests and a magnificent lake that looks more like an ocean, fringed with palm-trees. Yet amidst this beauty is the ever-present threat of natural disasters, most frequently severe droughts and flooding.

And the land lacks natural resources and is overstretched by an ever-growing population. Moreover, deeply entrenched social problems - poverty, malnutrition, HIV and AIDS - and other diseases like malaria strike children and women particularly hard in this landlocked, southern African country of 13 million people. More than 40% of the population lives below the poverty line and about one in every five people lives in extreme poverty, that is, they cannot afford to meet the daily recommended food requirements. Most precariously, their

dependence on rain-fed agriculture renders them vulnerable to extreme weather changes.

Notwithstanding these factors, children in Malawi face a better chance of survival now than they did before. The infant and under-five mortality rates declined from 104 and 189 per 1,000 live births respectively in 2000 to 72 and 122 in 2006, according to the latest Multiple Indicator Cluster Survey. The Inter-agency Group for Child Mortality Estimation (IGME) projected under-five mortality to be 100 in 2009. Yet too many children still

die of largely preventable and treatable diseases like diarrhoea, malaria, pneumonia, acute respiratory infections, AIDS and malnutrition. Lack of access to safe water and basic sanitation also contributes to poor health and the risk of early death.

Malawi remains one of the riskiest places on earth for expectant mothers, with a maternal mortality rate of 807 per 100,000 live births. The direct causes of death include infection of the uterus, obstructed labour, bleeding, eclampsia, and

abortion-induced complications. These deaths could largely be avoided if mothers could get to health centres in good time. Instead, they often arrive too late, delayed by slow decision-making and lack of transport. A lack of drugs and supplies, inadequate blood transfusion facilities, staff shortages and the high cost of services also result in mothers not receiving appropriate treatment. For all these reasons, together with the often-cited poor attitude of medical staff, only 54% of mothers in Malawi deliver with the help of a skilled attendant.



The causes of malnutrition include lack of information about feeding children, poor diet, frequent illnesses, and poor maternal nutrition. Perhaps half of all children suffering from acute malnutrition are infected with HIV.

While the government's roll-out of free anti-retroviral therapy has dramatically reduced deaths, AIDS continues to devastate or at least hamper the lives of many children and women. The HIV prevalence rate is estimated at 12% among those aged 15-49; 15% of women and 11% of men are living with the virus. Mother-to-child transmission accounted for 17,000 new HIV infections among newborns in 2008 and in that year, an estimated 102,000 children were living with HIV. Malawi has a huge orphan population - just over a million - of whom half have lost one or both parents to AIDS.

Most children in Malawi will not develop to their full potential. Only 30% of the 2.5 million children aged

between two and five years attend either a pre-school or a community-based childcare centre. Although primary school fees were abolished in 1994, the quality of education remains poor.

There is on average one teacher for every 107 pupils. In some schools, learning often takes place in poorly constructed and decrepit buildings, grass-thatched shelters or even in the open under trees. Some schools have neither water nor sufficient or separate latrines for girls and boys. Other problems include lack of school materials for both pupils and teachers, and chronic hunger among the children.

Besides the lack of educational opportunities, many children and women suffer abuse, exploitation and violence in this relatively young democracy. There is no universal birth registration system, illiteracy is high, the media is still growing, gender inequality remains rife and most child protection legislation needs updating.

increase its social-sector spending. According to the African Report on Child Wellbeing 2008<sup>2</sup>, Malawi is among the top ten African governments that have increased the proportion of their budgets allocated to health and education.

The macro-economy has stabilized, thanks to the government's prudent fiscal and monetary policies that have enabled the economy to grow at an average of 7.5% and reduced inflation to single digits. The stable economy has enabled the government to

In recent years, however, improvements in Malawi's economic performance have brightened future prospects for children.

The African Report on Child Wellbeing (2008);  
How child-friendly are African governments?  
The African Child Policy Forum



## UNICEF has been operating in Malawi since 1964. The current UNICEF/Government of Malawi Country Programme of Cooperation aims to support national efforts to progressively realise the rights of children and women through improved child survival, development, protection and participation.

The programme is guided by the Convention on the Rights of the Children (CRC), the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), the Millennium Development Goals (MDGs) and the Millennium Declaration. It is also in line with the Malawi Growth and Development Strategy through the United Nations Development Assistance Framework (UNDAF) and contributes to sustainable economic development and food security, social protection and disaster reduction and management, access to equitable basic social services, HIV and AIDS prevention, care and treatment, and good governance. The country programme has also integrated the four cross-cutting areas of the UNDAF: human rights, gender, disaster risk reduction and capacity development for programme implementation.

The country programme has five programme areas:

- Health and Nutrition
- Water, Sanitation and Hygiene Promotion
- Basic Education and Youth Development
- Orphans and Other Vulnerable Children and Child Protection
- Social Policy, Advocacy and Communication.

The last two cut across all programmes, while the first three are sector-specific.

### THE HEALTH AND NUTRITION PROGRAMME

#### Issue

- One in 7 children in Malawi dies before their first birthday.
- One in 12 children in Malawi dies before their fifth birthday.
- Most children die of preventable and treatable diseases such as neonatal illnesses, pneumonia, diarrhoea, malaria, AIDS and malnutrition.
- One in 18 women will die from pregnancy-related complications.
- 46% of under-five children are stunted.
- 21% of under-five children are underweight.
- 60% of under-five children have vitamin A deficiency.
- 48% of pregnant women have anaemia.
- Up to 50% of malnutrition cases are associated with HIV and AIDS.
- About 12% of Malawians aged 15- 49 years are infected with HIV and AIDS.
- Mother-to-child transmission accounts for 90% of all new HIV infections in newborns (17,000 in 2008). Without any intervention, up to 35% of HIV-positive mothers will transmit the virus to the baby.
- About 100,000 children are living with HIV.

#### Action

The programme addresses these challenges through four projects: Child Health; Reproductive Health and HIV and AIDS; Nutrition; and Policy and Sector Reform. Many of the activities will take place in the communities themselves, which is a cheap and highly effective approach.

Child Health activities include:

- improving child survival and development using the

Integrated Management of Childhood Illnesses Approach, which takes a holistic approach focusing on the welfare of the child and not just the illness;

- promoting home visits, village clinic days, outreach programmes and supporting specialised clinics at the health facilities, such as antenatal clinics, mother and child clinics, maternity and paediatric wards, and nutrition rehabilitation units.

Reproductive Health and HIV and AIDS activities include:

- promoting access to skilled care;
  - supporting community mobilisation to increase demand for maternal and newborn health services;
  - upgrading health facilities, especially to deal with emergency complications before, during or after delivery;
  - improving access to and quality of sexual and reproductive health facilities, including family planning particularly for young people;
  - strengthening care of newborns especially during the first eight days of life;
  - scaling up the number of sites for Prevention of Mother to Child Transmission (PMTCT) of HIV.
- Nutrition activities include:
- therapeutic feeding;
  - community therapeutic care;
  - controlling iodine, iron and Vitamin A deficiencies;
  - supporting prevention activities, such as complementary and supplementary feeding, exclusive breastfeeding and growth monitoring.

Policy and Sector Reform Activities include:

- working with other UN partners to support health sector reforms.

#### Impact

By working with other partners within the sector-wide approach and the United Nations, the programme aims to achieve these results by 2011:

- 95% of infants fully immunized with all antigens.
- 60% of under-five children sleeping under long-lasting insecticide-treated bed nets.
- 60% of pregnant women sleeping under long-lasting insecticide-treated bed nets.
- 80% of infants exclusively breastfed for at least six months.
- 98% of children aged 6-59 months receiving a dose of Vitamin A every six months.
- 80% of HIV-positive pregnant women identified through PMTCT services receiving anti-retroviral prophylaxis.
- 80% of children born to HIV-positive mothers enrolled in PMTCT programmes receiving cotrimoxazole preventive therapy.
- 80% of children who have been tested positive for HIV accessing anti-retroviral therapy.

#### Key Donors

*Governments:* Canada, Denmark, Republic of Ireland, Japan, Spain, United Kingdom, United States. *UNICEF National Committees:* France, Germany, Italy, Japan, Norway, Switzerland, United Kingdom, United States.

*Other Sources:* OPEC, Micronutrient Initiative, United Nations Foundation, UN Fund.



## A TALE OF TWO PREGNANCIES AND TWO DIFFERENT OUTCOMES

# The maternity ward at Mangochi District Hospital bursts at the seams as pregnant women occupy all the beds and others sleep on the floor, even in the hospital corridors.

But Esther Makumba is neither expecting nor nursing a baby. Her baby died in the womb. “My mother was trying to deliver my baby at home,” she says from her hospital bed. By her side is her mother, Fatima Ali, who cannot hide her anxiety. She tries to occupy her five-year-old grandson but her mind is clearly on her daughter’s poor health.

Makumba takes time to catch her breath. She has developed a fever. “I was in labour for four days. I was in a lot of pain, so I wanted to go to the hospital, but my mother refused.” Instead, her mother decided to give her *mwana wa mphepo*, a local herb that speeds up contractions. Makumba’s uterus ruptured and the race to save her life was on. As there was no

telephone network or public transport in her village, family members took Makumba on a bicycle to the nearest health centre. It took them two hours to navigate the potholed dirt road. At the centre, the nurses phoned an ambulance and Makumba was transferred to Mangochi District Hospital where she arrived unconscious. An emergency operation removed the dead foetus.

Makumba’s is not an isolated case. In fact, she is lucky to have survived. As many as one in every 18 women dies from pregnancy-related complications, making Malawi one of the world’s riskiest places to have a baby. By stark contrast, the odds of a woman in Sweden dying from pregnancy-related complications are one in 17,400. The main causes

of maternal deaths in Malawi are haemorrhage, sepsis, pregnancy-induced hypertension, obstructed labour and complications from abortions.

The newborn baby also has a high risk of dying. The World Health Organization estimates that in developing countries, 40% of babies die within the first week of life, and most of the deaths are largely preventable. Childbirth, a completely normal and natural process, can often be a life and death affair.

“There is a lack of knowledge, as most women are illiterate,” says Amina Makanjira, the safe motherhood coordinator at Mangochi District Hospital. “The herb that Makumba’s mother gave her is widely used but it is very dangerous,” she says. Other traditional

beliefs also contribute to deaths. “People believe that they should have their first baby at home so that the father can confirm it is his,” adds midwife Makanjira.

Yet even when expectant mothers want to deliver at a hospital, there is little or no public transport. Many have to make the journey, heavily pregnant or in labour, on foot or by bicycle, along bumpy unmetalled roads. Complications often develop when the mothers are too young to have children or do not space their pregnancies. Only about 54% of pregnant women in Malawi are assisted by a skilled attendant at birth. These life-threatening risks have prompted the government, with support from UNICEF and other partners, to mount a campaign to convince

< The naked baby is placed on the mother’s bare chest and wrapped in place, rather like a young kangaroo in its mother’s pouch.



women to deliver in hospital. Community members, including village chiefs and Health Surveillance Assistants, are playing a key role. In some areas, UNICEF has supported the distribution of 'motorbike-ambulances', a scooter attached to a stretcher on wheels that is covered with a plastic tent to keep out the dust.

Mangochi's maternity ward bears testimony to the successful campaign. Makanjira says staff now face the challenge of a heavy workload and overcrowded wards. The hospital also has a 'Kangaroo Mother Care' facility where newborns are kept warm through continuous skin-to-skin contact with their mothers. By keeping mother and newborn together, Kangaroo Mother Care encourages mother and child to bond emotionally and enables the baby to breastfeed at will, giving the baby the energy to produce its own body heat. In some cases, this minimizes the need for incubators, which are prohibitively expensive for developing countries like Malawi. Thirty-five-year-old Asiatu Sampson, a mother of six, is waiting to give birth in hospital for the first time. All of her six babies were delivered by a traditional midwife at home. She

recently gave birth to twins but one died. However, it was not the death of her baby that persuaded Sampson to come to hospital this time. Sampson, who has never been to school, says, "It was the traditional chief who told me to do so." The midwife thinks that Sampson is expecting twins again. The two-hour journey on a bicycle was arduous. Yet, says Sampson, "I feel sure that this pregnancy will work out well." She has attended ante-natal consultations and sleeps under the long-lasting treated mosquito net she received during her first consultation. Sampson also took two doses of intermittent preventive treatment for malaria as well as iron and folic acid.

By contrast, Makumba's situation does not look hopeful. She is still weak and unwell. The nurse is not sure whether she will be able to have any more children. She is still young, but does not know her age and, like her mother, has never been to school. Her mother looks sorry and worried. "I have learnt my lesson now. The next time my daughter goes into labour, I will make sure I bring her to the hospital," she says.



As many as one in every 18 women dies from pregnancy-related complications, making Malawi one of the world's riskiest places to have a baby.

Only about 54% of pregnant women in Malawi are assisted by a skilled attendant at birth. This has prompted the government, with support from UNICEF, and other partners to mount a campaign to convince women to deliver in hospital.



## TREATING SEVERELY MALNOURISHED CHILDREN AT HOME

Bertha Muwoma feared the worst for her two-year-old son Brian. He had been in and out of hospital and this latest episode threatened to take him back yet again. Brian had a swollen stomach and limbs, clear signs of kwashiorkor, a severe type of protein deficiency malnutrition which, if untreated, can be life-threatening.

**“I was so happy when the nurse told me I could treat Brian at home,” says the 22-year-old mother of two. She had already begun to worry about who would take care of her other son, four-year-old Kesbel, while she stayed with Brian in hospital.**

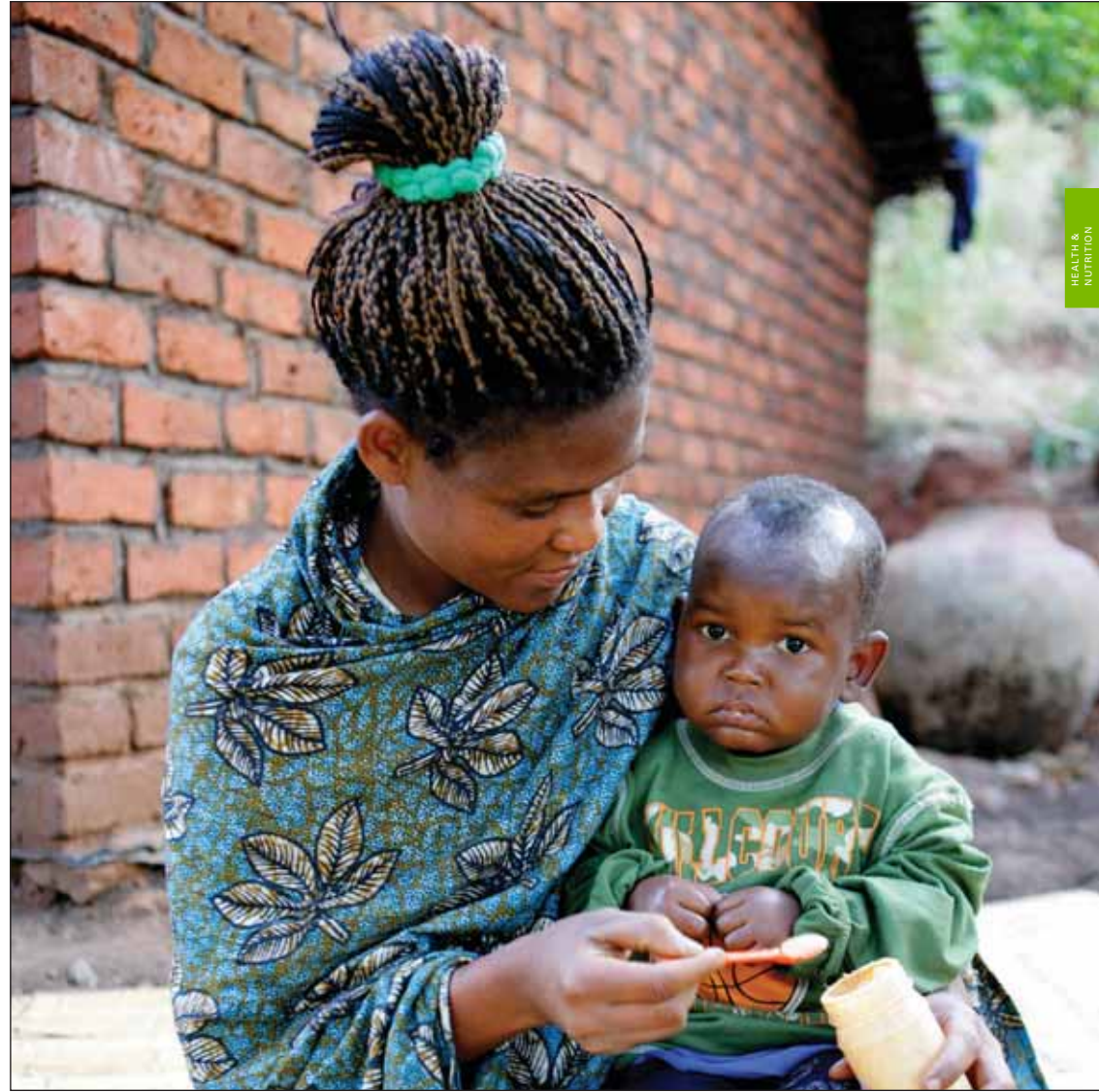
Her husband lives in South Africa and she is not sure when he will come back. Bertha has had this problem several times before. Brian is HIV-positive and has endured several bouts of malaria and severe diarrhoea. This time, Bertha looks confident as she cuddles Brian in her lap and lovingly spoon feeds him

‘plumpy nut’, the protein-rich peanut butter paste UNICEF procures to treat severely malnourished children. Brian loves it, which is helpful because she must give him the food every three hours, day and night. After one month of plumpy nut, the child then takes Likuni Phala, a supplementary porridge made of maize meal and soya, for a month.

Plumpy nut, manufactured locally in Malawi, has made the treatment of severe malnutrition much easier for families as it is administered at home. In a country where the nearest health centre could be up to 10km away, families find home treatment preferable, as it frees up their energies and time for other activities. It is also cheaper than the therapeutic milk which has to be administered in hospital under the supervision of a doctor. This is significant progress considering that malnutrition is widespread in Malawi and is one of the major causes of infant and child morbidity and mortality.

Wemah Mbalame is the nurse-in-charge of the Mpemba Health Centre Nutrition Rehabilitation Unit in Malawi’s commercial capital, Blantyre. She oversees Brian’s progress and keeps an eye on other children in the area too. She believes that most severely malnourished children, as long as they are not undermined by HIV, are better treated at home.

“Plumpy nut is easy for the mothers to administer, the children like it,



Wemah Mbalame is the nurse-in-charge of the Mpemba Health Centre Nutrition Rehabilitation Unit. She believes that most severely malnourished children, as long as they are not undermined by HIV, are better treated at home.



they are responding well and the mothers are able to stay at home, look after their other children, do their normal work and farm," she says. "The mothers have even started bringing their malnourished children to the health centre before they get too serious ill. I think it is because they know that they can treat their children at home."

Malnutrition is a big problem in Malawi, and has been since 1992 when the country suffered a devastating drought. Some 46% of children under five years are stunted, 21% are underweight and 4% are wasted. Micronutrient deficiencies are also widespread. About 60% of under-five children have vitamin A deficiencies and 48% of pregnant women suffer from iron-deficiency anaemia.

The reasons for the lack of progress are complex. A low level of maternal education and a lack of knowledge on good childcare practices, means children do not receive optimal nutrition and care.

Even when mothers do know about the importance of a balanced diet, poverty is so widespread that many families cannot afford to diversify their diets. Natural disasters such as droughts and floods add to the problem of poverty, as do recurrent illnesses such as diarrhoea and malaria.

In recent years AIDS has undermined gains made in child survival. At least 50% of acute malnutrition is associated with HIV and AIDS; an estimated 102,000 children are living with HIV. Nurse Mbalame counsels parents or caregivers whose children she suspects have HIV. "Most of the mothers agree to HIV testing, but some of them first go home to ask their husbands."

Malawi's national nutrition programme, supported by UNICEF, has preventive, treatment and monitoring components. It includes de-worming children under five years old, distributing micronutrient

supplements (such as vitamin A), improving the care and treatment of malnourished children in hospitals and communities, and regularly monitoring the weight and height of under-five children.

The programme needs the dedication of nurses like Mbalame to succeed. She walks as far as 15km on steep, hilly dirt tracks to see how the malnourished children under her treatment are responding. She also sees the mother and child once a week at the health centre. Community health volunteers play an important role too, visiting families to identify malnourished children.

Through the nutrition education programme, mothers are taught to recognise symptoms, especially the swelling of hands and feet, a sure sign of oedema. Nutrition and hygiene are also an integral part of the programme. "I learnt how important it is to wash my hands with soap or ash after using the toilet and before cooking," says Muwoma. "I use ash as I

can't afford soap."

The young mother also learnt about giving Brian a balanced diet and enough food. Yet it is not easy for Muwoma, who was orphaned as a child. She has no land to cultivate and does not know whether her husband has found a job yet. "Sometimes we eat three times a day, sometimes twice, depending on what is available," she says.

Yet, despite her problems, Muwoma is looking ahead and is determined to do the best for her sons. "I would like to go back to school in the future. I dropped out in form 1 because I became pregnant. But right now, I need to earn money, so I have a job working as a domestic helper."

She will receive only 2,500 kwacha (about US \$16) per month, but will have food and shelter free. "I have already told the woman who has employed me that Brian will need a good diet as he has suffered from malnutrition," she says.



## THE PEOPLE'S DOCTOR

“Good day doctor”, say villagers with warm smiles as Blessing Mwareya trudges up a stony track, looking smart in his light blue uniform, in the southern Malawian district of Phalombe.

His destination is a small mud home with a grass roof set on a hill near the stunningly beautiful Mount Mulanje. His patient, three-year-old Joseph, is seated outside on a mat, leaning against his mother. Although Joseph looks lethargic, he has made a dramatic recovery.

never been to school, feels lucky this time round, having previously lost two of her children to malaria.

In Malawi, one in every 13 children dies before their first birthday and one in seven will not make it past their fifth. These children die mostly at home from diseases that, like malaria, are preventable and curable. Other main child killers are neonatal diseases, diarrhoea and pneumonia. Half of all child deaths are nutrition-related.

## In Malawi, one in every 13 children dies before their first birthday and one in seven will not make it past their fifth.

“Three days ago, he had a high fever and was vomiting,” says Kathleen Ephram, a single mother of six, two of whom are under five years. “I carried Joseph to the doctor’s home.” It was a ten-minute walk, much nearer than the health centre which is 10km away. Moreover, Ephram did not have to wait for hours, as is customary at the overcrowded health centres. She was attended to right away.

Assessing Joseph’s symptoms, Mwareya diagnosed malaria and immediately administered the first dose of an anti-malarial drug. Joseph’s mother took the other dose back home to administer at a prescribed time. Ephram, who has

These tragedies could be prevented simply and cheaply by people like Mwareya, who is not a doctor, but part of a cadre of 11,000 health extension workers commonly known as Health Surveillance Assistants (HSAs). Already holding a secondary-school-leaver’s certificate, Mwareya underwent 11 weeks of training in the integrated management of childhood illnesses (IMCI), which emphasises treating the child in a holistic way and not just focusing on the illness. Thus the home - where most children die - is a key place to start.

Mwareya makes house-to-house visits, teaching the community about good childcare practices such as exclusive breastfeeding, use of long-

Mwareya welcomes patients to his house at any time of the day or night. "They say that I'm their doctor," he says proudly.



lasting treated mosquito nets, hand washing at key times, and ensuring a clean environment. And if a child gets sick, he has a stock of basic remedies like oral rehydration salts, anti-malarial drugs, and cotrimoxazole, an antibiotic to prevent opportunistic infections. If necessary, he knows when to refer a child to a hospital. The HSA programme is also complemented by monthly health outreach

activities, where nurses from the health centre join the HSA to carry out a variety of crucial health activities. These include vaccination, weighing, deworming and distributing long-lasting mosquito nets. Micronutrients such as iron, vitamin A, folic acid and iodine are also administered.

The HSA's work is carefully monitored by the village health committee which is composed of an equal number of men and women and serves for three years. Dixon Malefula, a father of ten, is the secretary of the village health committee and says that the HSA is making a big difference in his village. "The death of our young ones has reduced in this village since the HSA has been working here." He also lost two of his children in 2005 and 2007. "They had fevers. They would have been alive today had we had this health system then," he says emphatically. Malefula's job is to keep a record of the drugs given to HSAs and monitor their use. "They are administered well," he adds.

The District Health Officer, Raphael Piringu says the HSAs have been critical in reaching remote areas and populations where literacy levels are low. However, he says more visual materials, like flipcharts, are needed to boost health education outreach.

Piringu says diarrhoeal diseases have gone down and the district had not recorded a single case of cholera in two years. Malaria and HIV are still major problems and have even taken their toll of the HSAs. Out of the 279 HSAs trained, 11 have died of an HIV-related illness or malaria. There were already too few HSAs for the district of just over 322,400 people. And over half of them have to cover vast distances over hilly terrain on foot, as there are not enough bicycles for all of them.

Mwareya does not complain though. He takes pride in his work and says that although his official working hours are from 8.30am to 5pm, he welcomes patients to his house at any time of the day or night. "They say that I'm their doctor," he says proudly.





## PAIN FOR A PURPOSE

Rocking her baby, Maggie winces as the nurse pricks the heel of her six-month-old baby. The baby screams as the nurse firmly squeezes out drops of blood on to circles drawn on a special blotting paper. The blood is insufficient, so the nurse has to prick the baby's heel again.

## Maggie<sup>5</sup> is HIV-positive and it is significant that she has brought her young baby to test for HIV at the Ndirande Health Centre in Blantyre.

Previously, an HIV test for babies was only possible at 18 months of age and most women, like Maggie, who had not participated in the prevention of mother-to-child transmission (PMTCT) of HIV programme, would not have brought their children for testing at all or would have done so only when they were too sick to save. HIV develops fast in infants, and without treatment, a third of infected children will die of AIDS before they are one year old, according to the World Health Organization (WHO).

However, today in Malawi, an HIV test following counselling has become part of routine ante-natal care. And since 2008, the dry blood test for HIV, which allows a baby to

be tested one week after birth, is gradually being scaled up. UNICEF, along with other partners, has supported the training of nurses in PMTCT and dry blood testing.

As Maggie's case shows, the links between HIV diagnosis and care and PMTCT services have also been strengthened. Maggie's HIV status was not determined at the ante-natal clinic but when she was diagnosed with tuberculosis, which she is still being treated for. It was the nurse treating her for tuberculosis who recommended that she test her baby for HIV.

Mary Wiseman, a midwife who coordinates the PMTCT programme at the Ndirande Health Centre, says so many women want to test for HIV, and also to test their babies, that the staff are faced with a heavy workload. Yet, she adds, "It is a great job now, because most of the babies we see are now surviving. In the past, they would be dead by now."

Nurse Wiseman explains the process with enthusiasm. "It begins with counselling, which can last 30 minutes, or however long is needed." She is clearly dedicated to her work. Pregnant women who test positive for HIV are offered daily zidovudine<sup>6</sup> (AZT) from 14 weeks into the pregnancy and are counselled about aspects of the programme, including infant feeding. Most HIV-positive mothers choose to exclusively breastfeed as they cannot afford artificial milk.

<sup>5</sup>Not her real name to protect her privacy

<sup>6</sup>An anti-retroviral drug

Monitoring the health of HIV-positive pregnant women as well as their children is crucial. A Health Surveillance Assistant (HSA) visits the homes to counsel about infant feeding. "If they do not come to the clinic, we follow them up in their homes," says Agnes Katete, an HSA at the health centre. "I make sure they have tested their babies and encourage them to stop

breastfeeding at six months. I advise them about the food they should then give their babies." Since 2008, Nurse Wiseman says that out of 143 babies born to women who participated in the PMTCT programme at Ndirande, 136 tested HIV-negative. The seven who tested HIV-positive are now on anti-retroviral treatment (ART). The main problem with

the dried blood test is lack of transport. If the test fails to reach the nearest hospital for analysis within 48 hours, the blood sample has to be destroyed and the baby tested again. "This happens sometimes," says Nurse Wiseman.

Nationally, most babies are not even tested, even though AIDS is one of the main causes of Malawi's high infant mortality rate of 72 per 1,000 live births (2006). Despite having declined in recent years, this is still one of the highest in the world. The statistics are grim. There are an estimated 102,000 children living with HIV, of whom about 30,000 need anti-retroviral treatment to survive. At the end of 2008, about 24,000 children were on ART. Only 40% of HIV-positive pregnant women attending antenatal clinics were accessing anti-retroviral treatment. Almost 17,000 HIV infections among newborns each year are passed on from their mothers.

Although it has reduced, stigma and fear continue to hinder programmes to

prevent mothers from passing HIV to their babies and to test their infant. "Men especially need to be more involved," says Nurse Wiseman. "Most men refuse to test, and some women do not even reveal their status to their husbands."

However, gradually women are beginning to change their attitudes, like 28-year-old Mary Nyozani, who found out she was HIV-positive when she was pregnant. She takes particular care with her appearance and talks confidently as she plays with her bubbly two-year-old daughter, Cecilia. Her baby tested negative with the dry blood test. "I was prepared for either result, negative or positive. I would accept the condition," says Nyozani serenely. "The counselling I received here has been very helpful. I know my future is good. I feel healthy."

And as for Maggie, she says, "My husband has been supportive and I am no longer worried. My baby, she looks healthy. I think she will turn out HIV-negative." Maggie should know within the week.



HIV develops fast in infants, and without treatment, a third of infected children will die of AIDS before they are one year old.

## THE WATER, SANITATION AND HYGIENE PROMOTION (WASH) PROGRAMME

### Issue

- 25% of Malawians do not have access to improved water sources and 12% do not have access to improved sanitation.
- One-third of community water points are not operational.
- 33% of all primary schools have only basic sanitation, and 4% have no facilities for human waste disposal.
- On average, there is only one latrine for every 150 pupils.
- Lack of toilets or latrines and safe water contribute to pupil absenteeism and even dropout, especially for girls who have begun menstruating.
- Hand-washing practices are poor. Diarrhoeal diseases are one of the main causes of child death.
- Cholera and other diarrhoeal diseases are caused by unsafe water, poor hygiene and lack of basic sanitation.

### Action

The programme addresses these challenges through three projects: Support to Policy and Sector Reforms; Integrated Water, Sanitation and Hygiene Education and Promotion; and School Sanitation, Hygiene Education and Life Skills Development. Support to Policy and Sector Reforms activities include:

- policy development and quality assurance by technical ministries;
- developing information systems at local government level;
- building institutional capacity for government and partners;
- advocacy and programme communication;
- monitoring and evaluation.

Integrated Water, Sanitation and Hygiene Education and Promotion activities include:

- revitalising community management of water and sanitation alongside other child survival and development interventions;
- promoting toilet/latrine use and good hygiene, particularly hand-washing;
- providing water points in targeted areas;
- responding to emergencies.

School Sanitation, Hygiene Education and Life Skills Development activities include:

- providing safe water and separate latrines for boys, girls and disabled pupils;
- training teachers to facilitate hygiene education and improvements in schools;
- supporting child-to-child activities, e.g. sanitation clubs.

### Impact

The programme aims to achieve the following results by 2011:

- 75% of the population has sustained access to improved drinking water.
- 88% of the population has access to improved sanitation facilities.
- 100% of target primary schools have sustained access to safe drinking water and improved sanitation facilities.
- 60% of the population and 70% of school children nationwide apply at least three key improved hygiene practices.

### Key Donors

*Governments:* Canada, Denmark, Netherlands, Spain, United Kingdom, United States. *UNICEF National Committees:* Belgium, Canada, Germany, Japan, United Kingdom. *Other Sources:* United Nations Foundation, UN Fund.



## THE FIRST DROP OF WATER

# The anxiety etched on her face is palpable. Although the nurse assures her that everything will be alright, 20 year-old Joyce Banda is steeped in worry.

She has brought her six month-old daughter Mphatso to Kasungu District Hospital to be treated for diarrhea. During the night she has spent in hospital, Mphatso has been vomiting and is clearly getting weaker.

"It is clear that Mphatso has diarrhea as she has all the signs and symptoms. This is not the first time she has been brought in suffering from diarrhea," says nurse Bernadetta Kaleramayuni. Joyce explains that she has no access to safe and clean water in her village and has to rely on water from Bua river. Although the local health committee has taught her on how to use chlorine, Joyce says she cannot afford it. "I know the dangers of drinking

unprotected water, but I have no choice. We walk a long distance to draw water from the river. If my child is thirsty, I cannot deny her the only water I have." Mphatso will be discharged only when she gets better but Joyce doesn't know when that will be. It could take anywhere between three to seven days. Back in her village, there is excitement. The people of Chilowamadambe village have just been informed that a borehole will be installed. The usual morning chores have been abandoned as scores of people gather to witness history in the making.

Chilowamadambe village, located in Kasungu district in central Malawi has never had piped or ground water since the first settlements began appearing in 1966. Bua river has been the only source of water, exposing children like Mphatso to water-borne diseases. "Our women spend a lot of time in the hospital attending to their children. They could use this time doing other productive things if their children didn't fall sick so often," says Village Headman Luka Nyanja.

"Every year we have cholera outbreaks and lose at least five people. To make matters worse, we lose people to crocodiles. Each time before drawing water, we have to ripple the waters with a shrub just to scare the crocodiles away. Water is life and we cannot do without it.

Today, though, everyone is in a jovial mood. Thanks to UNICEF, a new borehole will be installed. "I know our ancestors are smiling, there can be no better gift to the people of my village. Thank you UNICEF," says Headman Nyanja.

UNICEF has supported the government to drill 63 boreholes in Kasungu district alone. The overall purpose of this project is to improve child health and wellbeing. Close to a million people will benefit. Villages like Chilowamadambe have been identified by the district authorities working together with traditional leaders. For children like Mphatso, a healthy and disease-free life is finally within reach.



Twelve-year-old Joseph Chinkhadze knew that each time a fly landed on his food, it probably carried his neighbours' faecal particles. "I wasn't surprised to see the flies as I knew people living here used the bush around my home as a toilet."

Twelve-year-old Joseph Chinkhadze knew that each time a fly landed on his food, it probably carried his neighbours' faecal particles. "I wasn't surprised to see the flies as I knew people living here used the bush around my home as a toilet."

So it was a huge relief when a team from the local government office visited Gwengwe village, in the central Malawian lakeside district of Salima where Joseph lives, to get them talking about their toilet habits.

"Our entry point was the village headman. We told him we would like to learn about how his community was living," explains Noel

Khunga, the Environmental Health Officer for Salima district. At first the people were too embarrassed to say anything, although Joseph and his peers in the village knew better.

"We got the people to participate using local materials like sticks and sand to represent their homes and where they relieved themselves. With the help of the flies, they soon found out that that they were actually eating each others' faeces," says Khunga. "They wanted to know how they could change this situation."

After three hours of animated discussion, the villagers were convinced that everyone needed to

build a latrine with a cover. A committee was formed consisting of five men and five women as well as a children's group led by Joseph. The approach received the blessings of the village headman, Jamitan Watson. "This initiative is very important as it plays a key part in our survival. The toilets protect us from getting diarrhoea." The sanitation committee and the children's group were trained by the local government team, with technical support from UNICEF, on topics such as good hygiene, washing hands with soap or ash at key times, and keeping the latrines clean.

It took the community one year for everyone to use

a pit latrine, earning itself the status of "Open Defecation Free" (ODF), meaning that it had successfully eliminated defecation in places other than a toilet or pit latrine. Joseph and his group, as well as the committee, played a pivotal role in urging people to dig latrines, even if they could afford only the most basic type of latrine. Locally available scrap metals were used as lids. "I used to visit households that did not have a latrine or had poor hygiene and explain to them what they needed to do. People were keen to do it, once they understood," he says. Although his family already had a latrine, Joseph concedes that it wasn't covered. They





During the first six months of 2009, 234 people were treated for cholera and three fatalities were reported in Salima district alone.

made one out of scrap metal and hooked it by rope to a beam above the enclosure.

The approach adopted by the village is part of an approach known as Community-Led Total Sanitation (CLTS), which UNICEF is supporting. Rather than simply build latrines for households, the approach focuses on enabling community members to realise that they have a sanitation problem and to devise solutions that are within their reach. This simple, low-cost community initiative can have a major impact on child survival, helping to reduce diarrhoea, which is one of the major killers of children in Malawi. And preventing recurrent diarrhoea is another way to counter malnutrition.

Community-Led Total Sanitation needs to be scaled up throughout the country, as only 24 villages in 2008 and 156 in 2009 had acquired ODF status. While the 2006 Multiple Indicator Cluster Survey showed that as many as 88% of Malawians had access to basic sanitation, many of the latrines were not used or were poorly maintained. And even if just one or two members do not have a cover over their latrine, flies spread disease to neighbours who do.



Cholera is a particular threat to all ages, especially during the rainy season. Every year, outbreaks of cholera bring untold misery and death to communities, particularly those along the lake. During the first six months of 2009, for example, 234 people were treated for cholera and three fatalities were reported in Salima district alone.

Since it was declared ODF, Joseph's village has not recorded a single incidence of cholera or diarrhoeal disease. "In the past, there had been a lot of diarrhoeal diseases in this village especially during the rainy season from November to March, but in the last year there have been no cases," says Khunga.

But the village is not complacent. The sanitation committee and Joseph's group have continued with their activities. They hold monthly meetings with their community and twice a month conduct street theatre with themes based on environmental sanitation. The crowds revel in the plays as they are also a great source of entertainment for the village.

"The number of flies has dramatically reduced," Joseph says with a chuckle.



**Issue**

- Despite the abolition of school fees in 1994, over 10% of eligible children in Malawi do not attend school.
- About 70% of children enrolling in standard 1 have not had access to any early childhood development programmes.
- There is on average one teacher for every 107 pupils.
- The lack of separate latrines for boys and girl leads to girls' absenteeism and in some cases dropping out of school.
- Literacy among young people aged 15-24 years is 83%.
- HIV among young people aged 15-24:
- Prevalence among pregnant females attending ante-natal clinics: 14%;
- Comprehensive knowledge of HIV: 41% males, 42% females;
- Condom use at last high-risk sex: 60% males, 40% females.

**Action**

The programme addresses these challenges through three components: Quality Primary Education with Focus on Girls' Education; Youth Development and Participation and HIV and AIDS; and Support to Policy and Education Sector Reform.

Quality Primary Education with Focus on Girls' Education activities include:

- providing technical support for Early Childhood Development programmes which lay a firm foundation for primary school;

- promoting the Child-Friendly School Framework by providing technical support, building and rehabilitating schools, providing separate latrines for boys and girls, providing clean water, promoting good hygiene, supplying teaching and learning materials to selected schools;
- supporting in-service teacher training with a focus on interactive and gender-sensitive training, the use of locally available materials to develop teaching aids;
- supporting community involvement in schools.

Youth Development and Participation and HIV and AIDS activities include:

- supporting clubs that help teenagers avoid HIV infection and empower them to make responsible decisions about their health and lifestyles, such as Anti-AIDS clubs and the Sister to Sister initiative;
- supporting the development and implementation of a national youth policy and youth information management system;
- training young people in technical and vocational skills for a productive life. In the context of HIV and AIDS, the project aims to provide vulnerable young people with a reason to avoid behaviour that could result in HIV infection.

Support to Policy and Education Sector Reform activities include

- supporting the Ministry of Education, Science and Technology with policy development and sector reform;
- supporting the training of Ministry of Education personnel in the use of data from the Education Management Information System (EMIS) for planning and management. EMIS has also been made accessible to all stakeholders in the education sector.

**Impact**

The programme aims to achieve the following results by 2011:

- Over 95% of eligible girls enrol in school.
- 50% complete their primary education.
- 80% of primary schools (standards 1-8) use the child-friendly schools approach, including life skills for HIV prevention.
- 100% of teachers trained in the new curriculum, including life skills for HIV prevention, and 100% of schools equipped with new curriculum materials, including manuals.
- At least 75% of young people tested for HIV .
- At least 75% of young people have comprehensive knowledge of HIV.

**Key Donors**

*Governments:* Canada, Japan, *UNICEF National Committees:* Austria, Belgium, Canada, Germany, Japan, Norway, Sweden, Switzerland, United Kingdom, United States.

*Other Sources:* UN Fund.

## Just as hundreds of children flocked to secure a place at the newly-furbished Muwalo Primary School, thirteen-year-old Lefa Walter dropped out.

Children in her neighbourhood were keen to take advantage of the UNICEF-supported school. Unlike most other schools, it had newly-constructed, brightly painted brick classrooms, separate latrines for girls and boys, football pitches, teachers trained in child-centred methods and the pupils received school kits with basic learning materials. Moreover, there was an education ethos that involves community participation.

Yet Lefa had given up on her education because of

family circumstances. "My mother went to live in Blantyre with her new husband," she says, "twisting her fingers in her lap. The mother left Lefa and her two siblings to fend for themselves. Their father died in 2007 and they had no extended family in the neighbourhood who traditionally would have supported them. So instead of an education, Lefa focused on earning money to survive by carrying out domestic chores like fetching water and cultivating plots. Her situation was typical of many girls in Malawi

where only 16% complete primary school.

A month after she dropped out of school, Lefa received a visit from Stella Nyambo, a member of the school's mothers' group, who persuaded her to return to school. Lefa, who clearly loves school, did not need much persuading and is now in standard 5. Since Nyambo was elected in 2004 as a member of the mothers' group, she has managed to persuade 15 girls to return to school. "Some girls drop out to get married or because they are pregnant, but most leave so that they can earn money for food." The mothers' group plans to start a school feeding programme to keep children in school. "We hope that the community will contribute to this," she adds.

Fourteen-year-old Jennifer Mbaisa is a peer outreach worker who does similar work to the women in the mothers' group, except she has the advantage of being able to communicate more easily with her peers, being a child herself. "I was

elected by the other pupils, and I was so happy. I can visit friends who have dropped out of school, and help them return to school." She uses the example of Theresa. "She comes from a poor family, so her mother made her drop out of school to work in homes of other families. We talked first to her mother and then to Theresa. After a while, her mother agreed that she would work extra hours so she could afford to let her daughter return to school."

Nineteen-year-old Lexa Chimwala left school because she was pregnant. "I was in standard 8. I felt that it was the end of my schooling. Before I became pregnant, I had wanted to be a nurse." A peer educator told Lexa that she still had a place at the school. She returned to standard 8 while her grandmother looked after her baby. Lexa worries about her future because life has become a struggle since her parents died in 1999. She is not alone. At least 83 pupils at the school have lost at least one of their parents, many due to AIDS.



Despite the poverty, the community is more committed to education than they were before. "We give talks to the village head and we hold meetings in the community, explaining to the parents about the importance of school," says the group village headman, Letherford Verevere, a member of the school management. He works with the pupils, the mother's group, the Parents Teachers Association and the school management committee in a programme that aims to encourage girls to stay in school.

Jackson Chithokonya, a Primary Education Advisor, adds that enticing children back to school is now easier because the conditions are so much better than in most other schools in the area. "Many of the schools are just shelters made of grass and some of the pupils are even learning under trees." The school's headmaster Lameck Chauluka is clearly excited about the improvements to his school, which has given it the status of a "child-friendly" school. He has witnessed numbers mushroom from 600 to 1,037 pupils in just one year, but that has brought problems too. In standard 1, there are 230 pupils to just one teacher. "We cannot put desks or chairs into the classroom because the pupils will not fit," he says.

Although the comprehensive hygiene education sessions conducted at the school every week have reduced illness, the school still needs more latrines. Only eight latrines service the entire school and there is no running water.

Lefa's problems are also not over. "We can eat only once a day after school," says Lefa, who is extremely thin. They eat nsima (a thick porridge made from maize flour) and usually pumpkin leaves. "I feel hungry in class and when I go to bed. We don't have school uniforms and no shoes, and I have to share my friend's pen," she says softly.

Her mother came for a brief visit six months ago, but the person who checks up on Lefa regularly is Stella Nyambo from the mother's group. "She visits me and my sister and brother twice a week. She sees what problems I have and gives us soap when we need it," says Lefa.



When Lefa timidly takes her leave from the room, Nyambo adds, "She is so interested in school but she is so poor. Lefa still has to work in other people's fields so she and her siblings can have food to eat."



## Fifteen year-old Ennifer Dzimuzani has big ambitions of becoming a medical doctor, a dream that she is nurturing deep in the dusty plains of the Shire Valley in southern Malawi.

Fifteen year-old Ennifer Dzimuzani has big ambitions of becoming a medical doctor, a dream that she is nurturing deep in the dusty plains of the Shire Valley in southern Malawi.

If she achieves her ambitions, she will have surmounted incredible odds. No member of her family has gone beyond secondary school, and her parents are peasant farmers earning an income barely enough to sustain her and her two siblings. Fortunately for Ennifer, school costs are minimal as the government abolished primary school fees in 1994. She will, however, need to raise money for her secondary education.

She comes from Chikwawa, a district that seasonally teeters from one humanitarian crisis to another. Located in the lower area of the Shire Valley, the district suffers from seemingly never-ending cycles of drought and flood, the latter often displacing thousands from their homes. It is one of the poorest

districts in the country, with some of the highest rates of child wasting - an acute form of malnutrition characterized by thinness - and lowest school enrolment, attendance and completion rates.

Ennifer attends Mfera Primary School on the outskirts of Chikwawa district. Heavy rains in January 2007 led to massive flooding as the Mwanza, Madziabango and Mikalango rivers burst their banks. More than 20,000 households were affected and crops, livestock, and property destroyed.

Ennifer's school was not spared either. Built in 1925, long before the Malawian nation was born, its weather-battered classrooms barely withstood the flooding but the toilets, made of sticks and grass thatch, were simply washed away. Pupils had to relieve themselves in nearby bushes, posing great safety risks for girls.

Mfera is a mix of the old and the new. Next to the decrepit classrooms lie two gleaming blocks recently

constructed by the Department for International Development of the British Government and UNICEF through the Schools for Africa Initiative.



"We used to get rained on in the old classrooms," says Ennifer. "We would sit on the wet floor, shivering from the cold. It was difficult to learn under such circumstances and some pupils stopped coming to school."

The new classrooms are spacious, well ventilated, and stocked with desks. The floors are constructed with cement, the walls of sturdy brick and the roof made of iron sheeting, making them better able to withstand flooding the next time. These new blocks are a far cry from the mud-walled, thatched-roof structures that still accommodate some of the pupils.



"Absenteeism has gone down," says head teacher Moses Mangwaya. "Even children who had left school, especially girls, have come back."

The flooding of 2007 was followed by poor rains in 2008. The nutrition situation in the district worsens during the peak hunger season between October and April when food stocks from the previous year usually run out and the new maize crop is not yet ready for harvest. The situation is also compounded by seasonal outbreaks of cholera.

UNICEF has provided water to Mfera and to other schools in the district and has constructed latrines. In the aftermath of the floods, 20 boreholes were drilled in Chikwawa, 30 others rehabilitated, and piped water systems in schools and villages upgraded. Chlorine sachets were distributed to schools and hygiene education campaigns stepped up in order to forestall cholera outbreaks.

These interventions ensured that pupils like Ennifer were able to continue with their education uninterrupted. She looks forward to the primary school leaving examinations at the end of the year. If she does well, she will be selected to form 1 at Chikwawa Secondary School, 10km from her village.

"I want to be a doctor because I admire Sister Thoko, a doctor at Mfera Hospital. I want to achieve what she has achieved."





## Malawian youth have a refreshing way of tackling the challenges of HIV and AIDS. “Yesterday, we performed a play about violence against children. In the play we showed how the guardian abuses an orphan.”

Malawian youth have a refreshing way of tackling the challenges of HIV and AIDS. They are more open to new information and possess some rare insights, having witnessed attitudes to the disease evolve from secrecy, dread and stigma to more open discussion about a disease that can now largely be prevented and managed.

“Yesterday, we performed a play about violence against children. In the play we showed how the guardian abuses an orphan,” says 13-year-old Chifuniro Nkhwimba, the elected chairperson of the Kafulu Anti-AIDS Club, a vibrant group of 65 pupils of the Kafulu Primary School in Lilongwe, the capital of Malawi. Any pupil can join once they are in standard 4.

The theme of the play is an issue that Chifuniro, an orphan himself, feels passionately about. About 550,000 children have lost one or both parents to AIDS; most of them have endured the psychological trauma of caring for and witnessing their loved ones die. Thereafter they have to grapple with the demands of life. Orphans are more likely to be denied their basic human rights and are especially vulnerable to abuse and discrimination.

“My mother was sick and passed away four years ago,” explains Chifuniro. He now lives with his aunt, who also cares for two of his cousins who have also been orphaned and her own two children. “I am very happy with her. She treats us all well,” he adds.

One in 11 pupils at Kafulu Primary School has lost one or both parents. The club is one of many set up around the country, with support from UNICEF, to help pupils make responsible decisions about their lifestyles and health. Guidance is provided by the club patron Foster Phiri, also a teacher at the school. “We encourage the pupils to learn on their own; we don’t teach them but just offer advice,” he says.

Club members participate three afternoons each week in popular activities such as peer-to-peer education, sports, talks, campaigns, dance and theatre. During many of these activities they transmit messages on HIV and AIDS and life skills. As well as activities within

the school, they also conduct outreach activities, sometimes walking as far as 15km to reach a community. It is not always easy for club members, says Chifuniro. “Some of the pupils mock us and they say the reason that we are in the club is because we are HIV-positive. We try to explain to them the importance of this group. We also see the benefits in the community. Some of the people come back to us and say they have got themselves tested for HIV after hearing our messages.”

Young people, especially girls, are more vulnerable to HIV infection. About 10% of young people aged 15-19 are HIV-positive, and many of them are no longer in school. As well



One in 11 pupils at Kafulu Primary School has lost one or both parents.

as the school clubs, out-of-school youths are targeted in other ways, through youth clubs and Youth-Friendly Health Services (YFHS), which are clinics providing sexual and reproductive health information and services in a non-judgemental and sensitive manner.

The YFHS centre also provides sports and recreation facilities, and screens films on health issues and hygiene. The TV room is so popular that it is regularly packed with young people, often with no room for sitting or even standing. The centre also has football teams.

Rhoda Chiume and Kondwani Dzumani, both aged 24, are volunteer peer educators with the Kawale Youth Club in Lilongwe. Strategically attached to the YFHS, they conduct community talks to out-of-school youths, encouraging them to use the services of the YFHS. "They are enjoying themselves while learning at the same time," says Kondwani, who trained as a journalist. "It is especially effective as the youth don't have much to do

in the communities." Rhoda, who stopped school when her father died, says that girls are especially in need of this support. "Some girls get pregnant and then get thrown out of home, and they can indulge in risky behaviour."

The work of the anti-AIDS clubs, peer education clubs and the YFHS seem to be paying off. Young people talk more freely about their sexuality and have an opportunity to learn skills for life in a friendly, fun environment.

More young people are also coming out to test for HIV, points out Bahat Nyirenda. In the previous month, over 100 people came in for an HIV test, of whom almost half were aged 15-19. In the same month, over 600 young people under the age of 25 visited the YFHS for a variety of health problems, including family planning and treatment for sexually transmitted diseases as well as for information.

"Stigma around HIV is not such a problem now amongst the youth, at least in the cities," says Nyirenda.



The TV room is so popular that it is regularly packed with young people, often with no room for sitting or even standing. The centre also has football teams.

**Issue**

- About 29% of children aged 5-14 are involved child labour.
- Sexual exploitation, abuse and child trafficking are believed to be on the increase but more reliable statistics are needed.
- There are more than one million orphans, of whom 550,000 have lost at least one parent to AIDS. These children are particularly vulnerable to various forms of exploitation and abuse.
- There is no universal birth registration system in the country.
- Current legislation related to childcare, protection, justice, adoption and inheritance is outdated and does not meet the requirements of the Convention on the Rights of the Child.
- Inadequate and low staff capacity in the social welfare system limits the government's ability to provide protective services for the most vulnerable children.

**Action**

The programme addresses these challenges through two projects: Support and Care of Orphaned and Vulnerable Children (OVC); and Child Protection.

Support and Care of OVC activities include:

- supporting the government to develop and implement a strategic human capacity development plan to upgrade protective services to families;
- advocating for a strong policy and legal framework to protect OVC;
- supporting the development of national structures, such as the monitoring and evaluation framework, technical working groups, quality improvement standards and others, to assist the government to lead and coordinate a national response to protect vulnerable children;

- improving Early Childhood Development (ECD) services through the development of an ECD curriculum, harmonisation of training and other interventions;
- supporting community-based childcare centres (CBCCs) to deliver a complete package of services to children under five years through ensuring trained caregivers, providing learning and play materials, and garden inputs to improve micro-nutrient intake;
- Linking community centres with activities that deal with child health and prevention of mother-to-child transmission of HIV;
- supporting the scaling up of programmes that care for, support and protect orphans and vulnerable children, including psycho-social services such as children's corners, which offer a safe place for children and young people to meet and receive counselling;
- supporting the government to put systems in place to protect the child in adoption and fostering, and to implement guidelines in line with international standards for alternative care.

Child Protection activities include

- strengthening legal and policy frameworks to protect children;
- strengthening multi-sectoral state systems to develop a protective environment and effective referral system for children;
- Strengthening the justice sector to appropriately address child victims and offenders through strengthening the police and also establishing child-friendly courts;
- working with civil society to promote a clear understanding of human rights, particularly children's and women's rights;
- advocating for the enactment of the Childcare Protection and Justice Bill;
- supporting the setting up of a

child helpline;

- supporting activities in school that protect children;
- providing technical assistance for training community workers, police and others who come into contact with children who have suffered abuse and exploitation, and children who have come into conflict with the law.

**Impact**

- Key expected results by 2011 are:
- 50,000 orphans and other vulnerable children receive psycho-social support through 450 children's corners and 1,400 home-based care volunteers.
  - 300,000 under-five children benefit from early childhood care and learning through 3,000 community-based childcare centres (CBCCs).
  - 800 Community Child Protection Workers actively helping people realise their rights and duties.
  - 80% of 'cases' resolved in the informal justice systems.
  - Nine child-friendly courts set up and operational.
  - 80% of births registered by school-entry age.
  - The Hague Convention on Protection of Children and Cooperation in Respect of Inter-country Adoption ratified.
  - Child Care Protection and Justice Bill enacted.
  - Wills and Inheritance Bill enacted.
  - Child labour reduced to 5% of children aged 5-14.
  - 401 Victim Support Units functional.
  - 50% of cases of gender-based violence prosecuted per year.

**Key Donors**

*Governments:* Australia, Belgium, Canada, Netherlands, Norway, United Kingdom.  
*UNICEF National Committees:* Germany, Luxembourg, Norway, Spain, Sweden, Switzerland, United Kingdom, United States.  
*Other Sources:* UN Fund.



At the Chimteka childcare centre in Mchinji, a small town on Malawi's western border with Zambia, a group of young children shriek as they play on slides and swings and kick a ball in the spacious grounds.



The community volunteers who staff these centres have established children's corners where children who have lost their parents come to play and to express their feelings.

Inside a large airy room decorated with colourful educational posters, another group of children play with dolls, building blocks and read picture books with simple alphabet and numbers.

In a primary school classroom, located on the same premises, three older children reflect on their time in the centre. Eight-year-old Samuel Chiwoka says he prefers attending the primary school. "It is better for me now as I am older," he says, brimming with confidence. "I am now in standard 2."

Ten-year-old Manesi Buka at first disagrees, saying, "I prefer the childcare centre to the school because I had good food there and I didn't go hungry." Then she adds, "But I also enjoy school. I like maths and life skills. I learnt the alphabet and my numbers before I came to this school. I also learnt about other things like HIV and AIDS. They told us that we must not use each others' needles for piercing our ears."

"And not to share your toothbrush," adds ten-year-old Jane, who is HIV-positive and who appears to be responding well to anti retroviral treatment. She smiles broadly as she enthuses, "I learnt many things (at the centre); how to wash my hands before eating and after using the toilet." The centre has running water and separate latrines for the boys and girls. "And I also learnt to pray before eating."

It becomes clear that all three children value their experience at the centre. It prepared them with basic cognitive and life skills, which they can share with their parents or guardians, and it also gave them a smooth transition to primary school, which was deliberately built in the same premises. The only primary school in the area used to be 4km away from the childcare centre. Many of the young children would interrupt their education at that vital period between pre-school and primary school because of the long distance.

Community-based childcare centres (CBCCs) provide many of the early learning activities in Malawi. According to a 2008 UNICEF study, 88,000 orphans and 16,000 children with special needs were registered in the country's 6,000 CBCCs. Mostly located in rural areas, the CBCCs are attended by children aged between three and five years at no cost. However, an estimated 70% of children enrolling in primary school have not had the chance to attend a childcare centre.

As well as providing a nutritious meal, the community volunteers who staff these centres have established children's corners where children who have lost their parents come to play and to express their feelings. This might include remembering their loved ones in a 'memory box' - which can contain anything the children like that reminds them of their parents.



UNICEF supports the training of the volunteers and parent committees which oversee the CBCCs. UNICEF also provides toys, books and games. Naomi Janson, who has worked as a volunteer along with three others at the Chimteka centre for 11 years, says the training has been valuable. "We learnt how to be more child-centred. Before the training, if the children did not read properly, we would punish them. But we learnt that this is not right. It is our job to get the children interested using more exciting methods, and if they aren't interested, we shouldn't force them."

She adds, "We were also not so good with hygiene. Now we always make sure there is soap in the latrines and we always accompany the children when they go to the toilet." The centre is open five days a week from 7.30am till noon. All the children are fed each day with food grown in the centre's plot, farmed by community members.

Janson, a 32-year-old mother of four, two of whom are registered in the centre, was elected by the community to work as a volunteer at the centre. "I feel I am contributing something important to my community and I see it as an honour to have been elected."



## HOW TO DEAL WITH DOMESTIC VIOLENCE: THE 'DILEMMA' FOR POOR WOMEN

When Ellen, who is eight months pregnant, returned home after visiting her mother, she was shocked to find her husband had abandoned her, taking most of their belongings with him.

"He took plates, a mattress, a sofa, chairs, kitchen utensils and pots, clothes belonging to my three children, bed sheets and my mobile telephone," says Ellen<sup>9</sup>, who is still stunned by her husband's action.

Ellen, who works as a security guard, bought most of the items that her unemployed husband took. After trying in vain to phone him - he had turned off his mobile phone - and his brother, who said he did not know her husband's whereabouts, she decided to go to the police station in the centre of the capital, Lilongwe. She did not know that there was a Victim Support Unit

annexed to the station that dealt with such cases. "I waited for a few days to see whether he would come back, but he didn't, so I came to report him to the police. I didn't know about this centre."

The Victim Support Unit is bustling with activity. Ellen is remarkably composed as she tries to stop her three-year-old son fighting over food that has been given to him and his six-year-old brother while they wait. She is just one of many women and children in the unit. Other days, it can be even busier, comments Oliver Soko, the Officer-in-Charge at Kanengo Police Station. "There are so many women with their children

that some days it looks like a post-natal clinic." Remarking on Ellen's predicament he adds, "This case is typical not exceptional."

At least now there are places where those who suffer domestic violence can be assured of a sympathetic ear and legal assistance. The Victim Support Units are attached to most police stations throughout the country. UNICEF has supported both the training and setting up of the units, which provide counselling, legal advice, assistance in prosecutions and sometimes a kitchen and temporary accommodation for the survivors of such

violence, most of whom are women, as well as their children.

However, Malifa Kapindira, a Police Sub-Inspector who has been working in the Victim Support Unit for nine years, says that prosecutions for cases of domestic violence are rare despite increased awareness in the community that it is a crime. "Most women are not working and they are dependent on their husbands."

Although Ellen is working and has a higher level of education than most women, having completed eight years of school, she too does not want to take her husband to court. "I just want help in getting our possessions back. I cannot have him living with us again," she says as she tries to control her emotions.

Asked how she feels now about her life, Ellen says thoughtfully that she would like to upgrade her education. "Then I can get a better job to support my children."

<sup>9</sup>Not her real name

## Soon after both her parents died, eleven-year-old Joyce<sup>10</sup> was raped so violently that she could not walk for two years and had to undergo four operations.

Soon after both her parents died, eleven-year-old Joyce<sup>10</sup> was raped so violently that she could not walk for two years and had to undergo four operations.

Joyce is gradually recovering, with the support of her grandmother, who she lives with, and specially trained police officers who counsel her. She smiles shyly as she limps over to greet her visitors, after carefully putting down a bucket full of water. One of the visitors is a police officer who has stood by her over the past two years. As usual on these visits, the police officer is dressed in plain clothes. He asks Joyce whether she is still in pain and how she did in the last school exams.

"I can now walk to school, but my legs hurt

sometimes." She points to a long, jagged scar on her leg that gives her the pain. Then she pauses as if to regain her composure. "I am second place in my class." It is a remarkable achievement as she missed two years of school after the rape. For a long time she could only walk with the aid of crutches.

Getting Joyce to become self-confident was a long, stressful haul. It took one month for anyone to understand what had happened to her. "Her family thought she had been bewitched," says Sergeant Malango Mwasinga, who is clearly protective of her. "Play therapy was instrumental in both eliciting information about the crime from Joyce and also in helping her to emotionally overcome the trauma."

This type of therapy involves giving a wide range of toys, such as dolls modelled on an extended family, household items, guns and farming tools, to children who have suffered abuse to see how they play with them. "We don't guide the children; we just let them play randomly. It is the manner in which the children play and the toys that they select that is significant for us. For example one child takes a doll that looks like the father and she starts hitting it, saying: 'I hate you because you hit your child'. Play therapy is really working. It is very difficult to get children to talk about such things. Instead, they communicate through playing," says Sergeant Mwasinga.

Joyce was too frightened to talk about the rape. "He

had told her that he would kill her if she told anyone," explains the police sergeant. Her cousin had raped her during the afternoon in a field when nobody was around and then carried her home before fleeing. He was later arrested and in a court case, in which Joyce identified him, he was sentenced to 14 years in prison.

UNICEF has provided equipment for the play therapy and ongoing training sessions for the police. In addition, UNICEF has supported the setting up of Victim Support Units (VSUs), which are now attached to police stations in urban areas throughout the country. The units are staffed by male and female police officers who have been trained to deal with domestic violence and child abuse.



<sup>10</sup>Not her real name

Most of the VSUs have a temporary sleeping space for children and their guardians, as well as cooking facilities. Those who have survived abuse, most of them women and children, are offered counselling and legal advice.

Most cases are never reported because victims are scared to report their family members and others are not aware of the existence of these services. Even when cases are reported, convictions are rare.

Patricia Njawili, coordinator of the Victim Support Unit at a police station in the capital Lilongwe says there are too few police officers trained to deal with child abuse and gender-based violence. She also says more outreach needs to be carried out in the communities. UNICEF has provided the police with motorbikes to do just that.

Yet the problem is great. About 9% of children aged between five and 14 years are involved in the worst forms of child labour, sexual exploitation and violence, according to the 2006 Multiple Indicator Cluster Survey. The reasons are complex but have their roots in widespread poverty, lack of opportunities and violation of the rights of girls and women, harmful cultural practices and poor levels of education.

Child protection is further complicated by the lack of a birth registration system in Malawi. Moreover, current legislation on child care, protection, justice, adoption and inheritance is outdated.



The draft children's legislation addressing these key areas has yet to be enacted by parliament. Even when the laws are passed, enforcement will be a massive challenge.

Joyce's case was so obvious due to the severe injuries she suffered that it was impossible to ignore. Her 61-year-old grandmother, a farmer, is clearly grateful for the support she has received. She is not only struggling to help Joyce, but following the death of her daughter, Joyce's mother, she is also bringing up two other grandchildren aged six and nine years. Joyce's youngest sister was only two months old when her mother died, and has been sent to an orphanage as the grandmother could not cope.

Despite all this, the grandmother seems determined to carry on farming and keeping her grandchildren in school. She is encouraged by Joyce's progress. "There has been such a big change in Joyce since that happened," says the grandmother. "She is now open and talks."

Joyce too is looking forward to a brighter future. Asked what her dream is, she replies decisively. "I would like to be a nurse." Her grandmother smiles tenderly, adding, "She has been talking about wanting to be a nurse for a long time now. I think it is because they have shown so much kindness to her."

**Issue**

- 40% of all Malawians are absolutely poor, living on less than 44 kwacha per day (US \$0.28); 22% of these are ultra-poor, living on less than 22 kwacha per day (US \$0.14).
- Children make up 51% of the total population and most live in grinding poverty, barely able to afford life's basic necessities.
- Investing in social services is perceived in some circles as 'social consumption.'
- Child rights awareness among the general public and children remains low.
- Monitoring and evaluation capacity remains weak.

**Action**

The programme addresses these challenges through four projects: Social Policy; Planning, Monitoring and Evaluation; Communication and External Relations; and Programme Communication.

- Social Policy activities include:
- advocating for and supporting the government to adopt a social policy and social protection programme for the poorest of the poor;
  - reviewing national policies and legislation to ensure they benefit the poor;
  - supporting the decentralisation process to ensure that children are prominent in district plans;
  - advocating for children to be at the centre of the Malawi Growth and Development Strategy.

Planning, Monitoring and Evaluation activities include:

- providing independent, periodic assessments of progress in the implementation of the Country Programme;
- conducting situation analyses on children and using the results to inform policy and programme planning;
- supporting national efforts to collect and document data on children.

Communication and External Relations activities include:

- advocating on issues that affect children and women, particularly their rights;
- mobilising resources for children;
- creating public awareness of the situation of children through the mass media and other forms of mass communication;
- creating and strengthening partnerships with civil society to support the realization of child rights; and
- promoting the participation of children in national planning and decision-making processes.

Programme Communication activities include:

- generating demand for services through communication and social mobilization approaches;
- strengthening household and community knowledge and practices in maternal and newborn health, nutrition, hygiene, and HIV prevention;
- scaling up those strategies that

reach households best, including the use of radio, capacity development of extension workers, and development of community dialogue tools.

**Impact**

- Key expected results by 2011 include:
- adoption of a social protection policy and programme;
  - 150,000 households reached through the social cash transfer scheme;
  - national capacity strengthened to monitor and report on progress towards targets and expected results in the Malawi Growth and Development Strategy (MGDS), the Millennium Development Goals (MDGs) and the UNDAF;
  - increased political commitment and resources for children through active involvement at policy level;
  - laws relating to children revised in line with the Convention on the Rights of the Child;
  - child participation promoted through the child parliament and other forums; and
  - caregivers in 80% of households engage in at least five key childcare practices.

**Key Donors**

*Governments:* Australia, Canada, Netherlands, Republic of Ireland, Spain, United Kingdom.  
*UNICEF National Committees:* Canada, Norway, Switzerland, United Kingdom.  
*Other Sources:* UN Fund.



## The brothers are still in shock. Their mother died only a month ago, and now they live alone. The youngest, Chisomo, which means “mercy” in the dominant Chichewa language, is just 11 years old.

“Before my mother died, she said I must spend our money wisely. She told me to buy fertiliser and farm produce as well as school materials and clothes for me and my younger brother,” says 18-year-old Loyid Josephy. His younger brother says nothing but just stares with large, sad eyes.

Their mother was referring to a monthly cash transfer of 1,800 kwacha (roughly US \$12) which the family started receiving in September 2008 as part of a social cash transfer scheme administered by the government with the support of UNICEF. The aim of the scheme is to reduce poverty, hunger and starvation in ultra-poor households through

a monthly cash grant. Qualifying under this criteria are indigent families headed by children, the elderly, persons with disabilities, and those with a terminal illness. At the time they were selected, the brothers were living with their ailing mother, their father having abandoned them when Chisomo was only a baby.

There is no doubt about the abject poverty the children endure. Their dank straw and mud hut, which has no windows except a crack in the mud wall, is almost bare. There is hardly enough room on the dirt floor to spread out their tattered sleeping mats. A few ragged clothes and a pair of old shoes hang on sticks poking out of the mud

walls and a few old cooking pots are neatly stacked in a corner with seven sacks of maize.

Jim Wotchi, the desk officer for the cash transfer scheme in Mchinji district where the boys live and where the scheme was first piloted, says despite their dismal living conditions, the cash has

There is no doubt about the abject poverty the children endure. Their dank straw and mud hut has no windows except a crack in the mud wall.

made a huge difference in the boys' lives and that of other poor people in his community. “Before they had the cash, the boys' school attendance was very poor and now they always go to school with uniform and school materials and they eat three meals a day.”

Loyid explains that he used the cash to buy two bags of subsidised fertiliser which has doubled their maize crop. “For the first time, we have enough food until our next harvest,” he says. He also bought a chicken, which he hopes will provide them with eggs. “We can eat three times a day. Before this, we used

to go to school without food. I also bought a school uniform, pencils, and I have even bought shoes for us,” he says as he looks down proudly at a pair of second-hand trainers.

The boys also intend to sell groundnuts to

supplement their income. “We’re not selling them just yet; we want to wait until the price is good,” says Loyid.

The process of selecting who should benefit from the cash transfer has a number of stages. The community, made up of a several villages totalling roughly 1,200 households, has a ten-member committee of five women and five men. All of them have completed at least eight years of primary school and are seen as energetic and committed members of the community.

The committee members explain to the community about the scheme and ask them to nominate the poorest families. The committee members then visit the families and rank them according to their vulnerability until they are left with the poorest 10% in the community; about 120 households. Most of those selected afford only one meal a day and are mostly orphans, of whom there are just over a million in Malawi, accounting for 15% of the country’s 6.8 million children under the age of 18 years. About half of them are orphaned by AIDS.

The community meets again to have another say on the final selection, just in case any candidate should be added or taken off. The selected households are not present in the meeting so that people can speak frankly. “It has been a smooth process and transparent,” comments Wotchi. After the families have been finally

selected, the grant they receive depends on the number of people in the household and how many are school-going. For example, Loyid and his brother are guaranteed 1,000 kwacha every month but they also receive an extra 800 kwacha bonus for attending school.

The families are advised about the different ways they can spend the money and at least once a month they receive visits from a committee member to monitor their welfare and how they are using the cash.

“They mostly spend the money well,” says Wotchi. “Many have used the money to buy fertilisers, school materials as well as cows, goats and pigs. The boys have spent their money wisely, but they could have done even better if their mother hadn’t been sick.” Loyid had to spend part of cash on transport as he accompanied his mother to and from the hospital in the last three months of her life.

The cash transfer programme was initially piloted in Mchinji district, then expanded to six others, as a means of testing the viability of cash grants as a social protection mechanism. At the beginning of 2010, plans were under way to design a national social protection programme, including cash grants, to cover the entire country.

A major challenge, concedes Wotchi, is that there are still many poor families that are unable to benefit

from the scheme. “Most in rural communities are poor, and even those who benefit, the money is not enough as prices continue to rise.”

Loyid needs no time to think about his challenges.

“The cash has helped us a lot, but now my mother has gone, we have to do everything alone - like cook, farm, clean and eat.”

Yet, he adds, he and his brother are determined to stay in school. Loyid says he would like to be a doctor.



The FM radio is lovingly unwrapped from its chitenje cloth. The women erupt into song, carefully recording it using the small handheld device.

Then one of them introduces the topic for the day - child abuse. One by one, the women have their say, discussing an issue that has increasingly worried them over the last few months.

The group of 25 women and one man are part of several radio listeners’ clubs that UNICEF supports as part of the ‘Community on Air’ initiative. They meet in the afternoon several times a week to listen to programmes broadcast on Dzimwe Community Radio, which broadcasts from Mangochi district on the shores of Lake Malawi. The station

broadcasts over a 100km radius to an estimated audience of 1.3 million listeners.

The women of the Sambwi I Village Listeners' Club have development of their village in their sights. After each broadcast, they discuss what they have heard - bulletins on tuberculosis, HIV and AIDS, malnutrition and other topical issues like children's rights. The idea is to identify problems in their community and come up with simple, low-cost solutions.

The part they really look forward to is where they record their own insert and the tape is collected by community journalists who will broadcast what they have to say. The station was initially supported by UNESCO but UNICEF has since stepped in by providing studio equipment, bicycles, and furniture. "I have been part of this group since it was formed in 2000," says the club's secretary, Fallesi Mbera. "It

has been part of my life. I have learnt a lot through our discussions, how to discuss in groups, and using my skills to share these messages with other villagers."

Mbera says in the past, the group was not taken seriously in the village and its voice was not recognised. But now, the group is heard throughout the village and they are able to influence decisions.

Through the recorded discussions, Mbera says the club has managed to put the village on the map. People in other districts can follow what is happening in the village and what women are doing to improve their lives and those of their children.

"They know that we have messages on breastfeeding and hand-washing and that we do not let our young children sit idle at home when it is school time," she enthuses. "You cannot listen to messages on radio and teach others and then go out

and do the opposite, it is not possible.

"We never used to allow our daughters to go to school - people rather opted to educate a boy than a girl. But we have talked about these matters and we can see it's important," says the divorced mother of four.

She says that through the programme, club members have been educated on the signs and symptoms of common diseases that afflict children and to quickly call for medical attention.

Fifty-two year-old Samson Milanzi, the only man in the group, says the club gatherings have become a daily part of his life. He doesn't think his gender is an issue.

"When I am with the group, I don't see them as women. They are my friends and I learn from them. I think men who think it is useless to gather in groups and listen to the radio together should come to me and I will tell them, 'you are missing a lot'."

The father of five says he has acquired skills on how to counsel his children and to be a supporting partner to his wife, who is also a member of the group.

"As a husband, I have learnt to work with women while sharing roles. I understand women better and the challenges they face. I am also able to improve the situation in my house because of this knowledge."

