

PRECIOUS LIVES

Malawi's Children

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY





PRECIOUS LIVES: Malawi's Children

FOREWORD

I recently visited a primary school in a poor area in Lilongwe, Malawi's capital city. It was one of the many schools that UNICEF supports with life skills and HIV/AIDS education.

An Edzi Toto club – an extra-curricular anti-AIDS club – was in progress. I was invited in and sat at the front of the classroom with 30 curious pairs of eyes peering at me. All activity stopped and silence made way for me to speak out.

Instead of making a short speech as I had intended, I decided to find out how much the children knew about child rights and their violations. So I asked the club, "What kinds of abuse are orphaned children in Malawi experiencing?" At least 15 hands shot up instantly, fingers clicking for attention.

"They work too much fetching water," said an eleven year-old girl.

"They are whipped," responded a boy.

"Their property is taken away from them," replied a third child.

And the list went on and on. In that instant, I realised that children intuitively know when things aren't right. The greatest gift we can give children is the opportunity for them to let us know what matters and for us to assure them that we won't let them down. Our responsibility is to nurture and protect these exuberant and fragile beings.

Here at UNICEF in Malawi, we try to do exactly that.

One of our main concerns is to shield children from the devastation caused by AIDS. The epidemic is wiping out whole families and depleting community resources. Malawi has one million orphans, half of whom have lost one or both parents to AIDS. Their needs are enormous.

Fortunately a lot of good work is happening in communities to look after vulnerable children and protect their rights. The Malawian Government is helping to keep parents alive by rapidly scaling up antiretroviral treatment of AIDS patients. More than 30,000 people are receiving free ARVs and that number is expected to increase to 80,000 in 2006, reaching close to 50 percent of those eligible for treatment.

Our next step is to improve the quality of services and scale up their coverage so that we stop babies from becoming HIV positive. We ensure treatment for those who are already infected and help prevent new infections among young people. Ultimately we try and create an environment where all children benefit from protection, love and supportive guidance.

We are proud of the progress we have made in the area of child health. Infant and child mortality rates have fallen as a result of strategies and programmes that address child survival in an integrated and community-based manner.

Our efforts to vaccinate children against preventable diseases have meant that Malawi is close to eradicating polio, measles and neonatal tetanus. UNICEF support has also helped bring safe water



and sanitation to 60 percent of Malawi's rural communities. Three million bed nets have been distributed to mothers and children to prevent malaria, the country's single largest cause of child death.

The challenge now is to tackle child malnutrition, which hasn't improved for more than a decade. Malawi is prone to droughts and recurrent food shortages yet we continue to look for ways of cushioning the blow on children.

Basic education is another area where great strides have been made.

In 1994, Malawi introduced free primary education. Children streamed to school in their thousands. Today 97 percent of children are enrolled in primary education.

Gender parity in enrollment has been achieved.

However schools are struggling to cope with the huge increase in pupils. Quality of education has been compromised. There are not enough classrooms, school toilets, water supply facilities and playgrounds.

This is why UNICEF is implementing a whole package of support in schools. It includes improving teaching standards, providing school supplies, rehabilitating school building and facilities, making schools more child and girl-friendly, involving communities in school governance and introducing life skills and HIV/AIDS education to the curriculum.

The Millennium Development Goals, which in essence are about children, are the pillars around which UNICEF is rallying partners to make a difference in children's lives. Our motto in Malawi is to make children everyone's business and we never lose sight of this.

We hope that this Country Kit will give you a glimpse of how Malawi's children and women are faring, and what we are doing to help them.

Warm wishes,

Aida Girma

UNICEF Representative in Malawi

November 2005





MALAWI COUNTRY PROFILE

People

- Population: 12 million
- Children aged 5 to 9 make up almost 16 percent of the country's population.
- 88 percent of Malawians live in rural areas.
- 81 percent of Malawi's active population is involved in subsistence farming.

Health

- The infant mortality rate is 76 deaths per 1,000 live births.
- The U5 mortality rate is 133 deaths per 1,000 live births.
- 48 percent of children aged 6–59 months are stunted.
- 22 percent of children are underweight for their age.
- Five percent of children are wasted.
- The maternal mortality rate is 1,800 per 100,000 live births.
- A Malawian woman will have an average of six children.
- 93 percent of women giving birth have received some form of antenatal care from a health professional.
- Life expectancy at birth: 41 years

HIV/AIDS

- National HIV/AIDS prevalence rate: 14.4 percent
- 900,000 men and women are living with HIV/AIDS in Malawi; 58 percent are women
- 80,000 children below the age of 15 are HIV infected
- 15 percent of girls from 15 to 19 are HIV positive
- 170,000 people, including children, need ARV treatment in Malawi



Education

- 96.6 percent of girls and 96.9 percent of boys are enrolled in primary school.
- Close to 60 percent of the population in Malawi can read and write.
- Urban literacy is much higher than rural literacy.
- The school dropout rate for Malawi is five percent.
- Children from female-headed households and those living in rural areas are more likely to abandon school.
- 8.5 percent of children aged 14–17 are enrolled in secondary school.

Water & Sanitation

- Two thirds of Malawian households have access to safe water; 85 percent for the urban population; 64 percent for rural.
- 2.2 percent of Malawians have a water tap at home.
- 46.5 percent of the population gets their water from a communal borehole or well.
- 2.8 percent of Malawians have a flush toilet.
- 57.4 percent of people use a traditional pit latrine.

Child Protection

- One million children in Malawi are orphans; 500,000 have lost one or both parents to AIDS.
- An estimated 8,000 children or more live in the streets in Malawi's major cities.
- There are more than 300 children detained in juvenile wings of prisons across the country.
- 1.4 million children, aged 5 to 17, in Malawi are involved in harmful child labour; more than half work in agriculture.
- Malawi is both a source and destination for women and children trafficked for sexual exploitation.
- 85 percent of children in working in the sex trade are between 15 and 17.
- Seven out of ten children working in the sex trade came from single-parent homes.

Development

- 42 percent of Malawians earn less than US\$ 1 a day.
- Malawi's human development index ranks 165th out of 177 countries.
- An average household income in Malawi is US\$ 420 per year.
- A household spends 56 percent of its income on food.

Geography

- Location: southern Africa
- Bordering countries: Mozambique, Tanzania and Zambia
- Area: 118,480 sq km of which a quarter is taken up by Lake Malawi, the world's tenth largest freshwater lake
- Climate: sub-tropical with a rainy and dry season
- Terrain: narrow elongated plateau with rolling plains, rounded hills and some mountains.



PRIMARY PREVENTION: LIVING BETWEEN A ROCK AND A HARD PLACE

**“Let’s go.” The man’s voice was demanding.
“No”, said Prisca, pulling away.
“Come with me,” he hissed.
“I said no,” she shot back, fear swelling in her chest.**

Seventeen year-old Prisca Phiri* found herself with a knife to her throat as the man tried to force her into a car. She felt the warm blood trickle down her neck and snapped. Anger replaced her panic. She pushed the man with all her strength and loosened herself from his grip.

They were outside ‘Chez Ntemba’, a popular nightclub in Lilongwe, Malawi’s capital. That Saturday night, the dance floor was heaving with sweaty bodies. People crowded the bar, shouting out drink orders to the frenetic bar tenders.

Prisca had come to the club in the hope of striking lucky. She was a prostitute.

She did not, however, want to go with this man. She could smell trouble and her gut told her to get away.

A police officer came to her rescue. He had been standing nearby the club car park and saw her being marched to the car. He ran towards her just as she broke free from her captor and arrested the man.

“The man wanted to rape me, ” she says, shuddering. She then gently fingers the one-inch scar on her long delicate neck, as if to reassure herself that she is still alive.



Up until a year ago, the idea of making a living as a prostitute never crossed Prisca's mind. She had finished primary school with flying colours and had been selected to go to Ekwendeni Secondary School in Mzimba, one of Malawi's top missionary boarding schools.

At the time her family was sliding deeper and deeper into poverty. There was not enough money to send her to school. Prisca's dream of making something out of herself slipped through her fingers.

Her family's fate had taken a turn when her father died of malaria in 1993. Her mother, Catherine, was left with seven children.

"My life changed when my father died." Prisca's chocolate eyes become moist. "He was the one that took care of us".

Her aunt and uncle pitched in, buying them food and paying for the school fees, but three years later, they too passed away.

In a bid to secure a breadwinner for the family, Catherine remarried but her second husband soon died too. In his wake, he left an even greater threat to Prisca's family: AIDS.

'My mother is infected,' says Prisca, "When he (the second husband) died in March 2005, my mother became sick. It was very bad. She was vomiting, coughing, she was weak."

Forty-two year-old Catherine is now a bit better. She is on antiretroviral therapy but she cannot look after her family.

"My mum, she can't work," says Prisca, her eyes dropping down to her lap where she is fidgeting with a rubber bracelet. "It was difficult for her to get food for us. So I started 'that' to help." Her shame is thick around her. "I really want to stop and go back to school."

Statistics in Malawi show that seven out of ten children working in the sex trade come from single-parent families. Around 85 percent of the children selling sex are girls between the ages of 15 and 17.

"Unemployment in Malawi is very high," says Ken Warren, UNICEF assistant project officer for adolescent development and participation, "In the townships, you find 70 percent of young people without work. Boys resort to crime and girls to prostitution."

Although UNICEF cannot stop school leavers like Prisca from entering commercial sex work, every effort is made to keep young people as safe and healthy as possible.

UNICEF supports anti-AIDS clubs in youth centres and youth-friendly health services where young girls can be counselled and tested for HIV. It is important for young people to know their

status so that they can make informed choices about their sexual behaviour. Life skills are also taught to young people so that they can take better care of themselves and live their lives constructively.

Prisca earns about US\$150 a month from prostitution, three times the monthly salary of a primary school teacher.

With her earnings, she is able to pay for the rent of the two-bedroom family house, her mother's favourite food – chicken, clothes and school expenses for her six sisters and brothers, and fashionable outfits for herself like the silver tank top and black sparkly hipster trousers she is wearing.

“I want to be an airhostess. I want to have my own office. I can't work in a shop”, says Prisca in defiance when asked why she doesn't chose another vocation that may be within her reach, “Do you know how much the salary is in a shop?” she asks with a smirk, “MK 2,000!” This is equivalent to US\$15 a month, a tenth of what she earns from selling sex.

Prisca takes us to her local anti-AIDS youth club, 'Counselling of the Adolescent and Youth Organisation' (CAYO), in Kawale, Lilongwe. We walk through the library that is plastered with posters: “Cool guys always use condoms”, “Sex can wait but my future cannot”, “AIDS is our problem.

Let us kill AIDS”.

We enter 31 year-old Levison Msakambewa's office. Levi, as he's known to friends and clients, is a peer educator and Prisca's Prisca's confidant. Prisca sits shyly in a chair while Levi explains what CAYO does. “We can provide counselling and moral support to Prisca but we can't give money for her family. We don't have the means.”

With additional resources, CAYO would be able to train young girls like Prisca in vocational skills that would help them chose a safer and healthier career. In the meantime, they do their best to encourage young people to practice safe sex and go for regular voluntary counselling and testing. Peer counselling is also given to alleviate the stress and anxiety that comes from working in the sex trade.

“Prostitution is a traumatising experience for most girls, says Ken Warren, “I have met many girls like Prisca who show signs of depression, regret, fear and hopelessness”.

Prisca is caught between a rock and a hard place but her will to live safely is inspiring.

“I use condoms,” says Prisca, “My clients complain sometimes but I can't lose my life because of money. I want to have a family of my own one day.”

* Not her real name





WATER AND SANITATION: MAKING OR BREAKING CHILDREN'S EDUCATION

A pair of boy's red boxers lies discarded at the back of Kafulu Primary School. Small neat mounds of rubbish - an assortment of broken bits of plastic, paper, stones and dirt - dot the terrain around the underwear, as if they are covering something that should not be uncovered.

The briefs are a strange sight. You can't help but wonder why they were left there until you talk to Foster Phiri, Kafulu's Standard 8 teacher.

"The children use this open ground to go the toilet," he says.

Kafulu Primary in Lilongwe's peri-urban Kawale neighbourhood is the kind of large, laughter-filled school that does what it can to make ends meet. A hand-drawn cross-section of the human eye, a pencil sketch of a bird with its body parts marked, and scenes from Lake Malawi are proudly taped, albeit a bit skewed, to classroom walls.

The school pulsates with 2,387 pupils that pour out of the classrooms at break-time to chat, tease, play and...go to the toilet. However the school only has one toilet for every 111 girls and one for every 127 boys.

The toilets are in an appalling state. The stench is hard on the nose, the washbasins haven't seen a drop of water in a while, and the floors are cracked like the earth's fault lines. The cleaning lady has no hope. The school cannot afford to buy her gumboots, gloves and disinfectant. Only those on the wrong side of the law and a few brave children dare enter.

"Thieves broke into the toilets last Saturday and stole the washbasin," says Foster with a sigh.



Female students, however, bear the brunt. Because of the lack of functioning toilets, boys often use the girls' toilets and harass them. These incidents go unreported because the girls are afraid of being beaten up by the boys.

"When the smell gets too bad, the girls are forced to urinate outside the toilet," says 13 year-old student, Elida Kanimamba, "Otherwise, we hold ourselves and get a stomach ache."

Schools become even more girl-unfriendly when girls hit puberty.

"When a girl has her periods, she goes to the toilet, says 13 year-old Mwayi Chisenga, "But because there is no water, she can't wash and prefers to go home."

Poor people in Malawi don't have sanitary napkins. Cotton wool or pieces of old cloth are used instead. Girls and women have to wash frequently. Parents are reluctant to send their girls to schools because their dignity and safety are compromised.

And the more a girl misses out on classes, the more likely she is to get discouraged and eventually drop out of school. Dropout rates in Malawi are high, especially for girls and orphaned children.

A UNICEF survey in 2002 found that out of the schools with water supply, a fifth did not have operational water points. School latrine to student ratios matched or were even higher than that of Kafulu Primary.

The introduction of free primary education in 1994 opened the floodgates as thousands of new pupils flocked to class. Schools were not prepared to accommodate a two-fold increase in student numbers. Inadequate or dilapidated school water and sanitation facilities have been one of the consequences.

"The impact of poor water and sanitation on girls' education is three-fold", says Sham Mathur, UNICEF head of the water and sanitation programme, "Physical, because girls are taken out of school to carry water, protection-related because girls are vulnerable to sexual abuse when walking to get water or going to the toilet, and educational, because schools are not girl-friendly."

UNICEF is now helping schools give girls more reason to come and learn.

Pupils, parents, teachers, community members and UNICEF have come together to develop a simple and low-cost design for a female urinal. The urinal can easily be built by the school and surrounding community using local material. Washbasins are built inside the block of urinals and latrines so that girls can wash in privacy and security.

UNICEF has helped build 1,000 latrines and 63 new water points in primary schools in Malawi. Hygiene education material has

been developed for the lower primary grades to teach children how to prevent cholera, diarrhoea and other water-borne disease. More than 1,000 water points have been repaired in communities surrounding schools.

In primary schools where clean and safe female toilets have been built, girls' education has reaped benefits.

Four hours north from Lilongwe along the coast of Lake Malawi, Chihame Primary School in Nkata Bay boasts a girls' urinal, a block of eight latrines and a washbasin. The school's water and sanitation facilities were built by the community with assistance from Canadian Physicians for Aid and Relief (CPAR), a UNICEF partner NGO.

You can tell that the school is proud of its toilets. They are spotless and smell clean. After school hours, students take turns fetching water from a nearby borehole and cleaning the urinals and latrines.

Richard Chipeta, the CPAR team leader responsible for water and sanitation says,

"I feel if it had not been for the good pit latrines, most of the girls would have continued to stay away from school."

During discussions with students and other community members, CPAR found out exactly how much the new toilets had helped to keep female pupils in class.

"Girls unlike boys are the easiest to send on errands, says Richard, "So if the toilets are not good and girls go back home to use the toilet, their parents usually send them on other errands and they never make it back to class."

In other parts of the world, school toilets and water are often taken for granted. Yet for Malawi's children, they can make or break their education.





INTEGRATED MANAGEMENT OF CHILDHOOD DISEASES: HOME IS WHERE HEALTH IS

It's a scalding 35 degrees centigrade in the late morning sun in Mchinji district. The
Zambian border is twelve kilometres away and not a smudge of cloud brings relief to this
central part of Malawi or its neighbouring country.

The shop fronts in Mchinji town are painted with bright ads, offering just what your
parched mouth and pounding head think they need: "Thandi: Oral Rehydration Salts",
"Panado: For Pain".

It's so hot you feel feverish. Or is it something more serious? When you pass another
shop front advertising "Novidar: A Single Dose for Malaria", you are tempted to leap out of
the car and buy it on the spot.

The heat however, hasn't cut your appetite. You can smell the sweetness of mandazi—
Malawi-style doughnuts—as they dance around in a pot of sizzling oil. In that moment, you
spot yet another hand-painted ad: "Kazinga: Vegetable Oil Enriched with Vitamin A".

What are all these ads telling us?

That Mchinji district, like the rest of the country, is affected by a number of preventable
diseases.

In Malawi, one out of every thirteen children die in their first year of life. One in seven will
never make it to their fifth birthday. Most children die of malaria, diarrhoea, acute
respiratory infections and nutritional deficiencies. Malnutrition and the lack of safe water and
sanitation contribute to half of all these children's deaths.

But disease isn't inevitable, nor do children that fall sick to these illnesses need to die.
Research and experience show that children can be saved by low-tech and cost-effective



measures such as vaccines, antibiotics, oral rehydration therapy (ORT), micro-nutrient supplements, insecticide-treated bed nets and improved family care and breast-feeding practices.

These measures as the basis of a UNICEF-supported programme in Malawi called the Integrated Management of Childhood Illnesses (IMCI).

IMCI was developed in 1992 by UNICEF and WHO as way of dealing with the leading childhood killers in the developing world. More than 80 countries have adopted IMCI into their health systems; more than forty countries are working closely with families and communities as a means of reaching vulnerable children.

IMCI focuses on both prevention and medical treatment.

How children are cared for at home and in the community has a decisive impact on their chances of survival. Communities are therefore taught about the importance of prenatal visits for a pregnant woman, exclusive breastfeeding for six months, immunisation, vitamin supplementation, malaria control, safe feces disposal, hand washing, and active participation of men in childcare.

Community health mobilisers called health surveillance assistants also train families in home management of illness

and how to recognise the warning signs of a life-threatening disease.

In health clinics, health workers are trained to examine and treat a sick child holistically. This means looking beyond the immediate symptoms to other underlying conditions such as mal-nutrition and HIV infection.

Forty kilometres from Mchinji town, along a road of rust-red soil, lies Chimteka trading centre. It looks like one of those dusty towns from a Western film. You'd almost expect to see John Wayne striding out of a building except that there's a long line of people waiting at the agricultural depot for their share of the newly introduced cheap government fertiliser. Chimetka farmers, like most in Mchinji district, grow tobacco as a cash crop and maize for subsistence.

At the local health clinic – Chiosya Health Centre – a woman with her ample breast exposed, walks out into the heat holding a sleeping baby. She seeks the shade of nearby tree where she hoists the infant onto her back and secures him with a kanga (sarong). She walks off.

Thirty-seven year Bertha Zulu, the clinic's health surveillance assistant, is about to do her rounds of the village. As a mother of a four-year old girl and guardian of three orphans, she knows only too well

how important it is to keep children healthy at home.

“My work involves giving health talks in the village and referring patients to the health centre and district hospital,” she explains, “I also do growth monitoring and immunisation for children.”

Bertha is a much-loved figure in the village. She’s been a health surveillance assistant for nine years. Everyone knows her.

“I like my job very much because I get to interact with people in the village,” Bertha says, “It sometimes takes time for people to change their behaviour. People need patience to grasp what I am saying.”

Health surveillance assistants are at the frontline of primary healthcare in Malawi. Originally recruited as smallpox vaccinators in the 1960s, they now form an extensive network of ground staff, bridging government health services and communities.

Bertha is visiting one of her favourite clients, 25 year-old Naomi Jameson, who lives a few kilometres away from the clinic.

Naomi, who is clad in a white blouse and a sarong depicting Samora Machel in military fatigues, is waiting inside her house. Her two youngest children, a three-year old boy and a five-year old daughter, play behind the house.

Her two-room mud-brick home is a heaven of cleanliness.

Traces of a sweeping broom crisscross the compact mud floor of her living room. A pair of black shoes sits on top of a roof beam. A clock stuck forever at 10.23 am, a radio, and a 2005 wall calendar from ‘NBS: Your Caring Bank’ hang off the wall.

There isn’t much room for anything else in the small front room except an important household resource: drinking water stored in a clean blue plastic bucket with a lid on it. Two plastic cups are attached to the bucket, one for taking the water out and the other for drinking.

In an even smaller bedroom, a green rectangular mosquito net covers a grass mat on the floor. Naomi bought her net a few months ago from Chioshya Health Centre at a subsidised price of 50 US cents. This was after Bertha gave a health talk on how malaria is responsible for most of Malawi’s child deaths.

“I sleep under the net with my youngest boy and girl,” says Naomi, “I want to protect myself and my children from the mosquito which causes malaria.”

At the back of the house, a latrine with a hygienic concrete slab is another source of pride for Naomi’s family. It’s an improved VIP latrine, the model promoted by UNICEF and partner organisations.

Next to the latrine is ingenious hand washing device: a plastic milk bottle that has been cut in half and perforated at the bottom. Water is poured into this ‘hand shower’ and then falls onto a pile of broken bricks. This prevents a pool of dirty water from contaminating the entrance of the latrine.

Bertha’s health talks and regular visits have paid off. Naomi seems to have her children’s health under control. Her next goal is to start a business.

“With MK10,000 (US\$75), I’d like to start a tea house, selling mandazi, scones and tea”, she says.

The family has already bought two piglets that will be sold in a year for up to three times the price.

With her Samora Machel sarong, there is no doubt that this young woman has what it takes to fight for her family’s welfare.



MALARIA CONTROL: NETS FOR ALL

Gospel music is blaring out of a radio. In a large warehouse room, men in blue protective overalls are stacking carton boxes as if building the Great Pyramid of Giza. A group of woman, dressed more casually, sit at tables humming to themselves and packing the content.

This is belly of Malawi's Insecticide-Treated Mosquito Net (ITN) distribution programme.

The warehouse, located in Blantyre, the country's commercial capital in the south, belongs to UNICEF's main NGO partner in the national malaria control programme, Population Services International (PSI).

It is here where ITNs and other products are assembled and repacked, ready to be loaded onto trucks and vans for distribution to shops and public health centres.

"In one day, 30 of us can repackage 200 bales of mosquito nets," says 25 year-old warehouse packer, Misonzi Hakisangoma, "Everyone likes this job and we don't get tired. We're used to it."

PSI, a US-based agency, is the world's leading non-profit social marketing organisation. It uses commercial marketing strategies to promote health products, services and healthy behaviour to help poor people lead healthier lives.

The Malawi ITN programme evolved over a period of two years, from 2001 to 2002, during a UNICEF-supported pilot project in Blantyre. It took eight months to expand the model from three districts to a nationwide programme covering all 28 districts of the country. In that time, 1,800 nurses were trained to promote and sell nets.



Heavily subsidised ITNs, manufactured in neighbouring Tanzania, are delivered through antenatal clinics. Since 93 percent of Malawian women visit an antenatal clinic at least once during pregnancy, the clinics provide an efficient and direct access to the main malaria risk groups: mothers-to-be and children under the age of five.

Green rectangular nets, preferred by rural people sleeping on mats, are stored at the health centre and promoted by nurses during their consultations with women. Only pregnant women and children under five carrying valid health passports or antenatal cards are eligible for the subsidised price of US\$ 0.5 per net.

The nets last up to three years and need to be retreated with insecticide once a year.

Other target groups (other than under five children and pregnant women) in rural areas are able to buy an ITN from a community health committee for just less than one US dollar. The unit price from the manufacturers is US\$2.25

Since 2002, Malawi has delivered over 3.5 million ITNs. The proportion of children sleeping under a net rose dramatically from seven percent in 2001 to 60 percent in 2005. Today, Malawi has one of the largest ITN distribution programmes in Africa.

“The Malawi model is recognised around the world as one of the success

stories in the global roll-back malaria partnership,” says John Justino, PSI Resident Director, “Few programmes have gone to national scale so quickly.”

In Bangwe Maternity Clinic, a twenty-minute drive from the PSI warehouse, nurse and midwife Melania Chikwekwe is taking a break from her demanding job.

“We get a lot of patients with malaria here,” she says, reaching out for a cup of tea, “We see about 30 people a week with symptoms of the disease – vomiting, diarrhoea, fever and general body pains.”

Malaria is a vicious killer of children and women in Malawi. It accounts for almost a fifth of all hospital deaths and 40 percent of outpatient visits.

Pregnant women are particularly vulnerable to malaria. Pregnancy reduces a woman’s immunity, making her more susceptible to infection and increasing the risk of illness, severe anaemia and death.

For the unborn child, maternal malaria increase the risk of spontaneous abortion, stillbirth, premature delivery and low birth weight – a leading cause of child mortality.

In children under the age of five, the malaria parasite contributes to Vitamin A deficiency and anaemia, and slows down a child’s growth.

“We encourage each and every mother and young child to sleep under a net,” says



Melania, “We demonstrate how a net can be used and after our health talk, the mother usually buys a net.”

The success of ITN delivery in Malawi is based on a solid partnership between the Malawian government, international donors, UN agencies and NGOs. The Ministry of Health provides leadership and overseas policy development and implementation. UNICEF, WHO, USAID, the Centre for Disease Control, Atlanta, and the British government’s Department for International Development (DFID) give financial support, technical expertise and policy input.

“The key for success is that all partners have decided on one strategy and there is a clear set of national guidelines for malaria control,” says PSI’s John Justino.

Plans are now being made to distribute free nets to the poorest of the poor. This supplementary programme will help boost Malawi’s goal of reaching global malaria control targets by the end of 2005. More importantly thousands of children will be given the chance to stay alive and lead healthier lives.

**LETS SUPPORT THE ORPHANS
ITS A RESPONSIBILITY FOR ALL OF US**

***KUSAMALIRA ANA AMASIYE
NDI UDINDO WA WINA ALIYENSE***

ORPHAN CARE: COMMUNITIES IN CHARGE

On the exterior wall of Namasimba, the entire English alphabet is illustrated with everyday animate and inanimate objects found in Baluti township, Blantyre, the home of this community-based child centre.

A drawing of a large axe with a brown wooden handle and grey blade lies next to 'A is for Axe'. 'B is for Bloom' doesn't correspond to a flower opening itself to the summer light but rather a broom. 'C is for Chicken' and a white hen with its red beak open is painted next to the letter.

The front yard is swarming with small children carrying bags of goodies almost their size. Mary's Meelies, an organisation that mills maize and provides porridge flour to children's centres and health clinics for children under five, has hosted a Christmas party for Namasimba.

Each child has received clothes, biscuits, crisps, a fizzy drink and sweets. In this impoverished community where many of the children are orphaned, some girls and boys stand around bewildered, clutching their gifts to their chests.

A group of five children sit in a circle singing Twinkle Twinkle Little Stars. None of them speak good English yet they have memorised the words and belt them out in all earnest.

"We like our teachers because they teach us the alphabet, singing and poems," says six-year old Boniface Masangano.

Boniface is a double orphan; he has lost both of his parents to AIDS. He is now being looked after his aunt who brings him to Namasimba for playful early learning and stimulation.



“My auntie buys me clothes, food, shoes”, says Boniface, “She washes me and brings me to school.”

There are about one million orphans in Malawi. Half a million of these children have lost one or both parents to AIDS.

Losing a parent to AIDS is terrible for any children, but children living in developing countries who lose parents to AIDS face unthinkable hardships.

Anecdotal evidence speaks of orphans forced into domestic work by their caretakers to earn their keep. Reminiscent of Charles Dickens’ *Oliver Twist*, pauper children are vulnerable to ill treatment. Orphaned girls are particularly at risk of

sexual abuse and exploitation. Stigma and discrimination trail these children everywhere they go.

“A lot of people in Malawi don’t have the resources for day-to-day living,” says Esther Ndaipalero, a social worker with UNICEF government partner, the Ministry of Gender, Child Welfare and Community Service, “They have to think twice before committing themselves to looking after orphaned children.”

Namasimba is one of the many community-based child care centres (CBCCs) that tries to lighten the burden of care for families.

CBCCs are not orphanages but rather

day-care centres, operating until mid afternoon whilst parents and caregivers are out working.

“We promote community care for children who have lost their parents instead of institutionalising them,” says Mayke Huijbregts, UNICEF project officer for orphans and vulnerable children, “Every child has the right to be loved and cared for in a family-like environment.”

Malawians would agree. CBCCs have existed for the past 30 years. Today there are around 1,700 CBCCs looking after more than 170,000 young children.

UNICEF has been supporting CBCCs since 2002. More than 1,000 volunteer caregivers and parent committees have been trained in early childhood development. UNICEF has also supplied centres with play and learning material.

Fifty-seven year-old Mary Agnes Chunga is Namasimba’s dynamic founder. Her office table is covered with children’s colouring books and crayons donated by UNICEF. Exercise books cut in two so that there is enough to go round lie in a heap in the corner. She’s just come back from a neighbour’s funeral up the road. The 30 year-old man died, leaving his fourth wife sick.

“Having seen the situation because of this deadly disease,” says Mary, “It came to

my mind to see the village chief. I wanted to get children together and start feeding them. There was so much hunger and children had no parents.”

A meeting, facilitated by a social welfare officer from the Ministry of Gender, was held with the whole community. Everyone agreed that something needed to be done for children in the neighbourhood. A committee was set up to run Mary’s child care centre. Namasimba, named after a nearby stream, was registered in 2002.

“We started with 25 children and we now have 400”, says Mary, “We first started with a makeshift shelter covered with plastic sheeting and then St Andrew’s Secondary School (a wealthy private school in Blantyre) gave us money to buy a house”.

Namasimba has ten dedicated volunteer caregivers. Two of the women are HIV positive.

“We don’t discriminate,” says Mary.

Mary saw one of the women washing clothes with her small baby at the stream. The woman looked sick, prompting Mary to invite her to the centre for some food. The woman’s baby soon died. Mary nursed the grieving mother back to health and now she’s been incorporated into the ‘Namasimba family’ and works as a caregiver.

“The spirit of volunteerism is with these caregivers because they can share their experience with others like them,” says Esther Ndaipalero, the social worker who often visits Namasimba to check up on how the children are faring.

“It’s true,” says 27 year-old deputy teacher and caretaker, Dorothy Kachule, “I have been here for some time and have even contributed my own personal resources just to make sure that the centre flourishes.”

With all the loving energy that is invested in Namasimba, it’s upsetting to hear that the centre’s fate hangs in delicate balance.

Funding from the Malawi National AIDS Commission has helped the centre buy the children’s food. But it’s running dry and will be phased out in December 2005.

“We’ll be stuck,” says Mary, “We’ve asked for contributions from our own community, but it’s not enough.”

CBCCs are providing an invaluable community service. As the case of Namasimba demonstrates, they are, however, struggling to keep up with the pace of Malawi’s growing ranks of vulnerable children.





PREVENTION OF MOTHER-TO-CHILD TRANSMISSION: MEN ARE KEY

Thirty year-old Rebita Venancio hitchhiked to Mwanza District Hospital. She's eight months pregnant with her fifth child. Her husband, a farmer, sometimes takes her to antenatal clinic on his bicycle but today he isn't available. When he is, he waits for her outside because as Rebita points out 'there are only women inside the ward.'

Rebita, who lives on the Malawi/Mozambique border four kilometres away, has come to the clinic for a physical check-up. She has already had her first HIV test but needs to come in for another one when the three-month window period elapses.

The M1—dubbed "the AIDS Highway" because of its booming sex trade that services truck drivers and local men—passes through Mwanza. At 18.5 percent, the HIV/AIDS prevalence rate in the district is higher than the national rate of 14.4 percent.

Rebita is concerned that her husband may leave her if she doesn't comply with his desires.

"I have no right to decide whether this is our last baby or not because all decisions rest with my husband who is the head of the family," she says, eyes cast downwards as she plays with her health passport, "If I object, he may end up picking another woman."

There is a deep-rooted belief in Malawi that the role men play in family affairs is one of control rather than shared responsibility. As mutu wa banja (heads of household), men often abuse their authority by having extra-marital affairs or drinking excessively.

In Mwanza district, however, men are starting to break with tradition.



In November 2004, the Ministry of Health, with support from UNICEF, pioneered an innovative project called the Male Champion Initiative. The aim was to get men more involved in their partner's reproductive health.

Men are encouraged to accompany their wives to antenatal clinics where services such as Prevention of Mother-to-Child Transmission of HIV (PMTCT) are offered.

"Women are afraid to go for voluntary counselling and testing because of stigma and the fear that they will get blamed for contracting HIV," says Dr. Wilson Tamaona, the Mwanza District Health Officer, "The Male Champion Initiative and PMTC are a great link to overcome this."

There are now 36 clinics out of the country's 524 hospitals and health centres that offer PMTCT. In 2005, UNICEF provided support to 30 PMTCT clinics by training nurses, supplying HIV test kits and providing overall project supervision.

In Thulonkhondo Health Centre, a bumpy drive through tangerine and mango orchards, Frighton Richman and his wife, Beatrice, are waiting for an ambulance. Their five-month baby boy is anaemic and needs to go to Mwanza district hospital, a half-hour drive away.

Frighton is cradling his son, who wears an amulet given by a traditional healer



around his neck. Beatrice sits on the floor with their cream-coloured dog, Jack, next to her feet.

They are one of the many couples that are part of the Male Champion Initiative at Thulonkhondo.

“When my wife was pregnant, we came together for an HIV test,” says Frighton, “We tested negative and were counselled to keep healthy.”

“I did not have a hard time convincing my husband to come with me to the clinic,” adds Beatrice, “I was happy he came with me. It shows that he loves me. If he had refused, I would have been disappointed and would have known he had other partners.”

The Male Champion Initiative was introduced to the community through

traditional authorities. Traditional chiefs were first approached and later a series of community meetings and drama performances were held to stimulate discussions around HIV/AIDS and PMTCT.

“We had to use the group village headman,” says Rex Bwanausi, the officer-in-charge at Thulonkhondo, “He is very influential in the village. Anything said by the headman is taken to be true.”

Women who come to the antenatal clinic with their spouses are attended to first. Once there, it is easier for health workers to get men to go for VCT. If they test positive, they are referred to the district hospital for antiretroviral therapy.

“The number of male spouses being tested for HIV has increased tremendously,” says Rex.

A floating trophy, based on the number of couples attending PMTCT services at a health clinic, was also introduced to encourage community leaders and health centres in the district to promote the Male Champion Initiative.

“There was a tug of war between health centres, says Rex with a grin, “Thulonkhondo happened to be the winner in 2005.”

Their traditional chief won the trophy and a bicycle to help him travel around the villages promoting the project.

An evaluation of the Male Champion Initiative shows that the use of traditional authorities as community role models has helped encourage male involvement in PMTCT.

The project has also helped improve the relationship between health workers and clients. Nurses are reported to be welcoming men to antenatal clinics and actively involving them in activities.

The Male Champion Initiative is now ready for expansion to other parts of the country hard-hit by AIDS.

“It is difficult to convince men in Africa to change,” say Dr Tamaona, “But if you do, you are very successful.”

People represented in photographs are not the people mentioned in the article



NUTRITION: FIGHTING MALNUTRITION AND AIDS TOGETHER

Hilda Khengere's mobile phone rings all the time. She presses it to her diamante-studded ear and talks rapidly as she gets up to walk to another room. Her red beaded AIDS ribbon, fastened to her chest, shifts with every movement of her white nurse's uniform.

In between calls, she directs her colleagues at the nutritional rehabilitation unit (NRU) like a seasoned orchestra conductor.

'This child, I'm going to let go home,' she says to another nurse just as the Nokia tune goes off again, 'The grandma is fed up of being here.'

The NRU, at Blantyre's Queen Elizabeth Hospital, is one of 60 centres supported by UNICEF where young malnourished children can be provided with lifesaving therapeutic food and medical attention.

In Malawi, almost half of all children under the age of five are stunted, a sign of long-term poor nutrition. Five percent are wasted or acutely malnourished. A fifth of children are underweight because they are either stunted or wasted.

The most recent Demographic and Health Survey for Malawi shows that malnutrition rates have not improved since 1992.

In 2005, Malawi was hit by its worst food crisis in more than ten years. Production of maize, the country's most important staple crop, plummeted to its lowest in a decade. Close to five million people, including one million children, needed food aid, nutritional rehabilitation as well as maize seeds and fertiliser.



Malnutrition is a critical factor in child survival. In the past, most malnourished children would stand a chance of full recovery but with the rapid spread of HIV/AIDS, many are doomed to a life of illness and frequent visits to health centres and hospitals.

Eighty thousand Malawian children under the age of fifteen are living with AIDS. Most contracted the virus from their mothers during pregnancy, childbirth or through unsafe infant feeding where mothers breastfeed and give their babies other food at the same time.

"We see about 1,500 children a year," says Dr. James Bunn, Hilda's boss, "Half of

our children have HIV infection and the mortality rate is high."

Dr Bunn, a lecturer from the School of Tropical Medicine in Liverpool and a consultant paediatrician specialising in children with AIDS, has been at Queen Elizabeth Hospital for two months. He came to work in Malawi because of the country's proactive approach to malnutrition and AIDS.

"The Malawian government is doing a lot more than other countries in the region to address HIV/AIDS and malnutrition together," he says.

The Ministry of Health, in collaboration with UNICEF, WHO and NGOs, is working

on a policy and guidelines for HIV/AIDS and nutrition. Malawi is the first country in Africa to produce its own ready-to-use therapeutic food for the management of severe malnutrition called Plumpynut.

As part of the country's Prevention of Mother-to-Child Transmission of HIV programme, UNICEF is also helping educate Malawians on infant and young child feeding practices. Infected pregnant women and mothers are counselled on what options they have to feed their babies, including exclusive breastfeeding for the first six months of a child's life.

Thirty year-old Blandina Chiphwanya is at the NRU with her three year old daughter, Patronella. The ward in which they sleep smells nutty and stagnant. Although it's over 25 degrees Celsius outside, the heaters are on to keep the sick children warm.

Patronella looks like she's been punched. Her small face is swollen from Kwashiorkor, a malnutrition disease. She was diagnosed with tuberculosis in 2004. She has been on medication but her cough and frequent fevers won't go away. This time round she has pneumonia.

'It makes me feel bad that my child is sick all the time,' says Blandina, "I can't work at my house anymore because all I do is take her to the hospital."

Blandina's two other children are healthy.

Treating a child for malnutrition in the context of AIDS can change the course of a family's life forever.

If after a week of specialised feeding, a child has not picked up weight, the NRU will send the child and caregiver for voluntary counselling and testing (VCT) at the main hospital. If the child tests positive and qualifies for treatment, she is put on antiretroviral therapy and sent home with a month's supply of drugs and Plumpynut. The therapeutic food is added to the child's porridge or eaten on its own until the child regains 85 percent of its normal weight for height. The ARVs need to be taken for the rest of the child's life.

"A mother needs to be 100 percent sure she can administer ARVs to her child," says Hilda, "That is why counselling is so important."

Eighteen year old Lonely Chiphazi, another mother at the NRU, seems to be a little luckier. She and her two year-old daughter, Kumbukani Smoko, have been for VCT. Both tested negative. Kumbukani however has diarrhoea and has dropped to just under seven kilos.

"I am sad that my daughter is sick," says Lonely, "But I am happy that we are negative. I can plan my life and avoid

mistakes in the future. The father is not a responsible man."

Outside of the NRU ward, a bright orange flame tree provides shade to women and children chatting, plating hair and watching people walk by. A hospital cleaner mops the staircase behind. Baby clothes, sarongs and women's blouses lay dripping over the ward's perimeter fence.

The world feels as if it has stopped yet behind the ward doors, everything is being done to keep the world going for thousands of malnourished children.



UNICEF MALAWI

**P.O. Box 30375
Capital City
Lilongwe3
Malawi**

Tel: (265-01) 770 788 / 770 770 / 770 660

Fax: (265-01) 773 162

Email: lilongwe@unicef.org

Text: Tamara Sutila

Research: Tamara Sutila and Kwakwarhi Mwanamai

Photography and Design: Giacomo Pirozzi