In the minds of most outsiders, Malawi conjures up images of sandy Caribbean-like beaches lining the sparkling deep-blue waters of Lake Malawi, one of the world’s great lakes. The tenth largest in fact. Travel brochures lure tourists to lush forest lodges and countless websites pay homage to the famous and intriguing Cichlid lake fish. Malawians like to call their picturesque country ‘the warm heart of Africa’.

Behind the veneer of beckoning holiday resorts lies a harsh reality. Malawi is extremely poor, does not have enough food to feed its people and is ravaged by the AIDS epidemic.

In 2005 Malawi ranked as the world’s 13th poorest nation out of 177 countries reported (UNDP Human Development Index, 2005). Around 65 percent of rural Malawians and 55 percent of town inhabitants live in dire poverty, earning less that one US dollar a day.

Malawi is also amongst the world’s 20 countries with the highest death rates. One in five children is likely to die before their fifth birthday as a result of disease – mainly malaria, inadequate healthcare, malnutrition and poverty. Almost half of all children are chronically malnourished. One in eight women die from complications related to childbirth, their health compromised by nutritional deficiencies and continuous bouts of malaria. An average Malawian is expected to live to only 39 years of age.

Most Malawians are subsistence farmers, cultivating a variety of crops including maize, beans, rice, cassava, tobacco and peanuts. A fifth of Malawi is taken up by Lake Malawi and only half of the remaining land is suitable for crop farming. The growing population, now at 12.5 million people living in an area a little bigger than the size of Portugal, has put pressure on the land, reducing the average landholding by 50 percent since the 1980s.

Food security is precarious and the country is prone to natural disasters of both extremes – from drought to heavy rainfall. In 2005, Malawi faced its worst food crisis in more than ten years. Production of maize, the country’s most important stable crop, was lowest in a decade. The AIDS epidemic and weakened government capacity in critical areas such as health care compounded the food crisis to create a deadly threat to the wellbeing and livelihood of millions of people.
The United Nations launched a Flash Appeal at the end of August 2005 to help the Malawian Government bring urgent humanitarian assistance to 4.8 million people, including one million children. Included in the relief package was food aid for families and individuals unable to feed themselves, nutritional assistance to the most vulnerable – children and women, and emergency agricultural assistance such as maize seed and fertilizer for farmers. The goal of the appeal was to avert hunger in the immediate term and promote the sustainable recovery of people's livelihoods in the long run.

HIV/AIDS is fast becoming Malawi’s number one social and economic problem. Close to a million Malawians are living with the disease. For the last seven years the national prevalence rate has stabilized at 14–15 percent (the current rate is at 14.4 percent) but 219 people in their most productive years of life continue to die of AIDS every day. Mothers, fathers, farmers, fishermen, teachers, doctors, nurses, police officers, extension workers and government officials are buried every week, their dependants and those they look after in their professional capacity robbed of support and guidance.

Essential social services are crumbling under the weight of human loss while the burden and cost of caring for the sick rises. It is estimated that HIV/AIDS patients occupy 50 percent of medical ward beds and that 70 percent of all TB patients are HIV-positive. Malawi cannot train enough professionals in the social services sector fast enough to replace those that are dying.

While many people see HIV/AIDS as an adult affliction, the impact of the epidemic is seen most cruelly in the rising numbers of children orphaned and made vulnerable by HIV/AIDS. Out of Malawi’s one million orphans, 500,000 have lost one or both parents to AIDS. Approximately 80,000 children under the age of 15 are HIV-positive themselves. Most contracted the virus through their infected mothers during pregnancy, childbirth or through breast milk.

As parents get sick and die of AIDS, family burdens shift to children, particularly girls, who are often forced to leave school to earn money, obtain food, care for the ill and other family members. Without care and support, these children face stigma, discrimination, economic and sexual abuse, hunger, homelessness, poverty, and cannot access education, psychosocial support, health care and clean water and sanitation.

Young people, especially girls, are at the centre of the HIV/AIDS crisis. Out of the 10,000 Malawians that are newly infected every year, teens and young adults in the 15–24 age group account for almost half of all new infections. Girls and young women bear the brunt. They are five times more likely to contract the disease than boys and men. In most cases, they do not have the know-how, skills and assertiveness to protect themselves.

Yet, young people are also key to overcoming the pandemic. Those that are positive can learn to lead empowered lives, and those that remain negative can be guided to stay healthy. Getting tested for HIV/AIDS and knowing one's status will be a vital tool in the fight against the disease.
Children and AIDS

The Young People

- 10,000 Malawians contract HIV/AIDS every year.
- 46 percent of new infections are found amongst young people aged 15–24 years.
- Girls account for 60 percent of infections in the 15–24 age group.
- Six young Malawian women for every one young Malawian man are HIV-positive.
- Research shows that young people become sexually active as early as 8 to 10 years old in some communities.
- Most studies show that young men have more partners than young women regardless of marital status.

The Children

- 80,000 children under the age of 15 are living with HIV/AIDS.
- 40 percent of malnourished children are also HIV-positive. Malnutrition speeds up the progression of the disease, and ultimately death.
- Mother-to-child transmission of HIV (MTCT) is the single largest cause of HIV infection in children.
- Up to 40,000 babies could be infected with HIV if nothing is done to prevent MTCT.
- Out of Malawi’s one million orphans, 500,000 are orphaned as a result of AIDS.

The Adults: those that look after children:

- 14.4 percent of Malawians in their prime years of life (15–49 years) are HIV-positive.
- 900,000 women and men are living with HIV/AIDS in Malawi; 58 percent are women.
- Half a million pregnant women need antenatal care to prevent mother-to-child transmission of HIV.
- A fifth of all Malawian households are looking after orphans; almost a half of these families are headed by girls, women or elderly women.
- Deaths rates have tripled since 1990.
- 80,000 people die of AIDS-related illnesses every year.
- 170,000 people need antiretroviral therapy; 22,973 patients were getting antiretroviral treatment in the second quarter of 2005.

The Landscape of AIDS

- Twice as many adults in towns are HIV-positive than in the rural areas.
- There are double the number of HIV/AIDS infections in the southern part of Malawi than in the North and Central Regions.
- Current infection trends show a shift in HIV/AIDS prevalence from the south to the north.
- In the capital, Lilongwe, the prevalence rate amongst young women attending antenatal clinics has declined by almost half, from 26 percent in 1996 to 16 percent in 2003.
Winning the fight against HIV/AIDS hinges on leadership. Leadership in the face of the AIDS crisis means breaking the silence that keeps the disease hidden. Leadership works towards HIV/AIDS prevention and towards treatment and care for those living with and affected by the disease.

In Malawi, the Government is taking a strong and determined lead in the fight against HIV/AIDS. Several high-ranking government officials have spoken out on the disease, including former president Bakili Muluzi who, during a public rally in 2002, revealed his brother had died of AIDS.

Malawi has created a favourable environment to scale up its national response to the AIDS epidemic by applying the “Three Ones” principle: one agreed HIV/AIDS Action Framework, one national AIDS coordinating authority and one agreed country-level monitoring and evaluation system, as well as policies and guidelines for particular areas of prevention, care and treatment of HIV/AIDS.
The National AIDS Policy

The National AIDS Policy (NAP) was launched in 2004 by former president Bakili Muluzi. This progressive policy provides a legal and administrative framework for the implementation of HIV/AIDS programmes and activities at all levels of Malawi society. It offers guidance on critical areas such as social and economic support for people living with HIV/AIDS, provision of care and treatment for all Malawians living with HIV/AIDS and the protection of their human rights and freedoms. An important goal of the NAP is to strengthen coordination and implementation of HIV/AIDS programmes.

The National HIV/AIDS Action Framework


The NAF emphasises eight priority areas for the next five years, namely; (i) prevention and behaviour change, (ii) treatment, care and support, (iii) impact mitigation: economic and psychosocial (especially for orphans and other vulnerable children, widows, the elderly and people living with HIV/AIDS), (iv) mainstreaming, partnerships and capacity building, (v) monitoring and evaluation, (vi) research, (vii) resource mobilisation, tracking and utilisation, and (viii) national policy coordination and programme planning.

The National AIDS Commission

The National AIDS Commission (NAC) was established in July 2001. It is the coordinating body for all HIV/AIDS activities in Malawi. The NAC’s specific mandate is to provide leadership in planning, organising, coordinating and setting standards and guidelines for the prevention and control of HIV/AIDS.

The NAC partners with public, private and civil society organisations to carry out activities guided by the National Strategic Framework for HIV/AIDS 2000–2004, and from 2005 to 2009, by the NAF. These include, among other initiatives, prevention of HIV and sexually transmitted infections, voluntary counseling and testing (VCT), prevention of mother-to-child transmission of HIV (PMTCT) and care and support to people living with HIV/AIDS, including community and home-based care for orphans and other vulnerable children.

The NAC is primarily a donor-funded organization. Since its onset, it has been supported by nine donor agencies—UNICEF, the Canadian International Development Agency (CIDA), the Department for International Development (DFID), the Norwegian Agency for Development Cooperation (NORAD), UNFPA, the US Agency for International Development (USAID), WHO, the World Bank and the Centre for Disease Control, Atlanta.

Guiding Action

Malawi has in place a number of concrete policies and guidelines that help implementing organisations provide the best possible services to people affected and living with HIV/AIDS. The National Policy on Orphans and Other Vulnerable Children (2003) and its recently launched National Plan of Action (2004) serve as a common reference tool for Government and all other stakeholders working to improve the lives of more than a million orphans and vulnerable children in Malawi, and promoting the rights of all Malawi children.

A policy and guidelines (2003) to prevent the transmission of mother-to-child HIV infection have been developed to guide health workers in planning, managing and evaluating quality PMTCT services such as awareness-raising and education, appropriate infant feeding, VCT, antiretroviral treatment and social support.
Specific guidelines also exist for Antiretroviral Therapy, VCT, Infection Prevention, Infant and Young Child Nutrition, and Reproductive Health, all of which can be used in conjunction with each other to provide a comprehensive package of interventions to affected people.

Sector-specific policies relating to HIV/AIDS, such as the Education Sector National Strategy for Combating HIV/AIDS (2005–2008), look at how to mitigate the deadly impact of the AIDS epidemic on government workers and end-users.

Raising Funds to Fight HIV/AIDS

Malawi has successfully raised funds for its national HIV/AIDS control programme, although with an ever growing number of HIV-positive people, the country will need continued support from the international community. More emphasis will also have to be put on children and young people that are so often missing from development agendas and programmes.

The Global Fund for HIV/AIDS, Tuberculosis and Malaria is by far the largest single contributor (39 percent) to the HIV/AIDS response in Malawi, followed by the Government of Malawi (31 percent), the UN family (18 percent) and foreign governments (12 percent).

In 2003, the Global Fund gave Malawi a grant of US$196 million for a five-year national HIV/AIDS programme to target all sexually active people in Malawi. The activities involve VCT, PMTCT, community home-based care, management of opportunistic infections including the provision of ARV drugs, systems strengthening and institutional support. Around 65 percent of the funds will go towards treatment of opportunistic illnesses and ARV therapy.

Malawi also receives external funding from other multilateral and bilateral donors such as the UN and foreign governments. The funds are channeled through an individual donor’s country programme of work to a range of implementing organisations in the country, including the Government of Malawi.

To complement the above methods of financing, an arrangement, brokered by UNAIDS, was made in 2003 between the Government of Malawi and four international donors (DFID, CIDA, the World Bank and NORAD) to pool funding around a common work plan, financial mechanism and reporting format. The pool, called the NAC Facility Grant, amounts to US$72 million for 2003–2008. The World Bank has contributed almost 50 percent of the funding through its Multi-country AIDS Program (MAP).

The Joint United Nations Programme on HIV/AIDS

The United Nations system in Malawi, comprised of eight UN agencies and programmes, including UNICEF, as well as the World Bank and the International Monetary Fund, set up a Joint Implementation Support Plan for Scaling Up the Fight against HIV/AIDS in Malawi in 2005. The programme is designed to support the eight priority areas of the National Action Framework for 2005–2009. It helps to coordinate the work of individual UN agencies in the field of HIV/AIDS so that programmes complement each other and duplication of work is avoided.
Keeping young Malawians HIV free and healthy

ISSUE

- Almost half of all new infections occur among young people aged 15 to 24.
- 37 percent and 25 percent of young men and women in the 15–24 age group were able to correctly identify ways of preventing HIV.
- Four percent and 3.7 percent of young men and women aged 15 to 19 reported having been tested for HIV and having received the results.
- 35.6 percent and 35 percent of young men and women in the age group 15 to 19 reported using a condom the last time they had sex.

ACTION

Life Skills and Youth Participation

Young people and children, especially those that are not infected by HIV, provide a window of hope in stopping the spread of AIDS. HIV/AIDS is a preventable disease. With the right knowledge and relevant life skills, most children, adolescents and young people can learn to stay healthy and constructively contribute to society.

UNICEF and its partners use a multi-sectoral approach to keep young Malawians HIV free and help those that are infected to live positively. Educational, recreational and healthcare interventions target children and young people in schools, youth centres and youth-friendly health services with a full range of options that are known to be successful in HIV prevention.

Life Skills in Primary Schools

In 1999 UNICEF and the Ministry of Education pioneered a life skills programme in Malawi for primary school children. The goal of the programme is to provide information on HIV/AIDS and other health risks, and to help children, especially girls, develop positive health and social skills so that they are able to control their bodies, health and future.

The initiative started with ten to twelve year-olds in Standard 4 and was gradually expanded in 2000 to include all lower primary grades. The United Nations Population Fund (UNFPA) focused on the upper primary level, incorporating the life skills programme into its primary and secondary school curriculum on sexual reproductive health.

The life skills programme helps children and adolescents deal with the demands of present day Malawi: HIV/AIDS, sexually transmitted illnesses, drug and substance abuse, relationships, violence and delinquency, harmful cultural practices, peer pressure and access to social services. Children are taught how to address these challenges by developing self-esteem, critical thinking, decision-making skills, creativity, entrepreneurship and peaceful conflict resolution. Participatory methods such as drama, song, debates and role-play are used in teaching and learning life skills.

UNICEF, with support from the Netherlands, Norway and Canada, has provided primary schools with Life Skills Education materials: training manuals, syllabuses, teachers guides and learners/pupils books for Standards 1–4 in all primary schools, and has helped train Standard 1–4 teachers in all of the country’s 5,168 primary schools.
Protecting Teachers

UNICEF also supported the NGO, Action Aid, to run a workplace HIV/AIDS prevention programme for educational personnel in six districts. Teachers, school managers and ministry personnel have been hard hit by the AIDS epidemic. Between 1999 and 2004, the education sector in Malawi lost 40 percent of its teaching and managerial cadre at central, division and district level. Deaths were disproportionately high among young male and female staff, corresponding to mortality patterns associated with high HIV/AIDS prevalence.

Anti-AIDS Clubs

School anti-AIDS clubs, popularly known as Edzi Toto (“AIDS not for me”) have been set up for children in all parts of Malawi. In September 2005, there were 4,162 Edzi Toto clubs with a membership of 144,000 children. These members reach out to other children who are non members. More than 80 percent of all schools in the country had an Edzi Toto club. The school clubs involve children in debates, drama, quizzes and sports where information on HIV/AIDS and sexual health is presented in creative and interactive ways, helping children identify and change risky behaviour.

In addition to the school Edzi Toto clubs, anti-AIDS clubs for out-of-school children have been mushrooming in youth centres across Malawi. In 1997 there were only 450 clubs. By September 2005, the number of out-of-school clubs had grown four-fold to 1,901 clubs. These clubs provide an entry point for peer education on HIV/AIDS awareness and prevention. Volunteer peer educators give guidance on how to prevent HIV infection, STIs and unwanted pregnancies. They also coach young people on a range of subjects such as sexuality, gender and interpersonal relations.

The school and out-of-school anti-AIDS clubs complement life skills education and strive to change sexual behaviour in young people. With parents and other community members participating in anti-AIDS activities, the clubs are also breaking communication barriers between the young and the old.

Youth-friendly Health Services

Access to information and to HIV testing is a fundamental human right. It is critical for sexually active young people to be aware of their HIV status so that they can stay healthy and prevent infecting others. Young Malawians have the chance to test themselves for HIV or other sexually transmitted illnesses, and get counseling and appropriate treatment through the country’s network of youth-friendly health services and Voluntary Counseling and Testing (VCT) sites.

A third of Malawi’s health care centres offer VCT. Three quarters of youth-friendly health services have VCT. Youth-friendly health services also provide condoms and contraceptives and serve as venues for socialising and peer education.

UNICEF supported 26 youth-friendly health services in ten districts, helping increase attendance from 11 percent of all young people in the ten districts selected in each of the three regions of Malawi in 2001, to 56 percent in 2004. The number of UNICEF supported youth-friendly health sites has increased to 111 in 2005. The vast majority of people getting treated for STIs at the youth-friendly health centres were girls and young women.

To increase coverage and quality of VCT services, UNICEF provided supplies such as HIV rapid test kits, gloves, lancets, capillary tubes, cotton wool, stop watches, furniture and other related supplies, technical guidance in the development of VCT guidelines and quality assurance tools as well as provision of on-site technical support to VCT site counselors. In 2005 UNICEF supported staff training in counseling and whole blood testing in VCT sites throughout the country.
Main Achievements

By September 2005, UNICEF and its partners in Malawi were able to:

- Provide 2.5 million primary school children – 73 percent of all primary school children in Malawi – with life skills education.
- Train more than 26,000 teachers to teach life skills and provide them with teaching manuals and learners books.
- Help set up 4,162 school Edzi Toto clubs, bringing HIV/AIDS education and awareness to more than 144,000 children.
- Support the growth of out-of-school anti-AIDS clubs, numbering almost 2,000 in 2005.
- Help increase attendance, especially of girls to family planning and STI treatment in 26 youth-friendly health services in ten districts.
- Support 73 VCT sites located in health facilities and youth centres in 2005.
- Train 63 health workers and 189 youth counselors working in VCT services in 14 districts; by June 2005 27,000 young people were tested for HIV through these sites.
**Going Big: A Scaled Up Response**

UNICEF and its partners are gearing up for the next challenge: to build upon what has been achieved so far and scale up efforts to lower and ultimately prevent HIV infection among children and young people. For the next five years — from 2005 to 2010 — a major drive using ‘captive points’ such as primary and secondary schools, universities, youth centres, health services and public spaces will be made to:

- get all school children to correctly identify two of the main ways in which HIV is transmitted,
- encourage 50 percent of all young people from 14 to 24 years of age to know their HIV-status,
- help 80 percent of all young people that test negative to stay negative,
- provide care and treatment to 90 percent of HIV-positive young people so that they can live positively.

Under the school life skills programme, 20,000 teachers and school managers will be trained in life skills education and will be provided with teaching and learning materials for the next five years.

The Edzi Toto clubs will be expanded from the current 4,162 schools to all of the country’s 5,168 primary schools. This will open the doors to HIV/AIDS education and prevention for an additional 100,000 children or more. Teachers and communities around primary schools will be mobilised to safeguard children, especially girls and orphans, from being sexually exploited and abused.

**It costs US$ 700 to start an Edzi Toto club in a school**

The number of out-of-school anti-AIDS clubs will be increased from 1,901 clubs in 2005 to 2,500 clubs by 2010, allowing up to 100,000 young club members to benefit from information, life skills, counseling and recreation. To strengthen youth participation, youth leaders and peer educators will be trained to provide psychosocial support to other young people.

An large-scale multi-media initiative, using TV, radio and video, will be carried out to raise awareness amongst young people about the dangers of HIV/AIDS and how best to protect themselves. The campaign will also be used as a way of promoting public dialogue on HIV/AIDS and breaking the silence that so often surrounds sexuality, reproductive health and AIDS. Secondary schools and youth clubs will be key participants in the campaign.

A Knowing Your Status campaign will be launched to increase the proportion of children and young people with knowledge of their HIV status from the current 7.1 percent to 50 percent. A communication strategy to mobilise the youth will be developed with door-to-door peer education as a main strategy. Ten thousand young people will be trained as peer educators, VCT motivators and life skills coaches. A further 3,000 HIV-positive young people will be trained as VCT motivators.

**US$100 will help train a young Malawian girl or boy as a peer educator**

UNICEF will advocate for the Ministry of Health to provide voluntary counseling and testing outside primary health care centres. Mobile VCT vans will be parked in strategic locations such as market places and minibus stops, and VCT services will be available in churches, youth centres, secondary schools, colleges and universities during ‘open days’. Young peer educators will visit bars and brothels to try and encourage young female sex workers to test themselves.

Government health centres will be geared up to offer a comprehensive VCT package and will be made more youth-friendly by training 1,100 health workers and 2,500 peer counselors and HIV testers. UNICEF will provide HIV test kits to health clinics as well as VCT services operating outside healthcare facilities.
UNICEF will help establish more ‘safe spaces’ where young people can access services and information on issues that concern them without any threat and risk. Youth clubs and drop-in centres will be rehabilitated and provided with equipment and supplies like furniture, library equipment, HIV test kits and related supplies, recreation and sports materials.

**For US$ 65,000 one mobile VCT van can service 50 young people a day**

Without an ‘enabling’ legal and administrative environment, it would be difficult to lower and prevent HIV infection in young people. UNICEF will therefore work with government to develop policies on youth development and participation. Furthermore, government and community institutions responsible for youth activities at national, district and community level will be strengthened to provide quality services to young people.

<table>
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<th>ACTIVITIES</th>
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<th>BUDGET (US$) 2007</th>
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PMTCT Plus

Helping mothers protect their children

ISSUE

- Almost a fifth of women attending antenatal clinics who test for HIV are positive.
- It is estimated that every year Malawi has 100,000 HIV-infected mothers.
- Mother-to-child transmission of HIV was responsible for infecting 80,000 children under 15 years of age infected in 2003.
- Up to 40,000 babies in Malawi could be infected every year if nothing was done to reduce mother-to-child HIV transmission.

ACTION

The most effective way of preventing HIV in children is to keep them from getting infected in the first place. In Malawi the vast majority of HIV-positive babies and young children have contracted the virus from their mothers during pregnancy, delivery or through breastfeeding. In the absence of any effort to lower the risk of ‘vertical transmission’, as many as 45 percent of babies born to positive mothers are likely to become HIV positive.

Recent research has shown that a range of interventions can cut the risk of mother-to-child transmission of HIV by half. In Malawi, two Prevention of Mother-to-Child Transmission (PMTCT) clinics were piloted in 2001 with support from UNICEF and Medecins Sans Frontières. Following this successful experience, PMTCT services were expanded to 15 sites in 2003, and in June 2003, a national PMTCT programme was launched. By the end of 2005, 36 out of the country’s 524 hospitals and health centres were offering PMTCT services.
The comprehensive package called “PMTCT Plus” includes:

- **Mother and child healthcare**: helps families protect their children’s health and assist health services to detect and manage illnesses. Appropriate feeding, growth monitoring, vaccination and management of childhood illnesses and diseases ensure that children live the healthy lives they are entitled to have.

- **Voluntary and confidential counseling and testing**, especially for pregnant women can lower the risk of mother-to-child transmission as well as prevent subsequent sexual transmission of HIV/AIDS. HIV infected women need counseling so that they can make informed decisions about their own as well as their families futures, and about infant feeding options.

- **Providing antiretroviral drugs to the HIV positive mother** and ensuring that safe delivery procedures are used during birth. AZT, administered from 36 weeks gestation through labour until delivery, or a single dose of nevirapine during labour and to the baby within three days of birth, are generally safe and can substantially reduce the risk of a mother transmitting HIV to her child.

- **Counseling on infant feeding options** to reduce the risk of transmission during breastfeeding. Counseling provides women with knowledge about the risks, benefits and costs of various feeding alternatives, including breastfeeding, so that the mother can make her own informed decision about how best and most safely to feed her newborn child.

- **Optimal obstetrical practices**: this includes antenatal care, labour and delivery care, and postnatal and follow up care such as counseling on nutrition and infant feeding, baby care, maternal and neonatal possible danger signs and giving vitamin A supplementation.

- **Family planning and counseling**: families receive counseling on family planning, pregnancy-related risks and safe sex practices.

- **Pediatric care and treatment**: babies born to HIV positive mothers given the antibiotic, co-trimoxazole, until they are tested for HIV. Children diagnosed with HIV/AIDS are put on ART.

Out of the 36 hospital and health clinics providing PMTCT in 2005, UNICEF supported 30 centres by helping train nurses, supplying HIV test kits and other supplies and providing supervision. Out of these 30 sites, 28 offered the comprehensive PMTCT Plus package of services.

However there are some concerns about the programme:

- **Coverage is still low** with only 6.6 percent of 524 health facilities offering PMTCT services. This is largely due to the fact that Malawi has limited expertise and a shortage of medical personnel to implement what is a relatively complex intervention.

- **Counseling services are not widely used** and are often of poor quality. Just over half of all pregnant women who visited PMTCT clinics in 2004 were counseled to take the HIV test. Based on attendance numbers, all the 36 PMTCT services in the country should have tested more than 126,000 women in 2004. However only a third of these women had their test. Lack of trained nurses, shortages of HIV testing supplies, overcrowding in health centres, stigma, low involvement of male partners and the fact that antenatal care and HIV testing facilities are often located in separate places were to blame for the poor quality of counseling and HIV testing.

- **Access and adherence to ARV therapy** is another problem area. In 2004 it is estimated that 2.5 percent of estimated HIV positive pregnant mothers were given nevirapine nationwide. In the UNICEF-supported PMTCT sites, only 41.1 percent of women were given nevirapine during delivery, based on a positive HIV test, and 32 percent of babies were provided with an infant formulation of the drug.

Hospitals do not always have ready supplies of ARVs. Medical workers have to spend a lot of time and effort educating patients on the importance of taking their drugs on time, every day, for the rest of their lives. Special challenges are presented by child patients whose medication needs to be supervised by adults, and illiterate people who cannot read labels on pill boxes.
Around 43 percent of Malawian women give birth at home and there are not enough traditional birth attendants trained in PMTCT and more specifically, on the use of nevirapine, to manage the administration of ARV therapy.

To increase public awareness and the use of PMTCT services, UNICEF and the Ministry of Health launched the Male Champion Initiative in 2004, an innovative community project that was piloted in Mwanza district. The idea behind the scheme was simple: since men in Mwanza were found to be making most of the key decisions on family matters affecting their partners and children, it would be wise to educate them on the importance of PMTCT and to encourage them to accompany their wives or girlfriends to the clinic. A year later the project was evaluated showing that a growing number of couples were visiting PMTCT services, and that nurses were actively involving men in health talks and other clinic activities.

The Malawi authorities are making progress in expanding the PMTCT programme. The new national HIV/AIDS policy will help to increase the provision of PMTCT services as it has made HIV testing a routine service to all pregnant women attending antenatal clinics unless they sign a form to opt out. A national strategy to scale up PMTCT has been developed and in 2005 was being revised to include ART for children and young women.

**Main Achievements**

By September 2005, UNICEF and its partners in Malawi were able to:

- Expand the PMTCT programme from one pilot project in 2001 to 36 sites in 2005, reaching more than 85,000 women,
- Offer a comprehensive package of PMTCT services, including care and treatment of children with AIDS, in 30 out of 36 hospitals and health centres,
- Place PMTCT as a key strategy and plan on the national agenda,
- Pilot a successful community initiative encouraging men to support PMTCT services.

**Going Big: A Scaled Up Response**

The knowledge, drugs and technology exist to prevent mothers infecting their children but the challenge is to bring PMTCT interventions to a greater number of women and children faster.

Working with the Ministry of Health, UNAIDS, WHO and other partners, UNICEF will step up efforts to scale up the national PMTCT programme from 2006 to 2010. The goal will be to:

- provide access to quality HIV testing and counseling to all pregnant women attending antenatal clinics,
- make sure that 80 percent of HIV-positive pregnant women attending antenatal clinics receive the comprehensive package of PMTCT services,
- bring ARV treatment to 50 percent of eligible HIV-positive women that have been identified through the PMTCT programme.

Interventions will be multi-pronged, using a variety of existing and new strategies. The Male Champion Initiative will be expanded to other parts of the country, especially those with a PMTCT component. Local communities, and especially husbands and partners, will continue to be actively engaged in promoting safe motherhood and PMTCT services.
**It costs US$ 1,500 to start a support group for HIV positive women**

The Male Champion Initiative will be complemented by creating social support groups for HIV positive women in all PMTCT clinics. The support groups will provide a safe and caring environment for women to come together and discuss issues related to their illness, such as stigma and social isolation.

HIV testing and counseling services will be strengthened so that they can be strategically used as entry points to PMTCT services for HIV-infected and breastfeeding mothers. UNICEF will support the implementation of a national policy on routine HIV testing for pregnant women. Rapid HIV testing kits will be provided to all PMTCT sites so that women can get their results the same day and benefit from immediate post-test counseling.

**Rapid HIV testing kits can be brought to Malawi for US$ 1.15 per person**

UNICEF will work towards having all PMTCT sites offer the full package of services by 2010, including ARV therapy, quality antenatal care, safe delivery, counseling on infant feeding, emergency obstetric care and proper postnatal care. This will be done through a training programme for all levels of medical staff and community workers. PMTCT clinics will be assured of a steady supply of ARV drugs, purchased under a grant from the Global Fund, and will be provided with supplies and equipment for safe deliveries and emergency obstetric care.

UNICEF will continue promoting the integration of PMTCT services with ARV treatment programmes so that prevention efforts are better linked with care, support and treatment activities. This will require a systematic review and re-orientation of mother and child healthcare services; strengthened referral mechanisms between different services; broadened partnerships with civil society, and public and private organisations; introducing PMTCT into the curricula of nursing and medical schools, and helping Government procure and distribute ARV drugs and other medical products to public hospitals and health clinics.

Infant and young child feeding will be another important area of work. In Malawi, women opt to breastfeed their babies for long periods whether they are HIV positive or not. In a context where safe and clean water is still hard to come by and personal hygiene practices are poor, the option of feeding babies with formula or using breastmilk needs to be weighed carefully. To maximize the chances of keeping babies and young children free of HIV, women need to be counseled on the best choice of feeding methods.

**A midwife can be trained to provide quality counseling on infant feeding for US$ 150**

UNICEF will therefore support high-quality counseling on infant and young children feeding practices within PMTCT clinics, and will also put into place mechanisms to follow up and support mothers who need continued help in the postpartum period. PMTCT services will work closely with the Baby-Friendly Hospital Initiative to make sure that the two programmes complement each other. A specific nutrition package for women and children with HIV/AIDS will be developed with WFP. The package will be implemented in all health centres providing PMTCT Plus services.

The PMTCT programme will also benefit from stronger monitoring and evaluation. Data collection and analysis, operational research, documenting ‘best practices’, and evaluating the impact of nevirapine treatment on pregnant women will be carried out to assess the effectiveness and improve coverage of PMTCT services.
<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>BUDGET (US$) 2006-2010</th>
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<th>BUDGET (US$) 2007</th>
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<td>Establishing support groups</td>
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<td>Orientating health workers and traditional birth attendants</td>
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<td>Providing basic supplies and equipment for safe delivery and emergency obstetric care.</td>
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<td>Revising and distributing guidelines and communication material on infant feeding and HIV/AIDS</td>
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<td>Training and supervising Baby Friendly Hospitals to implement a policy on infant feeding and HIV/AIDS</td>
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<td>Strengthening and expanding mothers groups in baby friendly hospitals and training them on infant feeding and HIV/AIDS</td>
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<td>Developing policy and treatment guidelines on nutrition and HIV/AIDS; collaborating with WFP on programme implementation</td>
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<td>Technical assistance training, procurement, advocacy, monitoring, supervision and reporting</td>
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<td>GRAND TOTAL</td>
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Almost all HIV-infected children acquire the virus from their mothers before or during birth or through breastfeeding. Although the precise mechanisms are unknown, scientists think HIV may be transmitted when maternal blood enters the fetal circulation, or by mucosal exposure to virus during labor and delivery.

HIV can also be transmitted from a nursing mother to her infant. In developing countries such as Malawi where mothers nurse their babies for a long time, an estimated one-third all HIV infections are transmitted through breastfeeding. Sadly most women living in poverty do not have the option of forgoing breastfeeding due to the lack of available clean water, sterile bottles or formula.

HIV-positive women who benefit from Prevention of Mother-to-Child Transmission services, including ARV therapy during delivery and a pediatric ARV formulation administered to the baby immediately after birth, can reduce the likelihood to HIV transmission to the newborn by 50 percent.

HIV infection is often difficult to diagnose in very young children. Infected babies, especially before 18 months of age, often appear normal and may show no telltale signs allowing for a definitive diagnosis of HIV infection. Moreover, all children born to infected mothers have antibodies to HIV, made by the mother's immune system, that cross the placenta to the baby's bloodstream before birth and persist for up to 18 months. Because these maternal antibodies reflect the mother's but not the infant's infection status, standard antibody tests are not useful in newborns or young infants.

In recent years, researchers have demonstrated the utility of highly accurate blood tests in diagnosing HIV infection in children 6 months of age and younger. The polymerase chain reaction (PCR) can detect minute quantities of the virus in an infant's blood. Another procedure allows physicians to culture a sample of an infant's blood and test it for the presence of HIV. However, well-equipped laboratories and skilled health workers are needed to carry out such tests, something not readily available in a resource-poor country like Malawi.

Progress has been made in the medical arena to understand the natural course of HIV disease in children. About 20 percent of children develop serious illness in the first year of life; most will die by four years of age. The remaining 80 percent of infected children have a slower rate of disease progression, many not developing the most serious symptoms of AIDS until school entry or even adolescence.
Children have a much quicker rate of progression from infection to full-blown AIDS than adults—months in comparison to years for adults. Many children with HIV infection do not gain weight or grow normally. They are slow to reach important milestones in motor skills and mental development such as crawling, walking and talking. Children with HIV suffer the usual childhood bacterial infections more frequently and more severely than uninfected children. These illnesses can cause seizures, fever, pneumonia, recurrent colds, diarrhea, dehydration and other problems that need urgent medical attention.

As in adults, treating HIV-infected children is a complex task of using potent combinations of antiretroviral drugs to suppress the HIV virus from multiplying itself. While children can expect to live longer and healthier lives in an age of highly active antiretroviral therapy, their treatment options are fewer and not as well understood as those for adults.

In developing countries, the difficulties in treating children with AIDS are compounded by the lack of medical facilities and technologies for early diagnosis of HIV, poor healthcare infrastructure and systems and insufficient skilled health staff. Appropriate pediatric ARV formulations are not available and doctors resort to splitting adult ARV tablets for children. Where treatments are available cost has been prohibitive, with pediatric formulations costing up to five times as much as ARV drugs for adults, in part because suppliers do not have large enough orders.

**ACTION**

Prior to 2004 little attention was given to pediatric AIDS in Malawi. The number of babies who received ARV therapy to stop infection from their HIV-positive mothers gradually increased from two in 2001 to more than a thousand infants in 2004, reaching a total of 2,979 by June 2005.

Recently UNICEF, WHO and UNAIDS have succeeded in placing the issue of ARV treatment for children and young women on the national agenda, helping to bring about better cohesion of PMTCT services with the country’s ARV treatment programme. Fifty-nine hospitals were providing antiretroviral therapy (ART) in Malawi in 2005. Through a grant from the Global Fund on AIDS, Tuberculosis and Malaria, and in partnership with UNICEF, the Malawi Government was able to increase the number of AIDS patients on free ART from 4,000 people in January 2004 to just under 23,000 by the end of June 2005. Five percent of these beneficiaries were children.

UNICEF played a key role in the scaling up of ART in Malawi by bringing ARV drugs to the country and conducting door-to-door distribution of supplies to all 59 ART sites. In October 2005 UNICEF, the Ministry of Health of Malawi, WHO and the US Government carried out a joint mission to see how PMTCT and Pediatric HIV care could be scaled up in Malawi. It was determined that entry points for children and mothers into the ART programme would include antenatal clinics, labour wards, pediatric wards, post natal clinics, child welfare clinics and nutrition rehabilitation units.

**Main Achievements**

By September 2005, UNICEF and its partners in Malawi were able to:

- Support increased coverage of the PMTCT programme, reaching approximately 3,000 babies with nevirapine,
- Advocate for priority to be given to pediatric AIDS in national policies, strategies and programmes, including technical input into the PMTCT and the pediatric scale up plans,
- Procure US$ 18.2 million worth of ARV drugs and other supplies for the treatment of HIV/AIDS of which US$ 1.8 million went to treating children with AIDS,
- Distribute ARV drugs to 59 health clinics administering ART; five percent of the drugs have been used to treat children.
Going Big: A Scaled Up Response

As Malawi paves the way for better care and treatment options for children with HIV/AIDS, UNICEF and its partners are planning to launch an ambitious pediatric AIDS programme from 2006 to 2010. The goal of the programme will be to:

• Test in a timely manner 70 percent of children born to HIV infected mothers in a PMTCT site,
• Provide co-trimoxazole to all children born to infected women in Malawi,
• Increase the proportion of children on free ART by 15 percent.

This will be done by collaborating with the Ministry of Health, WHO and other partners to develop appropriate policies and guidelines for the management of pediatric AIDS. Integration and linkages between the PMTCT and national ARV roll-out plan will be strengthened so that more children have access to life-prolonging medication and care. A national plan of action for pediatric care needs to also be put into place, including a well-defined care and treatment package for children infected with HIV.

As part of the on-going UNICEF drug procurement initiative, US$ 64 million worth of ARV drugs, co-trimoxazole and other medicines for opportunistic illnesses, nutritional supplements and HIV testing supplies will be provided to public and private health clinics from 2006 to 2008.

For US$ 8 a child with AIDS in Malawi can receive her monthly supply of ARVs

To increase public understanding of the little known and complex issue of pediatric AIDS, UNICEF plans to develop a communications strategy and produce related materials. Awareness-raising campaigns will be carried out in communities in all parts of Malawi. Partnerships with civil society and the private and public sector will be one of the main ways in which services for children with AIDS will be expanded.

A lot of emphasis will be put on training of health and community workers. Not only is pediatric AIDS a new and evolving field of knowledge and expertise worldwide, but the health sector in Malawi is further weakened by the lack of skilled health professionals. In 2005, there was one nurse to 4,100 people and one doctor to almost 55,000 Malawians. Training programmes are struggling to replace lost skills caused by a brain drain of doctors and nurses leaving Malawi for better paying jobs abroad.

US$ 400 will help train a Malawian doctor to treat a child infected with HIV.

UNICEF and the Ministry of Health will integrate training on pediatric AIDS into existing courses on Integrated Management of Childhood Illnesses (IMCI), PMTCT and VCT for medical students and working health professionals. One thousand health workers in 50 or more clinics providing ART and PMTCT will be trained in the management of pediatric care and children infected by HIV. Ten thousand extension workers will be trained to counsel mothers on breastfeeding and how to feed HIV infected infants and children. Treatment programmes for HIV-positive and malnourished children will be scaled up.

Community support groups, especially those that involve people living with HIV/AIDS, will be empowered to help infected mothers and children living in their midst. Home-based care kits, comprised of a carry bag, scissors, oral rehydration salts, paracetamol, calamine lotion, bandages, gloves, cotton wool and other supplies will be provided to community groups for this purpose.
One home-based care kit costs US$ 68 for one year

UNICEF will continue to support the national PMTCT programme. In particular, high-quality counseling on appropriate infant feeding and mechanisms will be put into place to follow up and support mothers that need help with infant feeding practices, breast health and maternal nutrition. Special attention will be given to HIV-positive mothers that want to test their children; they will benefit from stronger referral mechanisms to testing clinics with CD4 count machines. PCR testing for children below 18 months will also be put into place.

UNICEF will also help the Ministry of Health to monitor and evaluate the pediatric AIDS programme so that quality standards are reached and maintained. Local and international experts specialising in pediatric AIDS will be invited to Malawi to assist with programme implementation.

### BUDGET

<table>
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<tr>
<th>ACTIVITIES</th>
<th>BUDGET (US$) 2006-2010</th>
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<th>BUDGET (US$) 2007</th>
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<tr>
<td>Advocacy and development of policies and guidelines on pediatric AIDS</td>
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<td>Drugs for opportunistic infections, nutritional and micronutrient supplements, and other supplies for pediatric AIDS</td>
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<td>Equipment and supplies for mother and child home-based care</td>
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<td>Training extension workers and community-based support groups</td>
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<td><strong>GRAND TOTAL</strong></td>
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Protection, Care and Support

Looking after orphans and children affected by HIV/AIDS

ISSUE

- Malawi has one million orphans; 500,000 have lost one or both parents to AIDS.
- A fifth of all Malawian households are looking after orphans; almost half of these families are headed by girls, women or elderly women.
- 900,000 women and men are living with HIV/AIDS in Malawi; 58% are women.
- 80,000 children below the age of 15 are living with HIV/AIDS.
- 58 children die of AIDS every single day in Malawi.
- More than a third of severely malnourished children are HIV positive.

All around the developing world, the AIDS epidemic is producing orphans on an unrivaled scale. More than 15 million children under the age of 18 worldwide have lost one or both parents to AIDS. The vast majority of orphans – 12.6 million – live in Sub-Saharan Africa. With global infection rates still on the rise, HIV/AIDS will continue to inflict great suffering on children for the next decade. Because of the time lag of roughly ten years between HIV infection and death from AIDS, more and more children will be orphaned even in countries where HIV infection rates are declining.

In Malawi, orphans were traditionally absorbed into their large extended family of “mothers”, “fathers”, “aunties”, “uncles”, “brothers”, “sisters” and grandparents. These traditional safety nets are now unraveling. Extended families are struggling to keep up with the pace of looking after an ever-growing number of children orphaned by AIDS. More than two thirds of all Malawians live in dire poverty, earning less than one US dollar a day.

AIDS undermines the rights and wellbeing of children. For those that live in seriously affected communities, the whole nature of childhood is changing. Children are at increased risk of losing family property, the chance to go to school, to access healthcare and to grow and develop healthily. When a parent dies, children experience profound loss, grief, anxiety, fear and hopelessness with long-term consequences such as chronic depression, low-self esteem and learning disabilities. Many children find themselves heads of families with little or no adult supervision and loving support.

The stigma associated with belonging to a family that has been ‘tarnished’ by HIV/AIDS adds even more stress on children. Within the extended family, children orphaned by AIDS tell of being expected to work harder than other children in the family and of being the last to get food or money for school.

Girls often find themselves discriminated against in terms of inheritance, land, credit, employment and other basic services. To survive, they opt for high-risk, high return strategies such as prostitution. In Malawi, anecdotal evidence suggests that sexual exploitation of vulnerable girls is on the increase. The tragedy is that once girls settle into a life of commercial sex work, high earnings (by Malawian standards), alcohol and drugs, the process of rehabilitation is difficult and slow.
ACTION

A Global Drive

The report, *Children on the Brink 2002* – a joint UNAIDS, UNICEF and USAID publication – speaks of colossal gaps that remain between what has been, and what needs to be done to protect the rights of orphans and vulnerable children (OVC). Closing those gaps require the combined efforts of all those that are able to respond to the OVC crisis – government, donors, NGOs, faith-based organisations, the private sector and the countless community groups on the frontline of the response.

The United Nations, including UNICEF, and other partners have endorsed a global framework for action to deal with the growing ranks of OVC. Five strategies for intervention have been identified. They include: 1) strengthening and supporting the capacity of families to protect and care for their children; 2) mobilising and strengthening community-based responses; 3) strengthening the capacity of children and young people to meet their own needs; 4) making sure that governments develop appropriate policies, including legal and programmatic frameworks, as well as essential services for the most vulnerable children; and 5) raising awareness within societies to create an environment that cultivates support for children affected by HIV/AIDS.

A Big Step Forward

In Malawi significant progress has been made in addressing the urgent needs of a million orphans and vulnerable children. The country has developed a number of child-focused legal and policy instruments to help scale-up the response to the OVC crisis, including the National Orphan Care Policy (2003). UNICEF has played a leading role in these efforts by bringing together resources and a diverse range of stakeholders.
The response to the OVCs crisis has been further bolstered by the launch of a five-year National Plan of Action for OVCs (NPA) in 2005. The Plan was developed after an assessment (called the Rapid Assessment, Analysis and Action Planning Process) by UNICEF, UNAIDS, USAID and WFP of all OVC programmes and interventions in Malawi.

The NPA serves as a common reference tool for Government and all stakeholders as they work together to improve the lives of OVCs and promote the rights of all children in Malawi. UNICEF, in close collaboration with development partners, provided the Ministry of Gender, Child Welfare and Community Services with technical support to make the NPA the bold and progressive document it is today.

The NPA was given its first breath of life during the 100 Days Action Plan, which started in November 2004. Two hundred community child protection workers were trained to identify and register orphans and other vulnerable children, to set up Child Protection Committees and to report and follow up on child abuse cases. Additionally, an institutional framework for overall implementation of the plan was established.

Helping Communities Help Orphans

UNICEF has been especially effective in promoting innovative community-based strategies to provide care, support and protection to OVCs. Some 1,700 Community Based Childcare Centres (CBCCs) have been set up to look after children under the age of five and provide guidance and advice to their parents and guardians. More than 200,000 have benefitted from CBCCs to date. They are considered especially vulnerable because their development and survival are at risk of disease, malnutrition and lack of parental nurturing and care.

The community runs CBCCs using volunteer caregivers. Children are brought for playful early learning and stimulation as well as growth monitoring and nutritional support. Mothers and guardians are coached on infant feeding, vaccination and nutrition, and are referred to other social services. Around 40 percent of children coming to the CBCCs are orphans and require special support. UNICEF has helped develop a tool kit for CBCCs and trained volunteer caregivers and parent committees in early childhood development and CBCC management.

Children’s guardians and older orphans have also benefited from training in small business management skills and have been provided with start-up capital totaling US$ 150,000 in 2004. Psychosocial care and support is provided to older orphans and vulnerable children (from six to 18 years of age) through Children’s Corners. A Children’s Corner is not a structure or institution, it is a safe space where children can come to terms with the traumatic experience of poverty, disease and death of parents. Structured play, recreation and life skills are the main methods used to do this. Children come to the corners after school or at weekends, and are also fed a nutritious meal.

Many children in Malawi grow up without happy childhood memories. In the Children’s Corners, healing techniques are used such as a memory bag in which a child places all her fears or a hero’s book where a child’s damaged self-esteem is repaired by writing about how he perceives himself to be ‘hero’.

Music also plays an important role in helping children and youth express and deal with their fears and anxieties. Music is taught in Children’s Corners and instruments are provided to the children. In one case, a group of children have even produced their own CD with the help of well-known Malawian musicians. This is a great source of pride to them and contributes to self-esteem and confidence.

Child participation is essential in preparing them to make the right decisions about their lives. It is particularly important for orphans who often find themselves heads of their own households. Orphans Affairs Units have been established in Malawi to encourage greater child participation. Here children and youth, trained in child rights, life skills and HIV/AIDS prevention, provide peer support, counseling and intervene in cases of abuse and exploitation where they mediate with communities and authorities on behalf of their peers.
Feeding Children

Schools and teachers are critical to the development of OVCs, especially in the wake of the loss of parents and parenting. WFP, UNICEF and the Ministry of Education are working together on a school feeding programme in ten districts. The goal of the programme is to increase school enrollment and attendance, and reduce the high drop-out rates. All girls and boys that have lost both their parents, called double orphans, are given a take-home food ration as an incentive to stay in school. Around 210,000 children benefit from the scheme.

UNICEF, the Ministry of Health and the Christian Association of Malawi are running supplementary and therapeutic feeding centres for malnourished children and women in all of the country’s 28 districts. Malawi has the second worse rate for chronic malnutrition in southern Africa. Forty-eight percent of children are stunted. Three quarters of the country’s population does not have enough food to eat to provide the minimum amount of calories calculated by WHO to be sufficient for light physical activity. HIV infected children are more likely to be malnourished, and wasting has long been associated with AIDS.

Home-Based Care

Home-based care is another important component of OVC care and support. UNICEF has helped train home-based care volunteers, most of them women. The volunteers visit families in their areas with sick or dying people and provide practical and emotional support such as washing, feeding and counseling. Home-based care volunteers make their clients feel less alone and more loved, and in this process help other family members and neighbours reach out to people living with HIV/AIDS. The volunteers also serve as an important link in the chain of support for child facing orphanhood by helping identify vulnerable children in the homes they visit and referring them to social services. UNICEF provides volunteers with home-based care kits containing soap, bandages and ointment, as well as bicycles for transport.

Protecting Vulnerable Children

Sadly when children and women are made vulnerable by HIV/AIDS and left to fend for themselves, they often fall prey to greedy relatives. Property dispossession is a tragic but common occurrence in Malawi. It leaves vulnerable people homeless and puts them at even greater risk of abuse and exploitation. While the law protects women and children from property dispossession, traditional and patriarchal customs dictate reality.

UNICEF has attempted to redress this situation by creating public awareness of Malawi’s Will and Inheritance Act. The Act protects women and children from property grabbing. Radio dramas, community theatre, community dialogue techniques, collaboration with college law students, and the training of ‘gatekeepers’ such as traditional chiefs, village headmen and leaders of community-based organisations have been carried out to better protect women and children. The project is still small-scale and needs to be strengthened.

Keeping Track

Monitoring and evaluating policy and programme implementation represents a major challenge, as there are few well-developed indicators that capture the number of children reached, their location, the quality of care and whether activities are making a difference in the lives of children. UNICEF has been helping the Ministry of Gender to develop a National Directory on OVC Service Providers. The directory will indicate the types of activities carried out by organisations and the number of children they are reaching. The process of data collection started in 2003 and will be finished by the end of 2005.

A key aspect in reaching children is how well district government services are able to assist communities on the ground. In November 2005, district government officials started an extensive training programme in project management, accounting, and monitoring and evaluation.
Main Achievements
By September 2005, UNICEF and its partners in Malawi were able to:

- Launch a historic National Plan of Action for orphans and vulnerable children, and immediately kick start its implementation through the 100 Days Action Plan.
- Train 200 community child protection workers to identify and report on vulnerable children and child abuse cases.
- Provide learning and recreational materials to some 1,000 CBCCs.
- Train volunteer caregivers working in more than 1000 CBCCs and 961 parent committee members managing the CBCCs, benefiting more than 100,000 children under the age of five.
- Help establish 28 Children’s Corners, reaching 2,240 children.
- Give take-home food rations to 210,000 primary school children through a school feeding programme, in partnership with the World Food Programme.
- Train 3,000 guardians and older orphans in business management skills and provide them with start-up capital totaling US$ 150,000.
- Provide life-saving supplementary and therapeutic nutritional feeding to 65,000 moderately and severely malnourished children, including orphans and HIV infected children, and 40,000 pregnant and breastfeeding women.
- Train 1,410 home-based care volunteers and provide them with 1,000 kits and bicycles.

Going Big: A Scaled Up Response
With the NPA firmly in place, the road for scaling up the response to OVCs has been charted. The NPA is budgeted at US$ 206 million for 2005 to 2008, with US $70 million put aside for the first two years of implementation. It will not be an easy journey. Hurdles such as inadequate institutional and human capacity and the limited coverage of interventions for OVCs need to be overcome. UNICEF and partners will strive to bring quality family, community and government support to a greater proportion of OVCs. This will be done through a series of activities aimed at children at all stages of their development: infancy, childhood and adolescence.

The number of trained community child protection workers will be increased from 200 in 2005 to 400 in 2006. This will increase the effectiveness of their collective efforts to identify the most vulnerable children and refer them to social services.

Without birth certificates, children have no legal identity and can easily ‘disappear’ into the hands of child traffickers and ruthless employers who see them as cheap labour. They also cannot access social welfare without formal identification. UNICEF will therefore provide the Government with training, logistics, supplies and equipment to establish a birth registration system for all children.

It costs US$ 2200 to establish one community based child care centre for 100 children under the age of five

The number of UNICEF supported CBCCs will be increased from 1,000 in 2005 to 3,000 by 2010, reaching 350,000 children under the age of five with early childhood care and development activities. Older children will continue to be assisted through Children’s Corners. These psychosocial services will be expanded from the 28 corners to 1,000 corners by 2010, benefiting at least 200,000 vulnerable children. CBCCs and Children’s Corners will be linked with home-based care groups, life skills training for young people and legal aid for orphans and widows. Child participation in Children’s Corners will be promoted through a Children’s Parliament project. This initiative is based on a programme run by Consol Homes. UNICEF will provide staff training, material, equipment and programme monitoring and supervision for all these activities.
In close collaboration with the Government and development partners, UNICEF is exploring ways to strengthen social protection measures for families and children affected by HIV/AIDS. These measures, also known as “social safety nets”, can include cash transfers to people looking after orphans, child benefits, bursaries for schools, waivers for health care, school feeding, and food for work and cash for work.

**It costs US$ 2,000, per year to set up and maintain a Children’s Corner benefiting 200 vulnerable children**

A Child Friendly School Initiative – a package of rights-based school activities that promote girls education and provide safety nets for OVCs - will be implemented in 50 percent of all primary schools in the country by 2010. The school feeding programme will be expanded to 1,000 schools in collaboration with WFP and GTZ.

The number of trained community child protection workers will be increased from 200 in 2005 to 400 in 2006. This will increase the effectiveness of their collective efforts to identify the most vulnerable children and refer them to social services.

Without birth certificates, children have no legal identity and can easily ‘disappear’ into the hands of child traffickers and ruthless employers who see them as cheap labour. They can also better access social welfare with formal identification. UNICEF will therefore provide the Government with training, logistics, supplies and equipment to establish a birth registration system for all children.

By training paralegals and setting up victim support units, children in danger of being abused, exploited or disposed of their property will be provided with legal assistance and protection.

Policy development such as a Children’s Act and community mobilisation to eliminate property dispossession and prevent the sexual exploitation of orphans and other vulnerable children will underpin the delivery of services to children. UNICEF will continue to advocate for priority to be given to OVCs in national development plans such as the Poverty Reduction Strategy.

Mechanisms to strengthen working relationships between different stakeholders will be supported, and district and community capacity to plan, manage and monitor programmes in line with the NPA will be reinforced. Volunteers skilled in all aspects for OVC programming will be placed in district government services to boost capacity at that level. To broaden the scope of direct assistance to OVCs, strategic partnerships will be forged with national networks of faith-based organisations, community-based organisations and NGOs.

UNICEF will carry on strengthening monitoring and evaluation systems so that accurate information on OVCs is gathered on the ground and fed into advocacy efforts and programme planning, execution and monitoring. Where necessary, UNICEF will draw upon local and international experts to assist with programme implementation.
<table>
<thead>
<tr>
<th>ACTIVITIES (US$)</th>
<th>BUDGET (US$) 2006-2010</th>
<th>BUDGET (US$) 2006</th>
<th>BUDGET (US$) 2007</th>
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<tr>
<td>Supporting birth registration</td>
<td>1,000,000</td>
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<td>Feasibility study, technical assistance and training on social safety nets</td>
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<tr>
<td>Support 3,000 Community Based Childcare Centres</td>
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<tr>
<td>Establish 1,000 Children’s Corners</td>
<td>2,500,000</td>
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<td>Promote child participation through “OAU” style groups in all 1,000 Children’s Corners</td>
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<tr>
<td>Support 4,000 home-based care workers (training, kits, ambulance bicycles) and monitoring and evaluation</td>
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<td>Policy development and legislation review to strengthen protection of children against abuse, neglect, exploitation and discrimination</td>
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<td>Strengthen the justice system and community mobilisation to eliminate property dispossession</td>
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<td>Advocate against child labour and apply code of conduct</td>
<td>1,200,000</td>
<td>240,000</td>
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<td>Prevent sexual exploitation of OVC through a zero tolerance campaign and the application of a Children and Youth Bill</td>
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<td>Promote juvenile justice with emphasis on diversion, victim support and training of paralegals</td>
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<td>Technical assistance to district assemblies (through the UN Nationals Volunteer programme)</td>
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<td>Supplies and equipment for the districts</td>
<td>1,250,000</td>
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<tr>
<td>Train community-based organisations (CBOs) in psychosocial support, early child care, basic management and organisational skills</td>
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<td>Train and supervise an additional 200 community child protection workers</td>
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<td>Support networks for CBOs working in the area of children and HIV/AIDS</td>
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<td>Strengthen monitoring and evaluation, especially information systems at district level</td>
<td>2,500,000</td>
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<tr>
<td>GRAND TOTAL</td>
<td>25,000,000</td>
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Living with AIDS

Profiles by Gabriel Kamlomo

PROFILE 1

Janet: A mother of six at 16

At the age of 16, Janet has found herself playing the role of a mother to six sisters and a brother, courtesy of HIV/AIDS.

Just a month ago in August 2005, a sister, Aida, died of AIDS. Their father died in 2001 and was followed by their mother a year later.

This is a story of Janet Nkhalambankumutu, a living case of the harsh after-effects of HIV/AIDS in Malawi. She lives in Chiwembu village, six kilometres south of the Mwanza district capital. Mwanza district borders Mozambique and is part of what has been dubbed ‘the AIDS Highway’.

It’s 9.30 in the morning and Janet says the whole family has not had breakfast.

“We don’t even know what we will have for lunch,” she adds.

Janet remembers vividly how her father died after a very long illness that “kept mother by his side everyday”.

“After father died, mother’s stomach began swelling until she too died,” says Janet.

The only asset the family of orphans relied on, a five hectare piece of land, was taken away by her father’s relatives, leaving the children destitute.

With virtually nothing to do, some of Janet’s sisters, she confesses, are working as prostitutes. They also work in other people’s gardens in exchange for food.

Truck drivers using the AIDS Highway sometimes give them money. Other clients include local farmers. After the sale of seasonal harvests, these men, most of them married, have the money to ‘taste’ town girls who linger around the district capital looking for the next punter.

“We need food, clothes, we need lots of things. I do not like all this, but then what can we do?” she says.

None of the children including Janet are in school, a situation they attribute to their poverty.

“How do we go to school hungry? I would like to be in school but I only have the dress I am wearing,” she says.

Janet confides that when she goes to wash her dress at a nearby river, she has to hide naked in the bush until the dress dries up.

She dropped out of school in standard five. She has difficulty writing her name.

Janet, however, knows that AIDS is caused by a virus that can be acquired through sexual intercourse and that abstinence, faithfulness and use of condoms are key to slowing down the spread of HIV/AIDS.

The family lives in a grass thatched hut approximately 3.5 square metres. It is empty save for a worn out mat, a set of plastic plates and a dwarfed tin which serves as a cooking pot.

Child-headed homes, like Janet’s, are on the rise in Malawi, especially in the face of HIV/AIDS.
At 73, Edina ‘mothers’ seven

At 73, widow Edina Gilibati should have been quietly enjoying the tail end of her life if it were not for the seven great grandchildren whose parents, her grandchildren, died of AIDS.

She is back to being the mother she used to be.

Edina finds herself in the kitchen she left years ago to cook for her family, and she still has to wash dishes and clothes for some of the children. To add to her burden, she is expected to look for food.

“My grandchildren died one after the other. Now I am back doing what I was doing as a mother. Sometimes it feels like I am a mad person. I literally go around begging. At my age, I cannot till the land. I can’t even hold a hoe, yet I have all this responsibility,” Edina says.

Edina lives in a remote village in Mwanza district, a two-hour drive from Blantyre, Malawi’s commercial centre in the south of the country.

As we chat today, six of her ‘children’ are out to play with friends.

She has just recovered from a bout of malaria and faintly says, “You are lucky I can talk to you today”.

She doesn’t mince her words about her conviction that except for one, her grandchildren died of HIV related illnesses.

“It is promiscuity that is spreading this disease here,” she says, “Most of my grandchildren died of the same disease. I know”.

As she recounts her experience of looking after each of her sick grandchildren, a great grandchild sitting by her side starts to cry.

“I had no time for anything else. I had to be by their side almost day and night,” she says.

One thing she smiles about, however, is that all her ‘children’ are in school, thanks to the government’s free primary education policy. However, it may not be possible for them to go to high school as secondary education in Malawi is not free.

Edina is worried that there would be no option for any of her children who get selected for secondary education. She is too poor to pay for school fees and related expenses.

“That will have to be the end of their education,” she says.

Edina is strong. She has not given up as someone in her shoes may be tempted to do. She believes that life must go on in the face of the devastating impact of the HIV/AIDS. She is also an optimist.

“It is possible to eradicate this disease because it is possible to abstain from sex. I urge children and young people to abstain. AIDS kills. While there are other means of acquiring the virus other than sex, sex remains the most obvious one,” she says.

From a humble family of four children, Edina married a man with whom she bore five children. Her own children died of natural causes over the years.

“When you next come here, I will most probably be dead but not from AIDS. No. It is possible to live without sexual intercourse. I have done it myself. My husband died 16 years ago and I lived on,” she says turning to me and flashing a grin.

Life expectancy in Malawi is around 39 years.

A 70 year-old in this context will generally be stooped and walk with difficulty. Edina is no exception. She is a typical granny living in an impoverished setting in a typical Malawi village.
HIV positive or not, life goes on

After the death of her father, there was no choice for Annie Julio but to drop out of school. She trekked to Blantyre, Malawi’s commercial city in the Southern Province in search of employment. She got a job as a house maid.

Three years down the line, Annie loses her U$9-a-month job because she is pregnant. She returns home to face the shock of her life. She is HIV positive.

Annie, now 25, is the tenth born child in a family of 12. Her son, Joshua, is two and to Annie’s delight, “He tested HIV negative”.

Annie has no doubt she contracted the virus through sex while working in Blantyre. “Immediately after Joshua was born, I began experiencing strange health problems. That is when somebody suggested that I go for blood test. I was almost dying,” recalls Annie. It is a relief that unlike most people, Annie understood what being HIV positive means.

She is determined to go on with her life. She is now on antiretroviral drug treatment. “My CD4 count dropped drastically. It was serious,” she says.

However, until Annie discloses to you her status, one would never suspect anything. She wears a wonderful grin between her lovely dimples.

Restless Joshua is bouncing up and down in Annie’s lap as the mother narrates the story of her life.

“I am happy that my son is okay. That alone comforts me. I wish that when he grows up he becomes a priest,” she says.

Annie, a Catholic, believes that faith organisations also have a critical role to play in the fight against HIV/AIDS in Malawi.

She recalls how helpful her church was when she was advised to exclusively breastfeed Joshua for the first four months after birth and thereafter use substitute food.

Annie, a member of the local parish choir at Namitambo in Chiradzulu district, is also a volunteer and member of Namitambo Aids Support Organisation (Namaso) which has over 120 HIV positive members.

“We meet often and discuss challenges we face. There is a lot of stigma around. At least some of my fellow PLWAs (People Living With AIDS) experience this, not necessarily me,” she says.

It is here at Namaso that Annie has met the love of her life, a 32-year-old man who is also positive.

“We plan to get married. We’ve been counselled together and are aware of the meaning of what we want to do. We use condoms,” she says giggling, “ I love him so much.”

Today, Annie helps out at the local clinic in counselling fellow PLWAs.

Her biggest concern is that there are still people dying of AIDS because they did not heed advice to go for a HIV test.

“It hurts me a lot. Especially when you see a friend die they would have lived,” she says.

And when she urges her sisters to go for HIV tests, she has another problem: their husbands descend on her demanding to know “what authority I have to poke my nose in their family affairs”.

“Naturally, my sisters recoil for even if they went for the test, they would either keep results a secret or risk losing their marriages,” she observes.
Malawi is a society where men are generally the decision-makers at home and the breadwinners.

As harsh as reality is here, there is still time to smile. Annie is a reliable goal shooter in the Chiwayula village netball team. Today, her team takes on another from the neighbouring village.

PROFILE 4

Paediatric AIDS: Malawi’s growing puzzle

Three years after birth, Tita (name deliberately changed) has been visiting the local clinic every week.

Tita’s parents died of HIV/AIDS and Tita is also HIV positive.

She looks afraid. She is anaemic, malnourished and in obvious physical pain.

However, like any normal child her age, she is ignorant about what is happening to her just like she has no idea who and where her biological parents are.

To this day, Tita believes that Anan’dina, her aunt, is her biological mother, what with the love she shows her. Before she came here, Anan’dina gave her a bath, porridge and carried her on the back to a community-based child centre.

I met Tita on a Saturday morning at Namitambo AIDS Support Organisation (Namaso) in Chiradzulu district. She was among a hundred other children who were playing in the grounds at Namitambo.

She had come here for her weekly medical supplies and also her weekly ration of 15 kg of maize. Today, the organisation will also distribute second hand clothes to the children.

Difficulties associated with diagnosing HIV infection among children under 18 months, lack of adequate paediatric ARV training and lack of paediatric ARV formulation remain the major challenges in the treatment of HIV positive children.

Tita is but one of many HIV infected children shouldering the pangs of these challenges.

At Namitambo, scores of children access paediatric AIDS treatment. The majority of these children acquired the virus at birth or through breastfeeding.

Namaso Executive Director confesses that close to 98 percent of these children lost one or both their parents to AIDS.

In Malawi, where the AIDS pandemic has taken a toll, an average family of five will live on less than a dollar per day. However, scores of families are going without food and clothing and bedding.

Like a number of other southern African countries, Malawi is currently facing food shortages that, according to the UN World Food Programme, will affect close to half of the country’s 13 million inhabitants.