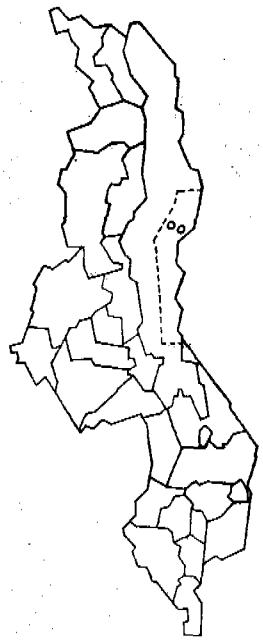
UNICEF



Strategy Paper

for the
Government of Malawi
& UNICEF Lilongwe
Country Programme of Cooperation
2002 - 2006

unicef

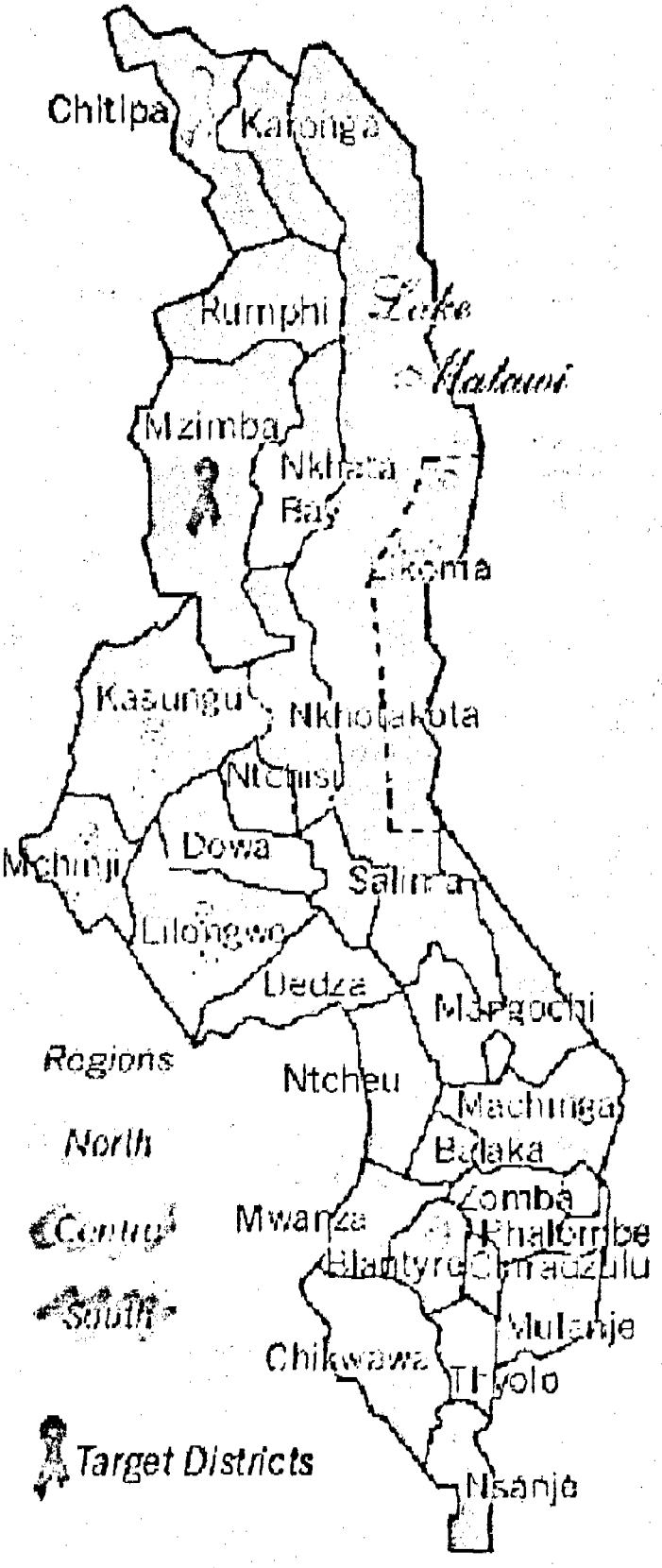
Draft for Discussion at the Formal Strategy Meeting
Lilongwe, 10th October 2000

TABLE OF CONTENTS

List of Abbreviations

ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
BSS	Basic Social Services
BMHI	Bakili Muluzi Health Initiative
CBO	Community-Based Organisation
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CIDA	Canadian International Development Agency
CPAR	Canadian Physicians for Aid and Relief
CRC	Convention on the Rights of the Child
DFID	Department for International Development
ECCSGD	Early Childhood Care for Survival, Growth and Development
EHP	Essential Health Package
EPI	Expanded Programme on Immunisation
ESARO	Eastern and Southern African Regional Office
EU	European Union
FAO	Food and Agriculture Organisation
GNP	Gross National Product
GOM	Government of Malawi
GTZ	Gesellschaft Technische Zusammenarbeit
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HRAP	Human Rights-based Approach to Programming
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide-Treated Net
MIE	Malawi Institute of Education
MP	Member of Parliament
MTR	Mid-Term Review
NACP	National AIDS Control Programme
NGO	Non-Governmental Organisation
PEA	Primary Education Advisor
PMTCT	Prevention of Mother-To-Child-Transmission
PTA	Parent-Teacher Association
SCF	Save the Children Federation
STD	Sexually Transmitted Disease
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBA	Traditional Birth Attendant
UDF	United Democratic Front
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNF	United Nations Foundation

UNFIP	United Nations Fund for International Partnerships
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB	World Bank
WFP	World Food Programme
WHO	World Health Organisation
WVI	World Vision International
YFHS	Youth-Friendly Health Services
YTSC	Youth Technical Sub Committee


Chitipa
Karonga
Rumphi
Lake
Nkhata Bay
Kasungu
Nkhotakota
Ntchisi
Dowa
Salima
Lilongwe
Dedza
Ntcheu
Machinga
Balaka
Zomba
Mwanza
Chikwawa
Nsanje
Regions
North
Central
South
Target Districts

SECTION ONE: SITUATION ANALYSIS

1-1 THE SITAN PROCESS

Building on the Common country Assessment (CCA) exercise, the Interim Poverty Reduction Strategy Paper (IPRSP) presented to the donors consultative group in May 2000, the MTR results, the situation analysis exercise was participatory, involving various stakeholders at the family, community, civil society, government, and international community level.

The CCA started in February 2000 after the United Nations Country Team (UNCT) steering committee made of the Head of Agencies set up the following working groups: Basic Social services which include education, health and nutrition, water and sanitation; Governance and Human rights; Population, Economic and Poverty Alleviation, the HIV/AIDS, Gender Equality and Women Empowerment. These groups made of representatives from the government, the civil society including NGOs, donors, Breton woods institutions, conducted the CCA which aims at assessing Malawi progress in light with the UN sponsored international Conferences.

A team of researchers of the University of Malawi conducted the situation analysis. The Human rights based conceptual framework in light with the convention of the Right of the Child (CRC) and the convention of the elimination of all forms of discrimination against women (CEDAW) was used to conduct the situation analysis. The Joint Co-ordinating committee (JCC), a body which oversees the GOM/UNICEF Country programme of cooperation development and implementation set up a technical working group to provide guidance to the Researchers. The situation analysis technical working group included representatives from line ministries, UN system, NGOs. This working group is co-chaired by the Ministry of Finance and UNICEF.

Methodology used for the situation analysis included: review of related literature and policy documents on the social, cultural, political, and economic situation of children and women. Key informants in a position to provide data and information on the situation of children and women were interviewed and these included officials from appropriate government ministries including health and population, education, gender, youth, and community development, agriculture, labour, water development, economic planning, environmental affairs, local government, and justice. Other Malawi development partners including the donors community, UN organisations, NGOs, CBOs working in sectors benefiting women and children.

The situation analysis also involved field consultations with people living in rural communities who articulated the causes and solutions to the problems of children and women. Participative Rural Appraisal (PRA), focus group and interview of vulnerable children were used to record the experiences, needs, and violations of the rights of selected girls (126), boys (112), and women (186), living in villages in Mzimba, Mchinji, Dedza, Mangochi, and Chikwawa Districts.

The programme working groups established to monitor the GOM/UNICEF sectoral programmes implementation provided technical input at the different stages of the SITAN. These groups also include adequate guidance to the Researchers on how to fill information gaps. Further, discussions were organised with stakeholders involved in GOM/UNICEF Country programme who provided during the 2000 mid year review of the Country Programme. The methodology of identifying key issues and for objectives and strategies formulation as adopted during the stakeholders meeting in Zomba is included in *Annexes 3-5 which gives examples of the process for the water and Sanitation Sector.*

1-2 SOCIO AND ECONOMIC CONTEXT

The constitution provides three organs of powers, which are the Executive, Legislative and Judiciary. The Constitution also provides for the establishment of the Human Rights Commission, Law Commission and the office of the Ombudsman. The executive is centred on the President and a cabinet appointed by the President. The current legislature is made up of elected members from the three major parties of United Democratic Front (UDF), the Malawi Congress Party (MCP) and Alliance for Democracy (AFORD).

After 30 years of one-party rule, Malawi, a nation of 9.8 million people, went through a transition to multi-party democracy in 1994. With a per capita GNP of $210[1], the country faces widespread poverty. The country's primary source of foreign exchange is through the sale of tobacco, an industry that is likely to face a global downturn. The country relies on one subsistence crop, maize, to feed itself. This leaves a large proportion of the population vulnerable to food insecurity and malnutrition when there is a poor harvest.

The population density is the highest in the southern African region with 171 persons per square kilometre of arable land. 72% of smallholders cultivate less than 1 hectare of land, and one-third of agricultural land is marginal and unproductive. Poor agronomic practices combined with widespread deforestation have caused serious soil erosion, loss of fertility and degradation to the environment.

The above factors have a negative impact on the nutrition status. Available data suggest that a large proportion of the population suffers chronic food insecurity; half of all Malawi children are stunted (chronically undernourished), with a third being underweight. Only 47% of the population have access to a safe source of water, and 97% lacks adequate sanitation facilities. Per capita income is about $210.

Adult illiteracy rate stands at 65% for women and 40% for men. The general adult literacy rate declined from 50% in 1990 to 42% in 1999. To address the low literacy rates, the government instituted free primary school policy in 1994. This was an enormously popular move, which resulted in attendance skyrocketing from 1.9 million pupils to 2.9 million. The primary school system was unprepared for such an increase and still strains to meet the demands. Only 23% of students entering primary school complete all eight standards. Secondary school achievement is also low – over each of the last five years fewer than 20% of candidates passed the national secondary school examination (MSCE). Currently it is estimated that 16% of teachers leave their profession annually.

The Malawi government ratified the Convention on the Elimination of All Forms of Discrimination Against Women in 1987 and the Convention on the Rights of the Child in 1991. The Constitution provides strong guarantees for human rights and freedoms. However, the entrenchment of democracy does not take place over night – the attitudes developed during a thirty-year period of dictatorship persist; though the intensity may be diminished. Dissent is not always tolerated, people are too often unwilling to speak up and act on their own behalf, levels of information are low, the concepts of rights are not fully understood, and women and children are disadvantaged.

The status of women needs marked improvement before they are assured of some measure of equality in society. Female-headed households make up about 35% of the total population of Malawi, but are disproportionately represented in the lower income distribution levels.

Children's rights are routinely abused as a result of poverty, HIV/AIDS and ignorance. Girls in particular are discriminated against, have low status and suffer abuse in many forms, from harmful traditional practices to rape to marginalisation to exclusion from education. Child labour is a problem particularly in the Tea/Tobacco Estates area. Although there are laws to prevent child labour, they are not enforced. There are few opportunities for disabled people to develop the skills or have access to the tools they require to live a life with decency and self-esteem. The above situation result in individuals being deprived of their rights to realise their full potential. Not only is their own human dignity impaired – their communities are deprived of needed talent.

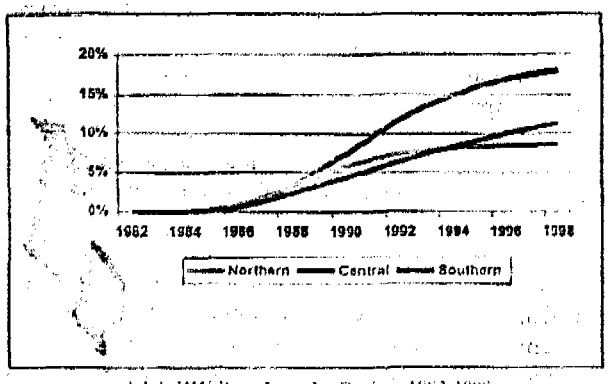
Organs of civil society hardly existed six years ago, have grown rapidly in number. These organisations are making contributions to the progress of participation and development. The consolidation of democracy and human rights requires the constant vigilance of both citizens and government. The constitution have facilitated the establishment of accountability institutions the Office of the Ombudsman, the Anti-Corruption Bureau,

[1] The Progress of Nations 2000

and the Law Commission. Additionally, a Human Rights Commission (with a Child Rights Unit) and a Parliamentary Committee on Women and Children have been established.

The GoM has stated that *"poverty alleviation is the operative development philosophy of the country."* The principal role of government is seen as providing a conducive environment for poverty reduction, and the success of the program depends on strong partnerships with NGOs, the private sector and donors. The government's Poverty Reduction Strategy Paper will be issued next year. For the past several years budgetary allocations to social services have increased over the years (as a percentage of GDP); however, expenditure levels directed to basic social services are low when related to the enormity of the problems being addressed. Next year will also see the preliminary results of the 2000 Demographic and Health Survey. Much of the information available in Malawi has been unreliable and/or old, the previous DHS was conducted in 1992. The current survey is expected to yield reliable information and will be a valuable tool for planning.

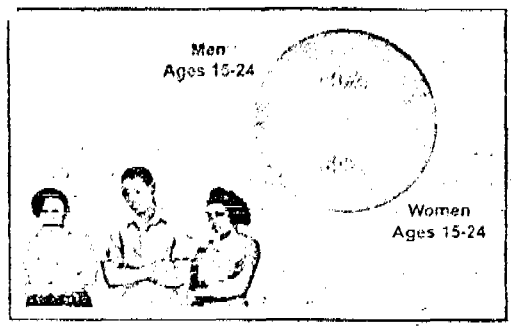
A policy that will have significant and widespread ramifications is the de-centralisation of government. Local government elections, scheduled for the latter part of 2000, will create district assemblies in each of Malawi's 27 districts. The structures and procedures set up will facilitate local planning in government and development. This coming milieu holds the promise for new approaches to delivery of services and community involvement.



Adult HIV Prevalence by Region, 1982-1998

Despite considerable investment by Government and its development partners in social sectors, infant and under-5 mortality rates remain very high at 134 and 213 per 1000 respectively. Maternal mortality is also very high at 620 per 100,000 live births. With the spread of HIV, even more mothers are dying, leading to a further increase in the number of orphans. 48 percent of children under five years old are stunted in Malawi, while 30 percent of children under five are underweight.

The HIV seroprevalence rate in Malawi is one of the highest in the world, currently estimated at 8.8 percent of the entire population. Within the 15-49 age group, 16 percent are estimated to be HIV-positive. Of this group, about 26 percent are thought to be infected in urban areas, 21 percent in semi-urban areas, and 12 percent in rural areas. The southern region is most affected with a rate of 18 percent, followed by the central region at 11 percent and the northern region at 9 percent[2].



Proportion of New Infections in Young Men and Women

The first cases of AIDS in Malawi were reported in 1985. As at June 1999 over 53,000 AIDS cases had been officially reported. However, since most cases are not reported, the NACP estimates that the actual number of AIDS cases from the start of the epidemic through 1998 was over 265,000. 46 percent of all new infections within the 15-49 age group in 1998 occurred in youth aged 15 to 24. Of these, 60 percent occurred in females and 40 percent in males.

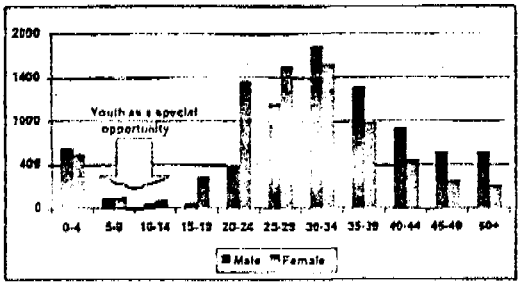
On average, 267 people are infected every day and 139 people die daily from AIDS-related diseases. HIV/AIDS is now the leading cause of death in the most productive age group (15-49), and 30 percent of the

[2] Figures taken from the National AIDS Control Programme's Sentinel Surveillance Report 1999
Charts on pages 2 and 3 taken from Malawi's National Strategic Framwork (2000-2004)

Ministry of Health's curative budget is now spent on AIDS patients. The life expectancy of Malawians has dropped from 45 years in 1995 to 39.3 years in 1998.[3]

Data show that females are at a much greater risk of infection when young. Looking at cumulative AIDS cases across age and sex, more females are infected in the 15-29 age group while more males are infected in the 30 and above age groups. Young women are suffering the largest burden. From 1997 to 1999, 30 percent of women who attended antenatal services in two major urban areas, Lilongwe and Blantyre, tested HIV-positive.

The number of AIDS cases in children under 15 years of age, estimated at 2.2 percent, emphasises the point that the main modes of transmission are through sexual contact from the age of 15 onward or through peri-natal transmission. The children under 15 provide a special opportunity to affect the future course of the epidemic.



Reported AIDS Cases by Age and Sex (1995-1998)

The number of children orphaned because of the AIDS epidemic is increasing alarmingly. It can be deduced from the NACP's 1999 Sentinel Survey Site Report that in the year 2000 there are more than 300,000 children in Malawi under the age of 15 who have lost either their mother or both parents to AIDS-related illnesses. For many children and families, the onset of AIDS signals the beginning of transition from poverty to complete destitution.

THE SOCIAL AND ECONOMIC IMPACT OF HIV/AIDS

The increasing number of AIDS deaths among productive adults in the public and private sector is draining the country's capacity and adversely affecting development efforts. HIV/AIDS is placing new demands on family resources and is reducing the time adults spend on economic activities. Medicines, treatments and other care often consume a large proportion of family income. As families experience economic pressure to generate cash, they often sell possessions and by the time death occurs, the family's economic situation has deteriorated substantially.

Government departments, private institutions and non-governmental organisations are all experiencing a loss in productivity and increased costs due to absenteeism, medical bills, funeral costs and payment of premature death benefits. Productivity in the various sectors is also being compromised by the replacement of experienced staff with poorly qualified and less experienced staff. The epidemic is affecting the government budget adversely by diverting financial resources from productive sectors to the care for those living with HIV/AIDS.

Diseases, which were less common and more easily cured before HIV/AIDS are suddenly re-emerging. There is presently a three to four fold increase in TB cases with about 20,000 cases reported in 1996 - an increase of more than 15,000 since 1985. The dramatic increase in TB cases can be attributed primarily to HIV infection. The strain that TB and other HIV-related illnesses exert on the national health budget has grown enormously and requires that more attention should be focussed on alternative approaches to management such as home-based care. The increase in the number of AIDS patients has put additional pressure on already poorly equipped health institutions.

The National AIDS Control Programme has projected that a minimum of 25 percent and as much as 50 percent of people currently employed in the urban-based sectors will have died of AIDS-related illnesses by the year 2005. Despite the fact that HIV infection rates are highest in urban areas, the absolute numbers of people infected and affected with HIV and AIDS are largest in rural areas where the majority of Malawians live, depending on subsistence farming for survival. HIV/AIDS will continue to divert labour from farming to care provision, thereby increasing food insecurity and threatening the survival of communities. At the community level, HIV/AIDS reduces the labour pool particularly for agricultural and skilled labour activities.

[3] State of the World's Children report 2000

The epidemic is devastating Malawi's economy, destroying the social fabric and rolling back most of the gains made in poverty reduction. The epidemic has generated a large number of orphans, whose care falls on extended families, stretching the capacity of the social safety nets. Many orphans are heading families and they are less likely to attend school, more likely to be malnourished and are very poor. Households are increasingly bearing the responsibility of providing care to the sick and the burden of care at the household level is largely borne by women and girls.

FACTORS THAT SCALE UP HIV/AIDS IN MALAWI

In spite of substantial awareness levels among the population, behaviour change is still limited and the rate of HIV infections continues to increase. This can be attributed to several factors, including the following:

i. Culture of silence – people do not talk frankly about STDs and HIV. The cultural values, beliefs and practices that put people at higher risk of HIV infection also affect the care and support of people living with HIV/AIDS.

ii. Low status of women in society - women have very little access to and control of resources and little power to make decisions about issues, which affect them. In families and communities they assume subordinate roles, taking responsibility for childcare and physical labour while men make the important decisions, particularly about issues related to sex and sexuality.

iii. Early sexual activity is also prevalent in Malawi. This early sexual activity increases the risk of HIV infection, particularly among young girls who are also particularly exposed to infection during some initiation rites. Teenage pregnancies and early marriages are of particular concern because they occur at a time when girls are not physically and psychosocially mature.

iv. Widespread poverty has caused economic vulnerability among communities. Many vulnerable groups, particularly women and adolescent girls, regularly find themselves in situations where they may be exploited, including sexual exploitation which is a factor in the spread of HIV.

v. Increased mobility of the population both within the country and abroad has increased the probability of people having multiple sexual partners and casual, unprotected sex.

HIV/AIDS as a Human Rights issue

The government of Malawi ratified the CEDAW and CRC respectively in 1987 and 1991. The state is under obligation to ensure universal access to the rights enshrined in these conventions. Malawi's new constitution has a chapter on human rights. Specifically, section 23(1) provides that "all children, regardless of the origin of the circumstances of their birth, are entitled to equal treatment before the law" while chapter 4 of the bill of rights deals with issues of gender equality, inheritance and guidelines on the family and marriage. HIV/AIDS has severely affected the human rights of women and children. Among economic, social and cultural rights affected by HIV/AIDS are the right to work, social security, education, full realisation of human dignity and personality, improved health status for individuals and families and provision of optimum health care.

The following rights are at risk because of HIV:

I. **The right to health:** more than 70 percent of hospital beds are occupied by people with HIV/AIDS related conditions. Infected persons do not have access to the medicines that can prolong their lives.

II. **The right to education:** teachers have been affected severely by the virus and the attrition rate in schools is very high. HIV/AIDS is the leading cause of death among teachers – it is estimated that around 10 percent teachers have died of aids. The resulting gap is difficult to fill due to the absence of qualified teachers, particularly in rural areas. Due to the lack of quality education, children and youth are not skilled and empowered to talk about safer sexual behaviour and practices with their sexual partners. With so many parents dying, children are forced to leave school to earn money for the family, resulting in the violation of their right to education.

III. **The right to non-discrimination:** people living with HIV/aids are often subjected to social exclusion and stigmatisation. As HIV is predominantly contracted through heterosexual activity in Malawi, having the virus is seen as a clear sign of infidelity, promiscuity or prostitution. This limits the possibility of people to discuss the issues openly, let alone to seek counselling and testing services.

IV. **The right to parental care:** the number of orphans is increasing rapidly due to HIV/AIDS.

v. **The right to protection from harmful traditional and cultural practices:** Women in Malawi rarely inherit property from their husbands and fathers. This makes women economically dependent, resulting in limited access to health services and lack of control of their own sexual and reproductive rights. While their husbands are alive, women are at great risk because of patterns of multiple sexual partners by men. HIV-positive women are often abandoned by their husbands, regardless of their husbands' HIV status. They are often blamed for the death of their husbands and their property is regularly grabbed by relatives when they are widowed and are often forced to engage in sex with their husband's relatives.

vi. **The right to freedom of reproductive choice, the right to privacy:** Unprotected sex, whether consensual, transactional (e.g. 'sugar daddy' syndrome), rape and defilement, or in early or forced marriage situations, constitutes the immediate cause of HIV/AIDS in Malawi. Underlying these factors is the situation where young people, especially girls, do not have adequate information on sexuality, growth and development and lack adequate psychosocial life skills to enable them to negotiate in risky situations. Some of the factors responsible for this include inadequate educational systems, non-supportive relationships with parents/guardians and elders, as well as negative peer influence, sometimes involving alcohol and substance abuse. The situation continues in adulthood, when women are often in similar situations with non-supportive and abusive spouses or relatives. The above is aggravated by an inadequate education system and the lack of friendly health and social services, especially for sexual and reproductive health rights.

vii. **The right to information:** Non fulfilment of the right to information is a cause and an outcome of HIV/AIDS. The lack of information is another contributing factor to a higher risk of infection and once infected, access to adequate information to make important decisions about care for themselves and others around them is often limited.

I-3 HEALTH

Manifestations of non-fulfillment of the rights of children and women are expressed by high rates of infant mortality (134 per 1,000) and under-5 mortality (213 per 1000). Both show marked urban-rural disparities. Neo natal mortality is estimated at 40 deaths per 1,000 live births.

Malawi shows one of the highest levels of maternal mortality standing at 620 maternal deaths per 100,000 live births.

(a) The immediate causes of maternal mortality include prolonged or obstructed labor, antepartum and postpartum hemorrhage, puerperal infections (post-abortion and puerperal sepsis) and pregnancy-induced hypertensive disease. All of these causes are medical and therefore the effective reduction of maternal mortality undeniably requires an efficiently functioning health care system where emergency obstetric care is available within 2 hours to most households.

Cause-specific morbidity rates amongst children are high. The prevalence of fever among children stands at 37% in urban and 41% in rural population. Malaria and diarrhoea continue to be the leading causes of outpatient attendance and hospital admissions among children under the age of five. Each child is estimated to experience and average of six episodes of diarrhoea per year. Pneumonia and other acute respiratory infections continue to affect children. It is estimated that over one thousand children die every year as a result of these infections.

The progress made in Malawi with regards to the reduction of vaccine preventable illness is commendable. The Expanded Programme on Immunisation has generally achieved coverage of over 80% for all antigens. As a result, there has been a dramatic reduction of vaccine preventable diseases including the virtual elimination of Polio. No confirmed case of Polio has been reported since 1992. Children still face occasional outbreaks of measles, although of a small scale. It is imperative, therefore to continue improving the quality of EPI services in Malawi in tandem with improving disease surveillance systems.

The life expectancy of Malawians has dropped from 45 years in 1995 to 39.3 years in 1998. Females are at higher risk of infection when young. Looking at cumulative AIDS cases across age and sex, more females are infected in the 15-29 age group while more males are infected in the 30 and above age. Young women are suffering the largest burden. From 1997 to 1999, 30% of women who attended antenatal services in two major urban areas, Lilongwe and Blantyre tested positive for HIV. Another study in semi-urban area in Mulanje District had showed a prevalence of 35.5%. The estimated rate for mother-to-child-transmission stands at 25% and therefore it is estimated that 38,000 newborn children are infected annually.

Child feeding practices (breastfeeding and infant feeding) are still not well understood. Only eleven percent of children are exclusively breastfed for the first 4 to 6 months. Supplementary feeding takes places at too early stages and therefore predisposing children to diarrhoea episodes, dehydration and risk of death. The duration of breastfeeding however, seems to be generous enough since most mothers breastfeed their children for over two years.

Children also suffer severe levels of iron deficiency anemia as well as vitamin A and iodine deficiency disorders. Although, there is no updated information on their severity, it is estimated that over half of the under-5 children and one third of women in reproductive age suffer moderate to severe levels of iron-deficiency anemia and vitamin A deficiency. The low levels of hemoglobin are worsened with the frequent episodes of malaria. Vit A deficiency predisposes children and postpartum women to more severe and life-threatening infections. Twenty seven percent (27%) of school-going children have goiter.

The prevalence of teenage pregnancy is extremely high in Malawi. Around 68% of women have had their first pregnancy before the age of 20. This alone is a significant contributing factor to the high levels of maternal mortality. Maternal mortality is higher at both extremes of reproductive period. Furthermore, most teenage pregnancies are unwanted or unplanned, some of them attempt to terminate the pregnancy. Abortions often result in complications such as port-abortal sepsis and hemorrhage. The contraceptive prevalence rate stands at 20%. The low use of contraceptives among teenage youth is a contributing factor to the high levels of teenage pregnancy, abortion and maternal mortality in general.

The fertility rate which stands at 6.7 and is one of the highest in Africa. As a result, a pregnant woman in Malawi has much higher risks of death as a direct result of pregnancy and its complications. The registration of newborn children is practically non-existent.

Access and availability of quality emergency obstetric services is fundamental to the reduction of maternal mortality. Since most of causes of maternal deaths are medical then the importance of having an efficient and well functioning maternal health care systems at all levels; the communities, the first level of health care and the referral hospitals. The effective reduction of maternal mortality demands to have emergency obstetric services within two hours distance from households. Efficient malaria prevention intervention with high coverage of bed net use, provision of prophylactic anti-malarial and adequate and prompt treatment of malaria will also make significant contributions to the reduction of maternal mortality.

(b) Four major providers compose the health care delivery system. The Ministry of Health and Population (MOHP) provides around 60%; the Christian Health Association of Malawi (CHAM) provides 37% and the Ministry of Local Government (MLG) provides around 1%. Other providers (private sector, commercial companies, army and police) provide 2% of health services.

In spite of the relatively wide network of health services, the public health sector in Malawi offers limited access to quality and effective health care. Approximately 46% of the population live within 5-Km radius of a health facility, which in some districts implies long walking distances due to the terrain. Furthermore, the health facilities are inequitably distributed and in some areas they are too close to each other while elsewhere there are no facilities. Most facilities have not been adequately maintained and are in a state of disrepair with no basic communication systems and equipment.

Qualified heath personnel is short and the available human resources are also not equitably distributed with the rural areas being neglected. The training outputs are low and attrition rates high due to advent of HIV/AIDS and exodus of qualified personnel to other countries as a result of the poor working conditions and low salaries. The MOHP and the donor community are in the process of addressing human resource attrition within the health sector by developing shorter training curricula and supporting the provision of salary top up incentives.

The availability of essential drugs, medical supplies and equipment is extremely limited. The drug budget has not kept up with the population growth and the inflation rate, since all drugs are imported and therefore paid with foreign currency. There has also been an increase in pilferage of essential drugs amongst health staff.

Universal access to health services and therefore equity in health care delivery is being challenged by the limited financial access to services in some geographic areas due to unavailability of free health care. In areas served by CHAM or private facilities, almost all services require payment. This often discourages the poor, who have no ability to pay, from seeking medical care. Women and children are mostly affected.

The GOM is in the process of implementing the Decentralization Act. It is aimed at devolving administrative authority to the district level. Government agencies at district and local level will become one administrative unit, through the process of institutional integration, manpower absorption, budgeting and allocation of financial resources. District Assemblies will assume decision-making responsibility and district level.

In order to effectively implement the Health Sector Plan, the MOHP plans to introduce the concept of Essential Health Care Package (EHP), the Bakili Muluzi Health Initiative (BMHI), the sector wide approach (SWAP), the decentralization of health care management and the introduction or strengthening of cost-recovery/user fees as key elements of health care delivery system.

The GOM/MOHP expenditure on health per capita has increased over the last 6 years from 0.3 USD in 1993/94 to 3.13 USD in 1998/99. This represents a dramatic increased. However, it is still below the WHO recommendation of 10.00 USD per person per year.

The government has given a high priority to the health sector. The average share of public resources (as proportion of GDP) devoted to health in the period of 1991/92 – 1998/99 was 9.4%. It had a period of decline to 6.3% in 1995/96. The efforts made by the Government of Malawi in the last years indicate a renewed effort to sustain the allocation of financial resources to the health sector.

The MOHP, in its efforts to address the strategies for resource allocation to the health sector and its efficient utilization, has adopted the Sector Investment Programme (SIP) and the Sector Wide Approach (SWAP). The development of SIP and SWAP are based on the support required to the efficient realization of the 1999-2004 Malawi National Health Plan, within the sectoral policies and strategies. The government and the donor community are to jointly support the review of present management systems and facilitate the phased introduction of management arrangements, health sector reform and capacity building within the public sector so as to create an environment for transforming health sector financing mechanisms to those that are based on sector-wide resource availability, projections and expenditure plans in line with the health sector policies and plans. Joint GOM/donor monitoring of sectoral performance is also part of this process. Basic Causes

Malawi is rich in its cultural heritage. However, there are rituals and practices that violate the rights of children and women. These include, widow inheritance or *"chokola"* and *"fisi"* or the removal of virginity of girls as part of the ceremonies leading to adulthood.

As a result of the above analysis, the main issues can be summarised as follows:

Key issues

Issue 1.	High infant and child mortality rates due to malaria, ARI and diarrhoea illnesses.
Issue 2.	Poor quality of immunization services.
Issue 3.	High levels of maternal mortality and morbidity due to poor care practices and delivery of maternal services.
Issue 4.	High levels of childhood protein-energy malnutrition and micro nutrient deficiencies.
Issue 5.	High level of teen age pregnancy due to poor access to quality and youth friendly reproductive services for young people.
Issue 6.	Increasing incidence of HIV/AIDS in children and young people.

Annex 1 Summarise the main capacity gaps among duty bearers pertaining to the above key issues

1-4 EDUCATION

The importance of education as a human right and key factor to development is fully recognised in Malawi. To this end, Malawi has ratified all international conventions, which raise education to the level of a human right, including the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women. Malawi's own constitution enshrines education as a right for all Malawians. Current programmes place access to good basic education at the centre of poverty reduction strategies. There is, however, a gap between policy statements/intentions and reality on the ground. The situation has been aggravated by the HIV/AIDS epidemic that has direct implications on enrolment, attendance, completion and staffing. The 4,765 primary schools and 952 secondary schools do not match demand. The formal education system is highly pyramidal and imposes severe structural restrictions to transition from one sub-sector to another. Out of 3million children who enter primary schools only 11 percent proceed to secondary. Transition is even more restricted from secondary to tertiary where only 3 percent are able to proceed to college level education. These limited opportunities for education are reflected in the literacy levels. Adult illiteracy stands at 65% for women and 40% for men. The general adult literacy rate declined from 50% in 1990 to 42% in 1999.

Early learning is an important area that has not received adequate attention in Malawi in spite of the benefits associated with it in terms of the stimulation and education of the child and empowerment of women. The steps taken so far have been modest and have not received sufficient government financial support. The Access to early learning programmes was 1% in 1994 and 26.6% in 1999 and efforts are under way to develop relevant syllabuses. An early learning policy is currently awaiting parliamentary approval. There were 216 CBCCs with 11,000 to 20,000 children in 1998. There is no official record of pre-school centres although indications are that there are more in urban than rural areas.

The development of early learning is hampered by lack of facilities/resources and lack of awareness at the family, community and national levels of the importance of early learning in the psychosocial and cognitive development of children. A major challenge in this sub-sector is HIV/AIDS which has led to a dramatic increase in the number of orphans with no parental care and HIV positive children who need special attention

Primary education has been declared free but not compulsory. The current NER is 83.3% for boys and 82.9% for girls. In terms of official policy, children begin primary education at the age of 6 years but girls enter late and are likely to drop out at puberty due to such factors as early marriage, pregnancy and parental preference for boys. For both boys and girls, poverty and the phenomenon of child labour contribute immensely to late school entry and, in a large number of cases, to non-enrolment. The phenomenon of non-enrolment has been accentuated by the HIV/AIDS epidemic that has created a large number of orphans who are forced into adult roles to look after themselves and their siblings. Very often this means child labour and early marriage.

Enrolment patterns in primary education are not even. They are affected by such factors as gender, urban-rural differences and distances from school. As a result of these factors, enrolment patterns favour boys and children

in urban centres. The mean distances to school are 3.4km for urban children and 3.7km for rural. It is important to note that distances to school affect girls more than boys because of fear of rape and sexual abuse.

A host of problems attend primary schools in Malawi. The class sizes are large, ranging between 60 and 120. Essential school supplies such as textbooks; copybooks and pencils are scarce. The number of untrained teachers in the schools is disproportionately high. All these factors impact negatively on the quality of primary education. There are high repetition rates - 50% of children who enter primary drop out before standard 5. These high repetition rates spring naturally from the factors referred to above. Other significant causes are child labour and loss of parents due to the HIV/AIDS epidemic. For girls, pregnancy and early marriage are leading causes of dropout. An important cause of repetition that is not fully documented is poor pupil performance. A 1999 UNICEF sponsored study revealed the magnitude of this factor in repetition. Repetition is highest in standards 1,2 and 8. In the lower classes repetition is associated with lack of learning materials and large classes, which lead to ineffective teaching. At standard 8, pupils repeat to increase chances of selection for secondary education. Also significant among the causes of repetition are such cultural institutions as 'Nyau', 'Jando' and 'Chinamwali' which are widely practised in Malawi and which lead children to miss schooling for prolonged periods of time. In most cases, they lead to dropout as 'graduates' from these ceremonies consider themselves ready for marriage. Hence, there is a direct relationship between these initiation ceremonies and early marriage. In the Central and Southern regions cattle herding affects school enrolment of boys. Other factors impacting on girl's education are such school-related factors as teachers' low expectations of girls' performance, sexual abuse of girls by both teachers and boys, which increase their vulnerability to HIV infection.

The introduction of free primary education in 1994 accentuated the problem of insufficient inputs and inadequate education personnel. It worsened the pupil-teacher ratio and led to a widespread shortage of teachers especially in rural areas where the vacancy rate stands at 30%. In addition, rural schools remain unattractive to trained teachers due to poor infrastructure and inadequate services leading to a situation where rural primary schools have a large proportion of untrained teachers. This problem is more pronounced with regard to female teachers who use marriage as an additional reason for seeking placement in urban areas.

Another serious factor impacting negatively on primary education is the limited capacity of teacher training colleges whose output is not able to keep pace with demand. The combined annual output from the country's colleges is 1800 which falls far short of the annual demand of 4500 teachers.

In spite of several GOM/donor initiatives, the shortage of furniture, textbooks and supplementary materials remains a major challenge. The shortage of furniture is more acute in rural areas where the majority of standards 1 – 5 pupils sit on the floor or under the trees. In these rural areas, sanitary facilities and safe water are found in a few schools.

The Ministry of Education has accepted the introduction of life skills as a subject in school programmes in response to the HIV/AIDS epidemic, the primary school curriculum has remained theoretical and examination-based with emphasis on memorisation. The system does not yet seriously address the important issues of health, nutrition and hygiene education. The threat paused by HIV/AIDS goes beyond children's right to survival. It threatens their right to quality education due to deaths of parents, frequent absence from school and irregular attendance and death of infected teachers. It is estimated that the education system has lost about 11% of its teachers. Further, the curriculum is overloaded and frustrates acquisition of critical skills. It does not respond to the needs of street children, orphans and adolescent mothers and to the special needs of hard of hearing and visually impaired children.

The pass rate for girls in the Primary School Leaving Certificate is lower than for boys. Boys perform better than girls do in all subjects except Chichewa. This low performance is reinforced, and perhaps is a result of, stereotypical notions about girls' capabilities, which are perpetuated by both teachers and school textbooks. The participation of girls in education is further constrained by a combination of such factors as low socio-economic status of family, poor educational background of parents, preference for boys and absence of facilities in schools, which ensure the safety and security of girls.

Secondary education in Malawi is severely constricted with only 11 percent of primary school graduates able to enter secondary schools. Currently, there are 40,000 pupils in conventional secondary schools, 100,000 in

community day secondary schools and an estimated 12 percent of the total in private institutions. Demand for secondary education is high and competition for the limited places intense. In secondary education, girls are even more under-represented although enrolment has been on the increase over the last ten years – 29% in 1980 and 39% in 1997. The ratio of girls to boys in secondary education is 1:4 and generally girls do not do well in science subjects. Because of tendency of older men, including teachers, to seek sexual favours from young girls, secondary school girls are at risk of contracting HIV infection.

Only 3 percent of the secondary school graduates make it to tertiary level. These are divided between the University of Malawi and technical and teacher training colleges. Enrolment at University of Malawi is 3,600 of which 25% are female. The six national teacher-training colleges admit about 8,000. The technical and vocational institutions enrol 1,300. Generally, female students still go for traditional programmes

Inadequate infrastructure is a major problem in secondary education. As in primary education, this sector also faces problems of shortage of qualified teachers, inadequate teaching-learning materials and low learning achievements. The secondary curriculum is even more bookish and outlandish as it is directed by an extremely theoretical examination system, which encourages memorisation. The secondary school curriculum has not yet adequately responded to the critical issue of HIV/AIDS. The little that is being done in HIV/AIDS prevention is through extra curricular Anti-AIDS clubs.

While a sizeable number of adolescents are in secondary and tertiary institutions, a significantly large number are out of school. They either drop out of school or never enrol. Out of 2.6 million 6-17 year olds in 1990, 50% were either dropouts or never attended school. Also there is a rising number of orphans, street children and HIV infected adolescents especially girls.

Adolescents encompass a mixed bag which, can also be divided between married and unmarried and rural and urban. They are not a homogenous group and their problems come in different forms. However, common to their problems is the need for opportunities and services for development and participation.

In response to this situation, the following measures have been adopted for the benefit of adolescents: policy of school re-admission after pregnancy, development of a national youth policy which aims at increasing maximum potential of young people, establishment of the National Youth Council to co-ordinate programmes and opportunities to articulate issues that affect young people. Other programmes include promotion of youth participation in decision making, family life education, sex and sexuality, and income generating activities. All these activities are used as entry points for HIV/AIDS education for adolescents.

Despite these initiatives, adolescents continue to have limited access to programmes that can fully meet their rights in a more holistic manner. The measures too are limited in coverage and the development and participation rights of adolescents remain generally far from being satisfied. Adolescents face a wide range of limitations. They have no voice in the legislative, executive and judiciary branches of government. They are often left out in decision making at household, community and district levels, and their access to secondary and tertiary education is severely constrained by structural barriers. They lack appropriate skills for gainful employment and a significant number are exploited as child labourers. The HIV/AIDS epidemic has increased their vulnerability as not enough is being done to provide them with adequate information, services and competencies to enable them make informed decisions. The adolescent girls in particular are constrained by sexual exploitation both in the community and school and have limited access to reproductive health and social services.

Although education receives priority treatment in government annual budgets, the sector remains under-funded. The limited resources for education have to meet the demands exerted by HIV/AIDS. An increasing school-age population compounds the situation. Hence there is low physical capital formation and widespread shortage of teachers and learning materials.

Given the social benefits of basic education and the current drive to reduce subsidies to the 'rich', who dominate secondary and tertiary education, government now allocates more resources to primary education. To that end, primary education received 57% of total education budget in 1999/2000, secondary 16% and

university 1.5%. This contrasts sharply with the situation in the 1996/97 budget where the unit expenditure per student by education sub-sector was as follows: primary (MK44.00), secondary (MK437.00), technical (MK1, 525) and university (MK9, 534). Government has adopted cost-effective measures that include a shift from boarding secondary to community day secondary schools to reduce unit costs. Because of the high personal benefits of university education, there has been a hike in University student contributions from MK1, 500 to MK46, 000 per year.

The role of donors in education is large as exemplified by the following statistics. Donor contribution to education development expenditure averaged 91% in 1996/97 and 87% in 1997/98. Another significant player in the development of education is the community. It is estimated that 75% of primary schools were built with community participation.

Key Issues

Based on the 1999 Mid-term Review, the 2000 Mid-year Review, the 2000 Common Country Assessment and the draft 2000 SITAN Report, eight clusters of issues in Basic Education were identified. Running through all these issues is the emergency created by the HIV/AIDS epidemic.

(a) Inadequate Opportunities for Early Learning

The development of early learning has been hampered by lack of facilities/resources. As a result, access is limited, centre-based and concentrated in urban areas. The curricula used in centre- based programmes are miniature school programmes and therefore unsuitable. A major challenge in this sub-sector is HIV/AIDS which has led to a dramatic increase in the number of orphans with no parental care and HIV positive children who need special attention

(b) **Non - enrolment, low enrolment and late enrolment**

Although Malawi has declared a policy of free primary education, enrolment is not compulsory. In fact, non-enrolment, low enrolment and late enrolment are widespread thus denying a large percentage of children of their right to education. The reasons for these are many. Among the immediate causes are factors such as household level choices, inadequate schools, lack of supportive home and school environments and distances to schools. The underlying causes include absence of a policy that makes basic education compulsory, economic hardships faced by many families that lead them to force children to work in order to augment household incomes, cultural practices that keep children away from school, parental preference for boys and the impact of HIV/AIDS, which interferes with the school attendance of affected children and has created a large number of orphans who find themselves performing adult roles to maintain themselves and their siblings. The children particularly affected by these phenomena are girls, orphans and working and street children. Another group of children affected are those with special needs who are denied their right to education because of failure of education programmes to respond to their special circumstances. Also, non-enrolment, low enrolment and late enrolment affect children in rural areas more than their age mates in urban areas because of limited facilities

(c) High Rates of Dropout and Repetition

It is estimated that 50% of all children who enter primary school drop out before standard five, a level at which children acquire permanent literacy and numeracy. The reasons for dropout are many and varied and include home/community factors and school-related factors. Initiation ceremonies, death of parents including long periods of sickness of parents due to HIV/AIDS and economic hardships are some of the home/community factors that lead to dropout. School-related factors include poor teaching, poor achievement, poor facilities including poor sanitary facilities and low perceived value of education. For various reasons, there are more girls dropping out than boys. The leading causes are pregnancy and early marriage. In some cases, parents withdraw their daughters from school when they reach puberty to avoid unwanted pregnancy. Girls also drop out because of poor performance caused by competition between schoolwork and household chores.

(d) Low Quality of Primary Education

The quality of education is largely a function of the inputs invested in it and is normally measured level of processes and outputs. While there has always been shortcomings in the quality of primary education in Malawi, the introduction of free primary education accentuated the problems.

Effective learning is constrained by a widespread shortage of basic textbooks and essential supplies. The shortage of classroom space, furniture for pupils and teachers and latrines and safe water sources make teaching and learning difficult and ineffective. Teachers are not only in short supply but they are highly demotivated due to a combination of low salaries, poor housing and inadequate supervision. Teachers have difficulty relating to individual pupils because of large class sizes. A large proportion of teachers, especially in rural areas, is not trained. Because of inadequate supervision from both the district and school levels, these teachers operate without support.

The school curriculum is theoretical and unrelated to life experiences of children. It does not engage adequately issues of health, nutrition, hygiene education and HIV/AIDS. Gender stereotyping predominates in both textbooks and teaching methods and this is reinforced by teacher attitudes. This will change when the new textbooks are introduced in schools. The current situation is worsened by the predominant use of transmission teaching methods, which encourage memorisation and do not promote pupil participation. The schools themselves still largely operate as 'islands' in the communities they serve. There is no significant community involvement in the affairs of the school except as sources of labour.

Lastly, there is no consistent and continuous system of tracking learning achievements as a way of guiding remedial action. A testimony of this and of the inefficiency of the primary education generally is the high rate of failure in the Primary School Leaving Examinations.

(e) Low Participation and Retention of Girls in Primary Schools

While there has been an impressive increase in the enrolment of girls in primary schools (from 333,495 in 1980 to 1,395,937 in 1998), the participation and retention rate has not registered commensurate gains. There are still more girls dropping out and their performance in all subjects except Chichewa is lower than that of boys. A range of factors explains this situation. The HIV/AIDS epidemic has increased the vulnerability of girls especially considering their engagement in sex at very early age of 10 years. Pregnancy (and fear of pregnancy by parents) and early marriages are the leading causes. There are many other factors. Cultural conditioning makes many parents prefer educating boys, especially when economic circumstances force them to make a choice. Girls are not considered permanent members of the household as they marry into other families. Most girls from poor families are more likely to stay at home to assist with household chores. In fact, studies have shown that for these poor families the opportunity costs of sending girls to school are higher for girls than boys because of forgone labour. Girls are also subjected to cultural and social practices that interfere with their right to education. For those who enrol in schools, the demand on their services at home for such activities as food preparation, fetching water, collecting firewood and looking after siblings may interfere with school attendance and school homework and hence negatively affect performance and persistence in the system. At school level, studies have shown that both male and female teachers consider girls lazy, unmotivated and unwilling to learn. These stereotypes also obtain in learning materials. In coeducational settings girls are silenced by both teachers and boys and are not given opportunities to participate effectively in classroom activities. Also the shortage of female teachers, especially in rural schools leaves girls with no role models.

(f) High Prevalence of HIV/ AIDS

The high prevalence of HIV/AIDS in Malawi poses a major threat to children's survival, development and participation rights. Close to 300,000 children have become orphans due to HIV/AIDS-related deaths. They are forced to leave school, first to look after sick parents and, secondly when these parents die to fend for themselves and their siblings. This affects girls more than boys. They are forced into the street and child labour including child prostitution.

At the same time children are exposed to the danger of HIV/AIDS infection through mother-to-child transmission, lack of preventative knowledge and competencies and the tendency of adult men to seek sexual

favour from young girls. Fuelling this situation is the widespread condition of poverty in the country which pre-disposes children to risky sexual behaviour.

HIV/AIDS threatens the viability of the education system itself. The rate of infection among teachers and other education personnel is high. It is estimated that the system has lost close to 11% of its teachers. This has direct impact on the quality of the education because of loss of qualified personnel and irregular teacher attendance during the long periods of illness.

(g) Inadequate Opportunities and Services for the Development and Participation of Adolescents

Adolescents are a heterogeneous group with varied needs. However, common to all adolescents is the need for opportunities and services for development and participation. They lack basic information and skills, support from adults and facilities, resources for training and recreation and gainful employment. They are a low priority group in terms of national allocation of resources and are subjected to school programmes that do not address their needs. Very often they are sexually abused, a problem more pronounced with respect to adolescent girls. The HIV/AIDS epidemic has heightened their vulnerability but there has been no meaningful support in terms of appropriate information and skills. For adolescent girls aged between 11 and 20, their rights to development and participation are not widely acknowledged and/or protected.

(h) Inadequate Financial and Institutional Capacities

Although education receives priority treatment in government allocations, the sector remains under-funded in terms of its needs. An increasing school-age population compounds the situation. Hence there is low physical capital formation and widespread shortage of teachers, learning materials and resources for supervision and monitoring. About 90% of the education budget go to staff salaries leaving a paltry 10% for improving learning.

Donors invest substantial resources into education but the utilisation of these resources is limited by low institutional capacities in terms of planning, implementation, supervision and monitoring

CAPACITY ANALYSIS OF DUTY BEARERS

Family/Household

- Poverty at household level
- Education not prioritized at household level
- Low education of parents
- Education seen as a specialist area for schools
- Competition between school demands and family chores or even survival needs
- Lack of information and appropriate skills
- Cultural beliefs and taboos
- Gender stereotypes

Community

- Lack of awareness and realization of role communities could play
- Conflict with cherished cultural traditions
- Communities not mobilized and organized for meaningful involvement in school affairs
- Poverty at community level
- Alienation and breakdown of community values and practices
- Low value on girls' education
- Absence of role models
- Social distance between schools and communities
- Lack of information and appropriate training among extension workers, religious groups and traditional media

School

- Poor teacher preparedness in terms of teaching skills
- Snobbish attitudes of teachers which prevents harnessing of community intellectual resources
- Poor school leadership
- Historical gap between schools and communities – 'island' perception of schools
- Lack of financial resources to meet basic teaching-learning needs
- Lack of motivation and resourcefulness among teachers

District Education Officers

- Lack of logistical support for supervision and monitoring
- Low level of skills and knowledge among district officers
- Low budgetary provisions for education
- Low motivation among district officers

Ministry of Education and other central government entities

- Low budgetary allocations to education
- Inadequate capacity of teacher training colleges
- Low teacher salaries.
- Lack of perceptive leadership
- Lack of appropriate training militates against inclusion of nontraditional areas in school programmes
- Low institutional capacities

NGOs and Private Sector

- Communities not organized for education
- Low community interest in education which is seen as a specialist area for schools
- Poverty and low disposable income
- Lack of incentives for private sector involvement in education
- Low motivation among government officials

International Community

- Low government absorptive capacity
- Restrictions imposed by donor conditions and mandates
- Weak government management capacities
- Low motivation among government officials

I-5 WATER AND SANITATION

Access to adequate water and sanitation is a basic human right. More than 50 % of the 9.8 million people in Malawi, including 80% of primary schools do not have access to safe drinking water and less than 10% have access to adequate means of excreta disposal.

Diarrhoea is the fifth leading cause of mortality in children aged under-5years; while cholera attacks 2.5 persons for every 1,000 persons per year. The Ministry of Health indicates that 40% to 50% of the school-going age children have bilharzia. The infection rate is much higher in the lakeshore and swampy areas. High prevalence of preventable diseases such as diarrhoea, cholera and bilharzia predisposes a poor nutritional status, which in turn predisposes the contraction of other opportunistic infections.

The high prevalence rate of HIV infection among the adult age group (age 15 to 49) presents further challenges to the prevention of water and sanitation related diseases. With weakened natural immunity, HIV infected people are prone to opportunistic infections in unhygienic or conditions of poor sanitation

The burden of disease, caring for sick family members and travelling long distances for water deprives women and especially girls of their rights. Firstly, the right to attain a high level of health is threatened. Secondly, without adequate sanitation in schools, some girls opt to absent themselves because of indignity especially when they are menstruating. At home, the girls spend long hours helping their mothers to fetch water from distant places. This leaves them less time for recreation in comparison to boys.

Key Issues

(a) Key Issue 1: Poor participation and inadequate community-based management including gender disparity

The involvement of many communities is limited to the provision of unskilled labour during the implementation phase, the operation and maintenance in the post-construction phase. Women and the poor in urban and peri-urban areas are particularly left out of the decision-making process. As a result, the communities lack a sense of ownership and when the water point breaks down, they expect the "planners" to solve the problem. Thirty percent of the facilities remain out of service because of ineffective community-based maintenance and support system.

Conflicting interests among leaders, political pressure on implementers and minimal community involvement, result in poor targeting of new installations under the accelerated new water points programme funded by the Government. New installations are being made next to existing ones that could have been rehabilitated at a fraction of the cost, while many other areas remain unserved.

Effective community-based management through village committees needs both the participation of women and the institutional support. Adequate institutional support to the committees in terms of training, spare parts distribution and quality installations are critical prerequisites to sustainable community-based system. If communities are to effectively manage the facilities, they need to appreciate the technology and maintenance options to facilitate informed choices based both on affordability and sustainability. The decentralisation framework being implemented in the country offers new opportunity for community empowerment.

(b) Key Issue 2: Low access to potable water and inadequate sanitation in communities, health centres and schools

Over 50% of the population walk over 500 metres for potable water sources, above the standard set in the National Action Plan. This is confounded by a growing bias towards machine drilled borehole technology, at the expense of other more cost-effective technologies such as protected hand-dug wells, hand drilled tube

wells, and the rehabilitation of existing gravity fed piped schemes. The limited use of technology options exacerbates low access, because the use of low cost technologies is a way of using limited resources to bring greater access to water and sanitation to more people in a short period.

(c) Key Issue 3: Low profile of Hygiene Education

External support agents, implementing ministries and NGOs tend to place a low profile on hygiene education. As such, communities place a lower priority on sanitation promotion and improved hygiene behaviours. Poor innovative means of delivering hygiene education, dismal resource allocation further contribute to perpetuate this low profile in communities.

Moreover, a focus on school-based hygiene education and sanitation promotion would raise the profile for hygiene education and the demand for better sanitation through the adolescent participation as change agents. Such a focus would improve school sanitation, and in turn, may retain adolescent girls because of restored dignity.

(d) Key Issue 4: Poor hygiene practices at household level

An indication of poor hygiene practices in areas with access to safe water results in a high occurrence of diarrhoea in children. This is related to poor handling and use of water, food, and waste management including excreta disposal. Rampant poverty and burden of domestic chores lead many primary care givers, particularly women, to compromise good household hygiene practices. This jeopardises the survival growth and development of children under the age of five. Children in female-headed households are particularly at risk, because their households often have a higher-level of poverty.

(e) Key Issue 5: Weak policy formulation and enforcement ass a result of absence of a coherent national sanitation policy and strategy framework

The absence of a coherent sanitation policy and strategy, especially for rural and peri-urban areas, has allowed the sector to develop in a disintegrated manner. Related to this, there is a general need to improve the legal and policy framework and to disseminate relevant laws, policies and guidelines to all stakeholders. Laws, policies and guidelines need to be updated and synchronised. Among the other issues to be resolved are:

The clarification of the authority responsible for the planning, implementation, enforcement and evaluation with respect to sanitation

The clarification of the Law/Act under which the community-based water committee may be registered in order to bestow legal protection to committee members and empower them to enforce by-laws. The programme will support the establishment of an Integrated Water and Sanitation Policy.

(f) Key Issue 6: Weak planning, programming and co-ordination; and weak monitoring & evaluation

The Ministry of Water Development has not been able to effectively co-ordinate the various stakeholders as reflected by the recent duplication of services in some areas, while others areas remain unserved. Correspondingly, District Assemblies have not had the authority to co-ordinate stakeholders at district level. Poor co-ordination is coupled by no monitoring and evaluating standards systems at community, district and central levels. Participatory monitoring and evaluation systems would enhance ownership and sector co-ordination.

(g) Key Issue 7: Inadequate environmental management leading to water contamination and pollution

The protection of water catchment areas depended on gazetted forest reserves with little community involvement. Where communities did not see any benefits from the reserves, they encroached, the land, clearing forests reserves and water catchment areas. The effects have been that many piped water schemes have either dried up or have reduced capacities. There is need to further promote collaborative efforts between

the communities, the Ministry of Forestry, the Ministry of Water Development and other stakeholders, in of managing and preservation of critical water catchment areas.

The peri-urban population is growing rapidly without matching infrastructure development. As such, water supply, sanitation and waste management services are not adequately developed by the City Assemblies. Communities in these areas have little option but to heap refuse or bury it in shallow pits near their plots. These areas often depend on shallow dug wells for their water supply and pit latrines for excreta disposal. The combination of shallow refuse dumping pits and a growing number of pit latrines poses a contamination threat to the groundwater sources. Furthermore, with no systematic monitoring of water quality, the extent of the pollution threat is unknown.

(h) Key Issue 8: Inadequate and ineffective training for extension workers and communities

Water Monitoring Assistants, Community Development Assistants and Health Surveillance Assistants do not receive training in participatory methods. The sector has recently adopted the Demand Responsive Approach (DRA), Participatory Hygiene and Sanitation Transformation (PHAST) and Participatory Rural Appraisal (PRA) methodologies. Despite this fact, there is still need to include such methods in the standard curricula for extension workers. Without participatory skills, the district supervisors are not able to effectively train, supervise, and support extension workers in their community-based work.

Cf. Annexes 3-4 Role and Capacity Gaps Analysis process

I-6 EARLY CHILD CARE AND IMPACT OF HIV/AIDS ON FAMILIES AND COMMUNITIES

Malawi has one of the highest rates of chronic malnutrition in the world, currently estimated at 48%. The situation has not changed much over the years, from 56% in 1981, inspite of overall improvement in macro-economic development indicators during this period. In addition, the rate of acute malnutrition has deteriorated from below 2% in 1981 to the current estimate of 7%. On micronutrient deficiencies, localised surveys in selected districts indicate vitamin A deficiency of up to 7.4% (night blindness) and 22% sub-clinical vitamin A deficiency. Furthermore localised surveys on iodine deficiency indicate total goitre rate of 27% in school children. Nutrition status of children is a proxy indicator of development and such high levels of malnutrition and micronutrient deficiencies in Malawi call for further analysis of factors that contribute to this situation. This section points out the importance of various care practices in the causality of malnutrition and the impact of HIV infection and AIDS.

- **Care for women**

Maternal mortality in Malawi is one of the highest in the world at 620/100,000 live births. Many women have too much workload and receive limited support during pregnancy and lactation. The contraceptive rate is very low at 14% and many women have frequent unplanned pregnancies. This gives women little time to rest and to provide adequate care for children. The prevalence of anaemia in pregnant women is very high at 56%, and preliminary results of a recent survey indicate that the situation is getting worse. Although over 90% attend antenatal clinics at least once, the first attendance is usually in the last trimester, giving very little time to improve the haemoglobin levels through iron supplementation and malaria prophylaxis. Many women are unable to attend clinics regularly and deliver at health facility because of long walking distance lack of transport, and harsh treatment of health personnel during delivery. On the other hand many traditional birth attendants are not trained and well equipped to detect high-risk pregnancies before delivery. In addition it is very difficult to manage complications when they occur during delivery far away from a health facility, with no emergency facilities. Furthermore many babies are born with low birth weight (20%) giving babies a poor start. All these are indications of inadequate care that women receive before and during pregnancy, and at the time of delivery.

- **Infant feeding practices**

The rates of exclusive breastfeeding are too low at 11% for the first four to six months of life and complementary foods are introduced too early, for some as early as the first month. The quality of

complementary foods is generally not adequate. They lack energy, proteins and vital micronutrients. The frequency of feeding is also not adequate for children. On average the meal frequency for children is twice a day, as for adults. This is partly due to household food insecurity in over 60% of the households that live beyond the poverty line.

- **Hygiene and sanitation practices**

The environment in which most children are raised has poor sanitation and hygiene practices. Many mothers do not regard child faeces as dangerous and hardly wash hands after changing babies' soiled clothes. Besides most people in general have poor hygiene practices and the environment harbours a lot of mosquitoes. This leads to frequent diarrhoea and malaria infections.

- **Child health care and health seeking behaviour**

Many parents delay in seeking and providing appropriate health care when a child is ill. Preliminary results of assessment of childcare practices at household and community levels in August 2000 indicate that the delay is mainly caused by limited knowledge of parents in management of various child illnesses in the home, limited access to drugs in the required amounts and long distances to health facilities. Fear of unfriendly attitude by health personnel is also a contributing factor. This means that children are exposed to infections longer than necessary and this retards their growth. Coupled with poor nutrition many children die of treatable infections, contributing to the high infant and child mortality rates estimated at 134 and 213 per 1000 live births respectively.

- **Gender Issues**

Most girls drop out of school and typically marry at young age 14-16, contributing to the low literacy level for women in Malawi, estimated at 29% while the national rate is 45%. Coupled with their low status in society in general, women and girls have low negotiating power. They have high workload, with little or no support from men and boys and have little access and control over household economic resources that are needed for improvement of health and nutrition. Furthermore they are usually not able to influence decisions that affects their own lives such as family planning. Participation in politics is weak. While 52% of the population is female, less than 20% of the members of parliament are women and have little influence over allocation of Government resources for the achievement of women and child rights.

- **Psychosocial stimulation**

Discussions with communities and extension workers held in August 2000 indicated that there is limited psychosocial stimulation through play materials given to the child or active interaction with parents. Because of high workload, the child is usually tied at the mother's back limiting the child's play environment and social interaction. In addition fathers spend limited time playing with their children and give little support to mothers.

- **The impact of HIV/AIDS on child caring practices and nutrition**

Malawi is one of the countries with the highest prevalence of HIV infection in the world – currently estimated at 16% of the 15-49 age group - and poses the most serious threat to the development of the country. Every day an average of 267 people are infected with the virus and 139 people die from AIDS-related diseases. The National AIDS Control Programme (NACP) estimates that 46 percent of new infections in 1998 occurred in youth aged 15-24 and females accounted for 60 percent of these infections. HIV/AIDS is now the leading cause of death in the most productive age group (15-49), and 30 percent of the Ministry of Health's curative budget is now spent on AIDS patients.

Some of HIV positive mothers pass on the virus to their babies during pregnancy, birth or breastfeeding, leading to HIV infected children who later develop AIDS. HIV positive mothers need to be counselled in order to make an informed choice on their reproductive health and appropriate infant feeding options. If this is not done, advances already made in breastfeeding promotion and child health can be reversed.
The burden of disease is increasing and HIV/AIDS depletes quickly the body's micronutrient reserves. Mothers have to spend more time and resources caring for AIDS patients with opportunistic infections.

AIDS orphans are increasing at an alarming rate. According to Government estimates, AIDS will orphan 300,000 children by the year 2000. While extended family relations within the communities care for orphans, the increased family size is stretching their economic resources beyond limit. Over 60% of the households in Malawi live beyond the poverty line and this is made worse because HIV/AIDS is affecting the most productive age group. Elderly women with little or no resources are increasingly caring for a large number of orphans. The girl child suffers more as she assumes responsibility for younger siblings and the family during illness and after death of parents. Orphans are not protected from physical and sexual abuse as well as child labour, denying them of their right to protection, health education and also development because of psychological trauma. Child headed households; street children and drug abuse by children are a common occurrence in severely affected areas.

HIV infection and AIDS have serious implications on resources for care, all childcare practices and the well being of children and women in affected families. In particular it poses a major threat to breastfeeding as a practice that has saved many children's lives in Malawi.

Key issues

(a) High malnutrition rates and micronutrient deficiencies, low birth weight, high maternal mortality and infant and young child mortality

Inadequate child feeding
Low Exclusive Breastfeeding, early introduction of complementary food
Poor quality of complementary food, infrequent feeding due heavy workload for mothers, food insecurity

(b) Inadequate care for women

Inadequate maternal nutritional status, early pregnancy,
Unplanned frequent pregnancies, irregular and late attendance of antenatal clinic
High workload, limited emotional support by family
High maternal mortality, Low birth weight

(c) Gender Issues

The plight of the girl child in fulfilling her rights
Limited support by fathers for pregnant woman and young child
Many women having little or no basic education, limited access and control of economic resources by women

(d) Inadequate care during illnesses

Inadequate home management of illnesses
Early stopping of treatment
Children not taken promptly to health facility after showing danger signs
Lack of knowledge in illness symptoms
Poor attitudes of health personnel
High morbidity, High mortality

(e) Poor Hygiene and Sanitation practices

Poor hygiene practice and sanitation
Unsafe disposal of child faeces and lack of hand washing
Limited access to safe water

(f) Inadequate Stimulation and psycho-social development

Limited psycho-social stimulation of child
Inadequate knowledge in psycho-social needs of children
Limited emotional and practical support by family to child development and nursing mother

(g) High prevalence of HIV/AIDS

Mother to child transmission during pregnancy, at birth and during breastfeeding
Infant feeding options for HIV positive mothers and mothers caring for young orphans
The burden of disease and management of opportunistic infections
Reduced income, high expenditure on health care
Increased mortality, increased time and resources spent on funerals
High infection on young people, especially girls aged between 15-24.

(h) Increasing number of AIDS orphans

Resource constraints in extended family relations who become primary caregiver for orphans
The girl-orphan assumes care responsibilities so early, preventing her from fulfilling educational rights
Sexual and physical abuse of orphans;
Property grabbing after death of parents

Senile grandmothers caring for orphans without support

CARE CAPACITY GAPS

- The major capacity gaps include limited responsibility to act, limited authority in allocation of resources, influence of religious beliefs and local customs, inadequate knowledge on rights of women and children, inadequate knowledge and skills in infant feeding, hygiene and sanitation, health and other child care practices.

- The capacity gaps at household level include food insecurity, low incomes and limited responsibility to support caregivers. Boys and men are not given child care roles during initiation ceremonies. A fundamental gap is inadequate knowledge of rights of women, girls and children.

- Community level capacity gaps include the following: limited motivation and responsibility of village headmen to support families with inadequate child care practices, lack of courage to change local customs, inadequate knowledge on rights of women and children, limited number of facilitators, limited resources including transportation for supporting child care activities in all villages. Insufficient co-ordination and integration of community based interventions. Inadequate skills to care for HIV/AIDS patients.

- The major capacity gaps for district officials include poor motivation to work because of low salary and economic hardship, inadequate technical planning in childcare activities and limited capacity in nutrition, limited funding for community level child care activities, and inadequate collaboration and co-ordination among stakeholders.

- Capacity gaps include poor motivation to provide support to districts, inadequate policies to protect breastfeeding, rights of women and children especially orphans, inadequate knowledge in human rights based approach to programming, limited resources allocated to basic social services and inadequate collaboration and co-ordination among stakeholders.

SECTION TWO
LESSONS LEARNT FROM THE 1997 – 2001 COOPERATION

II-1 Social Policy- human rights

Coordination with stakeholders at policy level is a key to accelerate advocacy for review and formulation of policies that have a direct bearing on the lives of children and young people. The programme has played a central role in the formulation of the Youth Policy, mother to child transmission of HIV, and the Early Childhood Development Policy, through such coordination.

II-2 Community based initiatives

- *The community school experience*, which involved communities for school development, proved to be a cost-effective strategy for increasing access to and improving of basic quality. By bringing schools nearer to the community, the community schools have helped increase enrolment and participation of girls and enabled children to begin school at the right age. The concept of community schools and community participation has been accepted and supported by all partners in primary education constitute a good entry point for sector wide approach. The new Country Programme must build upon the gained experience and widen the range of partners including NGOs.

- *Concerning orphans*, many communities have continued to organise themselves through community based organisations and with the leadership of village headmen and chiefs. They take responsibility to look after orphans. However there is a need to intensify the dialogue on rights of children and women to avoid various problems that orphans and families affected by HIV/AIDS continue to face as described in the situational analysis. Experience has shown that it is important not to isolate support for orphans from the rest of children in the family as that practice is not in line with the principle of non-discrimination especially when the rest of the children in the family are facing almost the same survival and development challenges. Furthermore planning of support for orphans should be carefully done so that their involvement in vocational skills should not prevent them from going to school. The programme must ensure that children who are supported continue with education during illness and after death of parents.

- The programme's efforts to improve intake of micronutrients particularly vitamin A and Iodine have yielded good results. Households using iodised salt have increased from a negligible proportion to over 60% in 10 years. Vitamin A supplementation in Malawi reached 100% through national immunisation days in 1998-1999.

- *Chronic malnutrition*, infant and young child mortality rates have not improved significantly in the last few years for several reasons. While child growth monitoring is an important process to detect growth faltering and take action early, counselling and support for growth promotion is not adequately done because health workers lack counselling skills and are exposed to high workload. A survey on household and community childcare practices was conducted in August 2000 and quantitative data is being analysed. Preliminary results of the qualitative part of the survey indicate that there are many factors that prevent primary caregivers from seeking and providing for these capacity gaps. The country programme needs to build on this approach as it helps to focus on community capacity development.

- *As far as community based malaria prevention* is concerned the main challenge is to bring the use of treated nets to a national scale in a sustainable and affordable manner, with appropriate schemes for equity. The successful implementation of the facility based IMCI and the overwhelming interest for the community IMCI represent an opportunity to seize to integrate all community interventions aiming at reducing child morbidity and mortality.

II-3 Youth Participation & HIV/Prevention

- The youth can easily be used as a resource, as they have ideas, are innovative and have the energy and enthusiasm that does not compare with the adults.

- The youth to youth approach has indeed proven to be an effective tool for disseminating information of HIV/AIDS and for providing young people with a platform to articulate their development and participation rights. The current programme has facilitated a network of over 3200 Anti-AIDS clubs in primary schools, over 700 out of school clubs, 70 Youth Non-government organisations and 27-district youth co-ordination structures countrywide. The youth groups have worked with communities in reaching out to many young people with a range of activities to promote their heath and development. This network will be extended in the next Country programme.

- Programming experience on HIV/AIDS education for in and out of school youth demonstrated that information alone is not adequate for behaviour change. There is need for a communication package that engages issues of motivation, interpersonal and psychosocial skills and the cultural, social and emotional environment.

- Youth activities have often lacked focus and a systematic approach that enable effective supervision and monitoring. Although the young people were active in the promotion of child, there was little involvement in issues of orphans, child labor, and street children.

II-4 Decentralisation

- The decentralisation of the programme to the district level has been an effective approach. The provision of funds directly to districts is a significant improvement and indicates that the decentralisation structure and strategy can improve efficiency in implementation. There is an increased responsiveness to management issues and accountability of the district staff. The districts are able to increase the programme implementation rate, achieve teamwork, partnership with communities. There is need, however to prepare seriously the DHMT to take on their new responsibilities progressively. Central level should be able to provide support especially at the early stage of implementation regular support early stage there is need for the central level to provide consistent support and supervision, especially for some new interventions.

II-5 Programme Management

- Co-ordination, ownership and leadership roles are not yet fully satisfactory in the CP. Active implementation at district level has not matched up with sectoral co-ordination. This has resulted in duplication of efforts in some cases. There is need to improve sectoral co-ordination mechanisms at all levels to ensure programme harmonisation and integration of capacity.

- The Country Programme should invest time and resources for Sector Wide Approach debate and development. This will require more discussions at national level with the Government and other partners. In this regard more harmonisation within the various sectoral programmes is needed to avoid duplication and to ensure more synergy. This requires a review of geographical target areas in order to merge the activities of the various projects where appropriate.

II SECTION THREE: PROGRAMME GOALS, OBJECTIVES AND STRATEGIES.

III-1 COUNTRY PROGRAMME GOAL AND OBJECTIVES

The overall goals and objectives of the country programme are:

- To contribute to create a conducive environment to meet the national goals of the right to survival, development, protection and participation of children and women.
- To contribute to the national goal of reducing HIV/AIDS transmission especially among children and young people and mitigating its impact on vulnerable groups.
- To strengthen the capacity of the different duty bearers to meet their obligations to children in order to reduce child and mother morbidity and mortality.
- To support the country's efforts to build capacity for poverty eradication by establishing effective coordination and collaboration mechanisms that enhance Sector Investments frameworks, Sectorwide approaches with the ultimate objective of bringing about sustainable development that benefit women and children.

III-2 COUNTRY PROGRAMME STRATEGIES

The Malawi Government and UNICEF country programme have identified, through a detailed strategy setting process based on the human rights approach to programming the following major strategies: Advocacy Social mobilisation, Service Delivery, Community Capacity Development and Institutional Capacity Building, Building Partnership and participation

(a) Advocacy and Social Mobilisation:

This strategy will facilitate the formulation of policies that advance child rights and promote survival, protection participation and development, including the judicial system. Advocacy and social mobilisation promoting the right of the child and women will be conducted in close partnership with civil society, especially the NGOs, the media, district assemblies and community leaders.

(b) Capacity Building:

Capacity building is one of the key strategies of the country programme to strengthen the ability to identify, plan, execute and monitor social policy interventions. Planning, coordination and monitoring capacity at national level to ensure a consistent and sustainable development of the social sectors along the principles of the sector wide approaches will be key features under this strategy.

Community capacity development on the other hand is a centerpiece of this strategy as it will allow a genuine participation of the communities to identify, analyse and plan for the major problems hindering the fulfillment of the rights of children and women based on the triple A process within a human rights approach to programming which emphasizes the role of the different duty bearers and takes into account their capacity gaps.
Monitoring and evaluation is expected to be high on the agenda of the country programme as a way to build capacity at all levels by promoting a culture of data collection and analysis for effective action and sustainable achievements.

(c) Service Delivery:

This strategy is mainly aiming to empower disadvantaged populations in districts and communities to access quality basic services such as health, education, and potable water. Groups of children and adolescents at higher risk and need the special attention, such as the orphans, working children, the girl child, children in the street and children subject to various forms of exploitation and harmful traditional practices. Special attention will be paid to the different sectors in the same area in a convergent manner so as to maximize the impact of the country program.

(d) Partnership and Alliance building

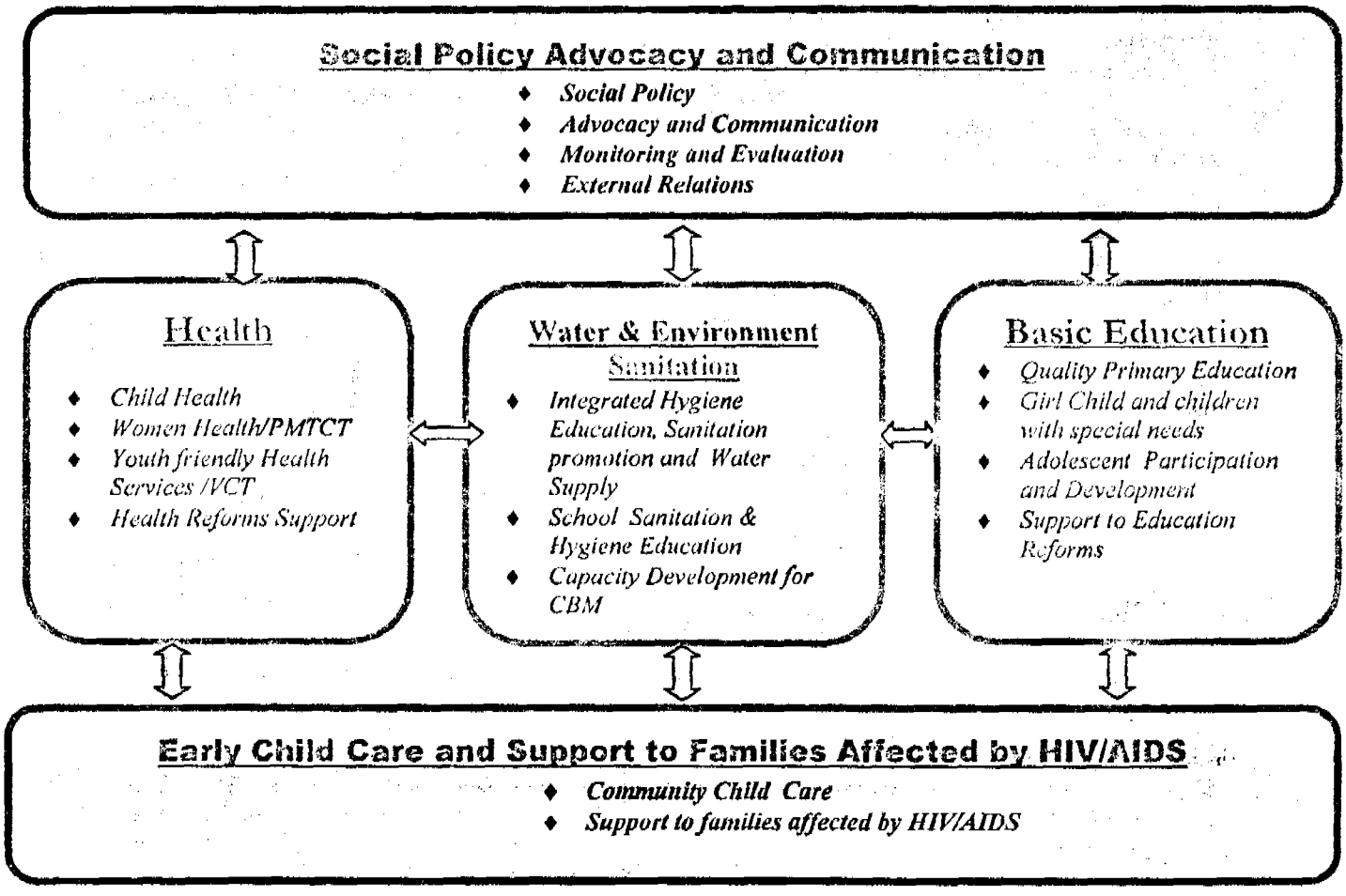
Partnership is key for the smooth implementation of the country programme as highlighted from the past experience. The country programme will consolidate the existing alliances and partnership with UN agencies through the UNDAF, with the Bretton Wood institutions, and with the NGOs, making sure clear and practical agreements are developed. Donor collaboration remains particularly important in the endeavor of assisting communities to know and understand how to access development assistance. The CRC offers a platform for collaborative programmi 3.

Alliance with media and the community leaders should be reinforced to ensure a greater success of community based interventions especially in the context of programme on mitigation and prevention of HIV/AIDS.

III-3 COUNTRY PROGRAMME STRUCTURE

The country programme is based upon the national priorities identified under the CCA, with poverty, HIV/AIDS, governance and gender, the key issues and gaps arising from the situation analysis. The programme is also build upon the new UNICEF agenda for children in 21 Century focussing on early child development, basic education and young people. The current programme has gathered substantive experiences and lessons clearly outlined during the mid term review which are also contributing to the programme design. The country programme developed in participatory fashion around the theme of HIV/AID and line with the human right approach to programming is community focus, decentralised and child centred.

The country progamme is made of five programmes, of which two are cross cutting, namely the Social policy advocacy and communication (SPAC) programme, the Early child care and support to families affected by HIV/AIDS, (ECC-FAHIV), and three are sectoral in nature. These are the Health, basic education (BASED) and Water and Environmental Sanitation (WES).



III-4 COUNTRY PROGRAMME COVERAGE:

All the five sectoral programmes have a national coverage, targeting the most vulnerable segments of the population, the most disadvantaged districts and communities. The Programme is converging in specific geographical areas to ensure a greater impact. Eight districts representing nearly 50% of the population will constitute the impact areas for the selected interventions. These are IMCI, PMTCT, VCT, and Malaria, Water supply.

Criteria for selection of impact district:

- Ongoing successful or promising activities in districts or communities (IMCI, VCT, Malaria, Community Schools)
- District with no or little support from other partners (Chitipa)
- Low level of basis social services access and coverage
- High densely populated districts with opportunities to introduce successfully new interventions (Lilongwe, Blantyre)
- Dynamic district executive committees with strong collaboration experience (Kasungu)
- Co-ordination of interventions under UNDAF (Districts covered by the Community IMCI. VCT project funded by UNF (Mzimba, Kasungu, Mchinji,)
- Highly motivated communities with good participation record (Mwanza).
-

Districts Selected: Total population: 4,900,000 (50%)
Chitipa
Likoma Islands
Mzimba,
Kasungu
Lilongwe
Mchinji
Blantyre
Mwanza

The CP will provide a minimum package of basic social including in the areas of Early Child Care, Health, Education, Water and Sanitation and HIV/AIDS to impact districts in close collaboration with line ministries and other partners.

III-5 PROGRAMME MANAGEMENT:

National level: The Government and UNICEF share responsibility of the management of the country programme. The Joint co-ordinating committee is responsible for overseeing the progress. Government has the prime responsibility of the implementation. The government and UNICEF will involve the NGOs in the implementation of the programme.
Within the government the Ministry of finance is the main counterpart co-ordinating the inputs of the government. In particular the Ministry of Finance is responsible for the government accountability. Within each line Ministry there will be a focal point for the country programme ensuring the co-ordination with other partners with ultimate objective to make substantive contribution to the sector wide approach.
Each project will have a designated project officer in the line Ministry who is responsible for the day to day management of the project
Each programme will have a programme working group made of the main implementers including at lower levels (districts, communities) of the programme regardless they are from the government or from the non governmental organisations or partners to ensure collaboration and co-ordination with all he stakeholders
The programme working groups should meet regularly to discuss technical issues as well as assess progress, including the mid year and annual review.
In UNICEF the Representative has the overall responsible for policy issues and resources commitment while the programme planning functions rest with the programme co-ordinator.
At district and community levels the district executive and the district assemblies when they are fully operational are responsible for the overall implementation of the programme.

IV- SOCIAL POLICY ADVOCAY AND COMMUNICATION

The Social Policy, Advocacy and Communications programme will support the country programme by providing intersectoral technical inputs and guidance for the development of policies, advocacy and communication strategies. The programme is also providing advice and support to community capacity development. This programme will work closely with other sectoral/thematic programmes to consolidate the needs of the country programme in terms of advocacy, policy dialogue, communication and monitoring & evaluation of the country programme.
Mechanisms for monitoring and evaluation are as important as the interventions themselves. A major focus of the new Country Programme will be to concentrate efforts on the development of programme wide monitoring systems to monitor the implementation and effect of key programme strategies, including communication, capacity building and community participation. As part of this effort, attention must be paid to ensuring the inclusion and follow-up of crosscutting issues within programmes especially gender and child rights. Mechanisms will be built into the programme to allow regular review of routine monitoring and evaluation plans and outcomes across the Country Programme, for the purpose of noting overlap and similarities between projects and programmes and identifying opportunities for synergistic action or research. The Integrated Monitoring and Evaluation Plan (IMEP) will be used more effectively to improve co-ordination of M& E across programmes and allow an overview of how performance and impact will be evaluated. This includes collection and use of data at community as well as institutional levels. In addition to working with partners on improving routine data availability and use, e.g. Human Rights Commission, the Country programme will also support efforts to collect, analyse and use additional information and research for advocacy.

IV-1 PROGRAMME OBJECTIVES

1. To improve the political and legal framework for the realisation of the rights of women and children.
2. To strengthen the campaign to break the silence on HIV/AIDS as a national emergency.
3. To assist Civil Society and the Government to implement sustainable community based interventions for the prevention of Child Rights violations.
4. To increase the availability and effective use of information management systems for policy formulation and programme design, implementation and monitoring & evaluation.
5. To develop and implement a research based communication strategy to influence attitudes to contribute to the fulfilment, protection and respect for the rights of the children and women.

IV-2 PROPOSED STRATEGIES

(a) Advocacy and policy dialogue

Advocacy will be taken up with policy and decision makers, opinion makers, donors and other stakeholders at national, district and community levels to develop a commitment to the realisation of rights of children and women as enshrined in CRC, CEDAW. It will also advocate for particular policies and interventions to be implemented at community, district, and national level in support of the objectives of the country programme.

- Engage in policy dialogue and to support initiatives at national level, district, and community level aimed at ensuring adequate allocations and more efficient use of financial and human resources in providing universal access to basic social services.

- Research and advocate for reform of current laws, protection measures and practices to uphold the rights of women and children particularly those especially in difficult circumstances.
- Advocate on behalf of girl child and support initiatives that encourages girl child rights as a prime concern in development plans and strategies at national level.
- Create an environment for increased debate on children and women's rights policies and relevant issues among policy and decision-makers and opinion leaders across political differences.
- Advocate for ensuring that all adolescents have access to a distinct juvenile justice system that includes adequate attention to delinquency prevention, systems of diversion from the formal justice system, and an emphasis on restorative justice and reintegration.
- Advocacy and advice on incorporating cross sectoral, people focussed and child rights principles within Sector Wide Approaches.

(b) Communication for empowerment and behaviour development.

Communication channels at all levels will be strengthened and will be used to build progressive commitment to participatory programmes and child centred services.

- Promote research into social, economic and cultural factors governing behaviour to strengthen effective design and targeting of intervention as part of the intersectoral campaign to break the silence on HIV/AIDS
- Strengthen the capacity of the formal media through training and provision of information and resources to bring about public awareness on the rights of children and women and change attitudes.
- Support training in participatory communication skills among partners, extension workers, managers and decision-makers at all levels.
- Strengthen the capacity of programme partners and extension workers to research and develop messages and culturally acceptable communication materials.

(c) Capacity Development

This strategy aims to empower communities and districts through improved planning and management of social development.

- Support social sector ministries, NGOs, and civil society in the development of policies that are consistent with the CRC and CEDAW.
- Support to institutional capacity building for Sectoral Wide Approach (SWAP) including sector situation analysis and policy development.
- Empowerment of communities and households through participatory and gender sensitive approaches:
- Develop community capacity for the children who have lost their primary caregivers to be protected and supported through appropriate care and that those separated from their families will be protected and reunited
- Build capacity to ensure that adolescents' rights to development and participation are given adequate attention in national development plans and sector plans, including the definition of national goals and targets
- Empower rights holders and strengthen the capacities of duty bearers at family, community, district and national levels to facilitate them to fulfil their obligations

(d) Building Partnerships

An enabling environment will be promoted at national, district, and community level through advancing the processes of decentralisation and encouraging extensive participation in support of programme goals. The aim will be to:

- Build strategic alliances with Government, civil society, academic and research institutions with the aim of expanding the CRC and child rights awareness
- Develop partnerships for child-and women-friendly services;
- Facilitate building partnerships with young people, through NGOs and other youth-serving organisations, in policy planning, implementation, monitoring and evaluation

IV-3 PROGRAMME CONTENTS

The Social Policy, Advocacy and Communications (SPAC) programme aims to enhance intersectoral planning, programming, monitoring and communications while supporting advocacy and social policy developments relating to child rights and gender issues. SPAC has cross cutting functions including Communication, Advocacy, Social Policy, Monitoring and Evaluation. The Programme will have 4 projects: *Social Policy Development, Advocacy and Communication in the context of HIV/AIDS, Monitoring and Evaluation, and External Relations.*

(a) Social Policy Development

The Programme would foster improvements in the *development of social policies and legal reforms*, and to assist NGOs and the Government to implement sustainable community based interventions for the prevention of Child Rights violations. This will be achieved through *increased awareness* of the principles of children's rights among different stakeholders, and by *facilitating advocacy as well as community responses* to gaps in the fulfilment of children's rights. The expected outcome is to generate a critical mass of dialogue and action on child-related issues that will warrant the systematic implementation of programmes for children within related administrative, legal and social reform. Taking into consideration civic movements, the programme will help create the momentum for the identification and definition of social policies that advance Child Rights and promote the survival, development, protection and participation of children.

This Programme component will strengthen Child Rights promotion in the country. The programme will foster the institutionalisation and co-ordination of people-centred policy development, both in Government and NGOs, with the aim of creating a broad-based alliance for public education and awareness on child rights. Improve policy development for the realisation of the rights of the women and children particularly children in need of special protection.

There is the need, for programmatic and advocacy purposes, to obtain local, situation-specific data, desegregated by age group and gender and use this to facilitate and influence decisions in favour of children. To achieve this, the programme will build support for and capacity in monitoring the situation of children vis-a vis their rights. UNICEF resources will be strategically used to strengthen advocacy and social mobilisation action directed at promoting further social investments on the part of the Government on programmatic areas covered by this Country Programme.

The programme will also support Government's efforts to increase its investment in basic social services and public goods benefiting children, and to improve the efficiency and effectiveness of public expenditure in programmes for children and women, by ensuring that decision-makers, NGOs, and communities have access to information for the identification and development of policies and activities in favour of children.

The increase in problems of child abuse and domestic violence, child exploitation and teenage pregnancy are a reflection of a deteriorating social environment in which children grow up. The programme will target the selected population groups with social mobilisation and communication strategies that promote the positioning of children and young people within the community and the family in a way that fosters the development of their identity, promotes their socialisation and cultural growth.

It is increasingly recognised that HIV/AIDS is seriously threatening human development in Malawi. To break the culture of silence on HIV/AIDS in Malawi, the Social Policy, Advocacy and Communications section will take the lead in promoting a culture of rights to ensure that the rights of women and children in the context of HIV/AIDS are fulfilled and protected at all levels.

Despite efforts to link Child Rights with Women's Right, the programme has not always been successful. To strengthen these links, SPAC seeks to devise mechanisms to ensure effective integration of programmes with gender and child related aims.

(b) Monitoring and Evaluation

Monitoring and evaluation are key for providing information about programme progress and impact, identifying new areas or emerging concerns, and laying a scientific basis for programme/project adjustment, as well as advocacy for both programmes and policies at various levels

As part of programme management, ongoing formative research will be used to identify new target groups or emerging issues and ensure timely inclusion in programming. Mechanisms will be built into the programme to allow regular review of routine monitoring and evaluation plans and outcomes across the Country Programme, for the purpose of noting overlap and similarities between projects and programmes and identifying opportunities for synergistic action or research. This systematic review will also be used to ensure projects are appropriately targeted, determining which groups are being reached and to what extent. Programme wide monitoring systems will also be used to monitor the implementation and effect of key programme strategies, including communication, capacity building and community participation, and to ensure the inclusion and follow-up of cross-cutting issues within programmes, especially gender and child rights.

Monitoring, evaluation and research will also constitute aspects of programme implementation in the Country Programme. Efforts to improve the availability and use of data for areas relevant to improving the situation of children and women.

This includes collection and use of data at community as well as institutional levels. In addition to working with partners on improving routine data availability and use, the Country programme will also support efforts to collect, analyse and use additional information for advocacy. This will include documentation of successful initiatives to facilitate policy recommendations and programme replication, as well as analysis and use of information on wider issues than those included in the Country programme which have a bearing on the fulfilment of children and women's rights. This documentation, together with regularly monitored information on the situation of children and women, relevant local and international research on children's issues and examples of best practices in programming will be maintained.

(c) External relations

In order to create a conducive environment for the realisation of child rights and gender equality this project will Increase awareness of child rights and gender issues among decision-makers, opinion makers, civil society and communities. Disseminate innovative information and communication materials on Child Rights and Gender Issues. Increase partnerships to build a broad-based movement for furtherance of women's and child rights. This project will increase media coverage of child rights and gender issues through national campaigns. Technical support will be provided to sectoral and thematic programmes in developing integrated communication strategies and IEC materials. External Relations and building strategic alliances continue to be one of UNICEF's comparative advantage in generating political concern and commitment to the development and participation of women and children.

(d) Advocacy and communication in the context of HIV/AIDS

This project will strengthen the campaign to break the silence on HIV/AIDS as a national emergency through increasing advocacy efforts to keep HIV/AIDS as a priority human rights issue on the national agenda. Also support sectoral programmes in influencing and sustaining behaviour change through development of innovative communication strategies and tools. To promote a change in attitudes and behaviour through training and sensitisation and develop alternative media channels to facilitate more open discussion of HIV/AIDS and eliminate stigmatisation.

(e) Programme Linkages:

SPAC is a cross cutting programme. This programme is supporting all the sectoral programme by providing technical inputs and guidance for the development of policies, advocacy and the development of communication strategies. The programme is also providing guidance, advice and support to community capacity development. The project officers will work closely with the different programmes and consolidate the needs of the country programme in terms of social mobilisation communication and monitoring.

V- HEALTH PROGRAMME

V-1 PROGRAMME OBJECTIVES

- To empower communities and young people to develop plans of action; based on the triple A approach; to reduce the prevalence of malaria, ARI, malnutrition among children under 3 years and mortality maternal.
- To empower the community to identify, and modify harmful traditional and cultural practices that predisposes women and children to HIV infection.
- To improve access of women, adolescents and children to quality and integrated health services including sexual and reproductive health services.
- To empower young people with reproductive health and life skills information to enable them manage their sexual and reproductive lives.
- To support the provision of Vit A supplements to at least 90 % of under five children and to at least 50% of pregnant women.
- To support the promotion and establishment of youth friendly health services.
- To reduce the incidence of MTCT of HIV by at least 50% in priority districts.
- To increase access of young people to voluntary counselling and testing in all appropriate and suitable health facilities
- To reduce the prevalence of HIV among young people by at least 25% of 2000 levels.
- To support the DHMT to plan, deliver, monitor and evaluate integrated child and reproductive health services in conformity with human right approach.
- To support the MOH/MOHP to develop sustainable policies and strategies to address prevention of HIV/AIDS, management of childhood illnesses and maternal health care.
- To support the development of training strategies to bridge gaps in availability of qualified human resources as a result of AIDS.
- To effective support the decentralisation process by human resource and institutional development.
- To promote the use of HMIS at all levels with emphasis on the use of information at the point of data collection, including the recording and use of basic information at community level.

V-2 STRATEGIES

(a) Social Mobilisation

Social mobilization is the leading force for social change and will be the most important strategy in the implementation of the health programme. It will focus on assessment, analysis and action taking by all social groups or stakeholders concerned in health and health sector issues by developing community profiles and action plans based on human rights approach to programming. It will be the leading strategy to implement all health related activities at grass roots and in close collaboration with community based stakeholders by empowering them to decide what is best for them, particularly children and women. Particular emphasis will be given to youth groups as targets for behavioural change and agents for social change. This strategic component will contribute to creating a high level of ownership and sustainability of the programme.

Social mobilisation will also be based on the assessment and analysis of the situation of children and women based on human rights approach to planning, monitoring and evaluation of health related activities that will be carried out by community based organisations. The active participation of the youth will particularly be sought at all times.

The primary thrust in this strategy is to primarily involve young people as a force for change, vis-à-vis prevention of STDs, HIV and AIDS.

The project will utilise participatory and innovative training packages will be developed to improve youth to youth and adult-child communication. The project will support community-based life skills for youth to enhance their abilities to sustain low risk and healthy behaviour. It will also target parents, opinion leaders because they play a prominent role in providing the necessary pre-conditions necessary for the development and change in young people's behaviour.

Particular attention will be paid to issues of gender by supporting equal involvement of men and women in health activities. The project will utilise interactive drama, sport and other mobilisation techniques such as soap opera for immunisation and micro nutrient supplementation.

Clear identification of duty bearers and capacity gaps will be carried out. Consequently, all activities must target the duty bearers for the fulfilment of the rights of children and women and at the same time they must address one or more of the capacity gaps identified in the planning process. Attention will be given to the participation of men in childcare and support to pregnant and lactating mothers.

The programme will support activities which will facilitate the development of mother-friendly communities based on the awareness that each pregnancy to women represent a higher risk of death, thus contributing to creating a sense of community responsibility for the well being of pregnant women.

It is hoped that social mobilisation will be the corner stone for social and behavioural change and clear strategic objectives for social mobilisation activities will be developed. It will focus on 4 high priority issues, namely: HIV/AIDS, teenage pregnancies, obstetric emergencies and home based management of common childhood illnesses. Focus on small number of issues will facilitate the process of making a positive difference create on the expected outcomes.

(b) Advocacy

Advocacy will continue to be the other pillar of the health programme. This will particularly focus on policy development for social change. It will target a rather small number of well-documented issues, which bear the highest priority for policy development on different levels of programme implementation.

The subject of sexuality is discussed in euphemisms, and not openly. As such, particular attention will be paid to bringing out issues of adolescent reproductive health in the open. Hitherto emphasis has been on manifestation of problems and generally ignored the root causes, most of which may be addressed through policy enforcement, open discussion, or simply a shift in the practices and tendencies at family or community level.

The key element will be information gathering and documentation of the existing situation and a clear vision of the desired situation in the future that will be used to advocate the necessary changes needed to facilitate the realization of the desired situation and the actions required by all duty bearers for the fulfillment of the rights of children and women. In addition, information on best practices on child and maternal care will be gathered and disseminated.

(c) Service delivery

The major strategy to deliver health services to children will be the promotion of Integrated Management of Childhood Illnesses at health facility level. In collaboration with Early Child Care section, the health programme will support IMCI activities at community and household levels. Social marketing strategies will be used to facilitate the adoption and utilization of impregnated bed nets to reduce incidence of malaria in children and women.

Health care service delivery will focus on ensuring that all children and women have access to quality of health care. It will support and promote the development and implementation of the Essential Health Care Package (EHCP). The health programme will provide medical and non-medical supplies in support to the implementation of the EHCP. It will actively avoid vertical interventions.

It will facilitate negotiations as part of the Sector Investment Programme and Sector Wide Approach for multi-donor support to the health sector (procurement of vaccines and cold chain supplies, bed nets, essential drugs, micro nutrients, etc).

The prevention of HIV transmission will focus on supporting the establishment of youth friendly health services and voluntary counseling and testing and will support public sector, NGO, and private sector partner to increase access and availability of youth friendly services in which VCT is available.

The prevention of mother-to-child transmission of HIV will be a high priority in the programme. It will support the establishment of these services at all appropriate and suitable health facilities, (public, missions, NGOs and private sector facilities). The programme will begin on a limited number of target districts but will seek to rapidly expand to the rest of the country.

The high attrition of qualified human resources due to AIDS-related mortality will be addressed by supporting appropriate short training courses. The longer term planning of human resources development is being addressed by the MOHP and the donor community by shortening the curricula of graduate training and exploring the payment of cash incentives to reduce the exodus of qualified staff to Europe and other African countries. All training activities, apart from the technical components, will promote child, youth and mother friendly attitudes among health staff.

It will also focus the use of health information and data to plan and monitor health sector activities and thus contributing to create a culture of data-based planning at all levels of the sector. However, UNICEF will focus and intensify it's support to the use of information for planning at district and health facility levels. It will ensure that data should primarily be used for better management at the point of data collection. This will ensure that proper attention is paid to accurate and timely recording of information and therefore creating a more responsible environment. Health facilities will be encourage to assign half a day every moths to discuss progress on health programmes using data collected at the health facility.

The collection and use of basic information on health by the community based organizations will also be sought. Particular attention will be given to the active participation of the youth in community based data collection, analysis, planning of activities at that level. This will encourage participation of the youth as agents of social and behavioral change.

Supervision and particularly supportive supervision will continue to be an important component of routine management an all levels. UNICEF will provide the transportation means and financial support to ensure timely supervision activities which will be focused on specific problematic areas of the health delivery system. The area of focus might change overtime as a result of making substantial progress on issues that had been supervised and closely monitored for a period of time.

In order to reduce maternal mortality, UNICEF health programme will support the expansion of maternal services to a level that emergency obstetric care is available within 2 hours distance between the homes and the health facility. The programme will also actively promote and seek ways of supporting the quality of maternal services including access to emergency obstetric care by all pregnant who require such services. Contributions to the reduction of maternal mortality will also be made by ensuring malaria prevention and the use of IBNs, the provision of prophylactic and efficient and prompt treatment of malaria according to the Abuja Declaration on malaria.

Youth friendly health care services will be of particular emphasis during the implementation of the health programme. Suitable information will be delivered and life skills training carried out. This will empower young people to take charge of their own health and negotiate relationships, including sexual relationships as a crucial component of behavioural change and take active and leadership role as agents for behavioural change.

The programme will support the sharing of experience among the UNICEF supported districts and the districts supported by other organizations as means of disseminating the best practices.

In order to expand UNICEF's support to service delivery, the health programme will actively seek to widen the range of strategic partnerships with NGOs, CBOs, church institutions and the private sector.

Based on experience and lessons learned, the programme will continue to strengthening links and partnerships with WHO and UNFPA. The programme will so strengthen partnerships with the MOHP and the DHMT by holding regular (monthly), review and planning meetings.

(d) Training and Capacity building

Training and capacity building are interrelated and therefore, not necessarily seen as one strategy. Training will relate to improving the knowledge, attitudes and skills to perform a task with an expected health outcome for individuals within the health sector. It will be based on the identification of tasks and gaps to efficiently perform them. Particular emphasis will be given to child, youth and mother friendly attitude and practices. It will monitor post-training performance to ensure quality improvements.

Capacity building will relate to empowering institutions and covers other areas such infrastructure development, organisation and institutional management capacity.

Capacity building will particularly focus support given to the decentralisation process at district level and will target all duty bearers at district level so as to ensure that gaps in human, organisational and economic resources are adequately addressed and supported.

Given the fact that most health workers had been trained on IMCI, the programme will actively liaise with academic institutions to institutionalise IMCI training into regular graduate training of nurses, midwives and physicians.

The training efforts will recognise the potential role of young people in community-based service delivery and will, therefore, the programme will support the training of young people to fulfil this objective.

The programme will actively seek to establish more meaningful partnerships with the DHMTs to build their capacity to and support the decentralisation process.

(e) Strategic Communication

Strategic communication will be the tool to achieve behavioural change. However, this time around, it will be well focused and targeted to specific issues (HIV/AIDS, teenage pregnancy, maternal mortality, and malaria and micro nutrient supplementation). In so doing, the likelihood of having a positive impact after an intervention will be higher that general communication strategies. Communication tools will be developed using participatory methodologies at community and health facility level. Especial attention will be giving to establishing partnerships with youth groups to disseminate information to youth in the communities. The programme will support the development of communication strategies to support youth to youth and child-to-child communication.

All communication, written and oral, will be tested on real life situations with women, children and youth. As a result of testing, messages will have better chances to be clearly received by the target groups and that the better likely impact on change of behaviour.

The programme will support the development of low cost appropriate technology and innovative approaches for information dissemination and the establishment of partnerships with the mass media to go beyond the commonly used billboards and posters.

Advocacy will be a common strategy throughout all activities, as well as in the delivery of the other strategies. The emphasis will be on:

- Targeting (in terms of audience and messages)
- Using different channels (print, electronic, and face-to-face (*interpersonal/interactive*), either singly and in combination)
- Enlisting the participation of critical players

V.3 PROGRAMME STRATEGIES

Project 1. Child health
Project 2. Women's Health/Prevention of Mother to Child Transmission of HIV
Project 3. Youth Friendly Health Services/Voluntary Counselling and Testing
Project 4. Support the Health Sector Reform.

(a) Child Health: Target population children under five years.

- Universal immunisation coverage for children under one year (20% increment).
- Improve the quality of immunisation services measured by the consolidation of successes of Polio eradication as well as eradication of measles outbreaks and reduction of measles cases by 50%.
- Support the introduction of new vaccines (combined DPT + Hepatitis B) and Haemophilus influenzae Type b) within the framework of Global Alliance for Vaccines and Immunisation (GAVI).
- Reduce the prevalence of Vit A deficiency by 50% (baseline data will be determined in 2001) by sustaining over 90% coverage of high dose supplementation of Vit A every six months.
- Virtual elimination of iodine deficiency disorders.
- Reduce the prevalence of iron deficiency anaemia by 50% reducing the incidence of malaria and iron supplementation once paediatric presentation of iron supplement is made available.
- Increase from 5% to 50% the proportion of children using and sleeping under impregnated bed nets.
- Reduce the prevalence of diarrhoea and ARIs by 50%.
- Support access to quality of integrated management of childhood illnesses in 6 target districts.
- Ensure the utilisation of child health data and information for better management of child health services in the UNICEF target districts.
- In collaboration and co-ordination with other UNICEF programmes, ensure adequate management of common childhood illnesses at household and community levels.
- Advocate and support the development of birth registration system in Republic of Malawi.

(b) Women's Health/PMTCT of HIV.

- Increase the proportion of women utilising health facility-based obstetric services for pre, natal and post natal care from 20% to 50%.
- Increase the utilisation of maternal health services and reduce case-fatality rate by improving the quality of peripheral health facilities and the district referral services.
- Support the supplementation of high dose of Vit A to no less than 90% of institutional deliveries.
- Support iron supplementation (or multi micronutrient) to at least 90% of women attending antenatal services.
- Consolidated the effective implementation and coverage of the Maternal Death Audit at district and community levels in targeted districts.
- Reduce the incidence of MTCT of HIV by at least 50% in the programme impact areas.
- Raised awareness on MTCT among health workers, community partners, NGOs, government counterparts and community-based organisations.
- To increase access to effective counselling and HIV testing services to all pregnant women at the appropriate and relevant health facilities.
- Provide voluntary counselling and testing of HIV to at least 50% of pregnant women attending antenatal services in the selected districts.
- Promote appropriate child feeding options for HIV-positive mothers.
- Provide medical and emotional support to HIV-positive women attending antenatal and to mothers attending post-natal facilities.
- Improve the skills of health workers and other caregivers who assist the pregnant women on MTCT to provide effective counselling, testing, and safe delivery services.
- Increase the skills of health workers and other caregivers on HIV/AIDS risl management.

(c) **Youth Friendly Health Services/VCT.**

- Reduce the proportion of young people (6 to 14 years) engaging on sexual activities from 50% to 30%.
- Reduce the proportion of teenage pregnancies from 30% to 15%.
- Continue using life skills fora in promoting healthier sexual practices among young people.
- Continue supporting the establishment of and access to youth friendly health services with focus on reproductive health and life skills and voluntary counselling and HIV testing to at least 85% of the youth in the selected districts.
- Widen the factual knowledge of young people on HIV/AIDS from 20% to 60%.
- Enhance the respect to the rights of adolescent girls.
- Improve support systems for, and decrease the stigma against HIV-positive adolescents.

(d) **Support the Health Sector Reform.**

- Strengthen, at central and target districts levels, the utilisation of data and information to plan, implement, monitor and evaluate the provision of health care services for children and women.
- Strengthen the capacity of target district for resource management.
- Strengthen the capacity of DHMT to undertake operational research and utilise the findings for better health service management.
- Support and strengthen in-service training and supportive supervision from central to district and district to health centre level.
- Strengthen the capacity of the DHMT to plan, implement and monitor health related activities in partnership with community-based organisations and households in order to improve the household management of common childhood illnesses and obstetric emergencies.
- Contribute to the formulation, implementation and evaluation of a sector wide approach that is providing a comprehensive essential health package at all levels.
- Support alternative health financing schemes that promote sustainability and effective participation as recommended in the health strategic plan.

(d) Programme Coverage: *National* EPI, Vitamin A Supplementation, Exclusive breastfeeding, Iron Supplementation, Promotion of Iodised Salt, Health Reforms support
Select Districts: PMTCT, VCT, Maternal death Audit Referral System, IMCI

(e) Linkages:

Policy development advocacy and social mobilisation with SPAC
Community IMCI, ITNs, Community nutrition with ECC-FAHIV
Hygiene and Sanitation with WES and Basic Education

VI- BASIC EDUCATION PROGRAMME

VI-1 PROGRAMME OBJECTIVES

Based on the role and capacity analysis, the basic education programme is aiming at filling the capacity gaps at the different levels of duty bearers in order promote, fulfil and protect the rights to basic education at different stages in their life cycle, in light of the current situation of HIV/AIDS in the country and the direct challenges it creates to the education sector.

To ensure primary school children acquire basic information on HIV/AIDS and life skills that enable them to make informed choices on sex.

To improve the quality of education in schools so that all learning environments are effective, healthy, gender-sensitive and enable children to attain desired levels of achievement.

To strengthen the capacity of girls to resist sexual abuse, improve their access, retention and achievement rates in basic education in project schools and advocate for the increased participation of girls in secondary schools.

To ensure that orphans, working children and other disadvantaged groups of children have ac :ess to life skills education and participate fully in primary education programmes or in programmes of comparable quality in target areas.

To reduce the impact of HIV/AIDS on adolescents through expansion of existing networks of extra-curricular activities and promote their development and participation and access to safe spaces, livelihood skills and opportunities.

To ensure teachers and other education personnel receive basic information on HIV/AIDS and life skills and facilitate the development and enforcement of a teacher's code of conduct that addresses the problem of widespread abuse of school children by teachers and other education personnel.

To support capacity development at national and district levels for sector policy development, sector planning, monitoring and evaluation and skills development and strengthen the capacity of communities to prevent, monitor and report abuse of girls in and out of school

VI-2 PROGRAMME STRATEGIES

In assisting the various groups of duty bearers to play their roles, the Basic Education Programme will employ a mix of strategies. At family and community levels, advocacy, social mobilisation and communication strategies will target attitudes, information gaps as well as establish and strengthen social structures. At the school, district and national levels, service delivery and capacity development will be used to develop technical and management skills. Advocacy and technical support will be the main vehicles for getting government to formulate appropriate enabling policies.

(a) Advocacy

At the national level, the Programme will continue to use research/studies/surveys and meetings of stakeholders on girls education, child labour, street children, orphans and adolescents to encourage formulation and enforcement of policies that promote the rights of children and adolescents. At community level, meetings will be conducted with traditional leaders and school development committees to encourage communities and families to prioritise education, support orphans and relate to children and adolescents on HIV/AIDS and sex

and sexuality issues. The current process of organising meetings with NGOs for purposes of getting them involved in programmes addressing issues affecting children and adolescents, with emphasis on HIV/AIDS and orphans, will be continued. Government will be encouraged to use such incentives as tax exemption as a way of getting the private sector to participate in the delivery of services to children and adolescents.

(b) Social Mobilization

Working through NGOs, religious organisations and traditional leaders to mobilise families and communities for HIV/AIDS activities, greater involvement in the protection and fulfilment of the rights of orphans, girls education, and greater involvement in school governance will be intensified. Linkages will be forged with the USAID-funded GABLE activities in mobilising communities for basic education.

(c) Communication

Building on the work being done in the current programme cycle through Anti-AIDS club for youth in and out-of school, youth NGOs, radio and traditional media, communities, youth and district and national leaders will be targeted for information on HIV/AIDS and importance of education, especially education of girls. Working through traditional authorities and school development committees, communities will be encouraged to evaluate cultural values that reduce rights of children and adolescents. Traditional and non-traditional media will be used to provide information on rights of children including information on sex and sexuality and create an enabling environment for behaviour change/modification. The current process of facilitating the establishment of parent-teacher associations and district level technical committees will be intensified to enhance involvement of families and communities in the development and participation of children

(d) Capacity Development

Capacity development will be a major strategy in Basic Education. At community and school levels, training activities will be used to ensure that teachers use child-centred, gender-sensitive participatory methods, to provide leadership and management skills to school heads, to strengthen school development committees and other structures that support development and participation of children and adolescents and to mainstream teaching of HIV/AIDS and life skills, health, nutrition and hygiene education
At the district and central ministry levels, workshops in and out of the country will be used to establish institutional capacities and to strengthen management and service delivery capacities, provide knowledge and skills and to strengthen the process of decentralisation.

(e) Service Delivery

The Programme will continue to provide essential teaching-learning materials, facilitate the development of HIV/AIDS education materials, promote the construction of classrooms and, in collaboration with the WES programme, provision of basic water and sanitary facilities. Technical, logistical and financial support will be provided in the areas of planning, management, supervision and monitoring. This strategy will be combined with social mobilisation, communication and capacity building, especially of communities, to ensure sustainability and ownership. The current efforts to strengthen the collection, analysis and use of data through provision of hardware and technical support will be continued.

(f) Partnerships and Linkages

The Programme will continue to promote partnerships with other UN agencies and relevant national and international stakeholders within the framework of SIPS and SWAPS. Within this context, UNICEF will share experiences in programming life skills as a preventive strategy against HIV/AIDS, community schools as a strategy for widening access and increasing the participation of girls. The existing partnership with UNFPA, UNDP and DFID in the areas of HIV/AIDS education and gender will be intensified. Special emphasis will be placed on leveraging resources for basic education and youth development and participation from the donor community. Linkages will be continued with such NGOs as Save the Children Alliance, Plan International especially at the implementation stage. Within the Country Programme, inter-sectoral linkages in programming for HIV/AIDS prevention, orphans, health and hygiene education and school sanitation will be continued to ensure a holistic approach to the fulfilment of the rights of children and adolescents.

VI.3 PROGRAMME STRUCTURE

On the basis of these objectives four projects have been identified for the Programme. These projects cluster the eight issues identified from the situation analysis and each directly addresses the HIV/AIDS epidemic.

(a) Quality of Primary Education and HIV/AIDS Prevention

This project will promote child-centred and gender-sensitive teaching -learning processes; promote teacher supervision; support incorporation of health, nutrition and hygiene education; provide learning materials and basic furniture; promote community involvement in school management; promote the development of schools as community resources; support provision of classrooms, water and sanitation facilities; collaborate with communities and other organisations on programmes that promote early learning and stimulation, support measures to increase learning achievements, support efforts to mainstream inclusive education.
A central component of this project is HIV/AIDS education. This involves promoting teaching of life skills in primary schools including teaching about the causes, risk factors and prevention of HIV/AIDS. As part of the HIV/AIDS prevention strategy, the project will promote peer education and development of psychosocial and cognitive skills; challenge harmful traditions and gender stereotypes;

(b) Participation and Retention of Girls and disadvantaged children in Primary Education

This project will support measures to ensure full and equal access to basic education for girls through community schools; promote retention, completion and achievement rates for girls; ensure elimination of gender discrimination in classrooms, textbooks, schools, home and community; promote teaching of child rights; mobilise families and communities against harmful traditions and cultural practices; promote enforcement of the policy of re-admission of girl mothers. It will promote measures to get the orphans, working children, street children and children with special needs into school and to remain there until they complete primary education or an acceptable equivalent. give particular attention to measures supporting the education of orphans; advocate for the eventual elimination of child labour. HIV/AIDS education including issues of sex and sexuality will be central to these interventions.

(c) Adolescent Development and Participation and Rights of Girl Child

This project will support the provision of services and opportunities for the development and participation of adolescents. Special attention will be given to HIV/AIDS and Adolescent Girls. The project will create safe and supportive environment for adolescents through policy development, systems of monitoring, inclusive programmes, provide adolescents with age and gender specific information and opportunities to develop life and livelihood skills through a range of channels, provide access to appropriate and effective services and opportunities, including for their physical and psychological health, education, recreation and leisure and promote participation of adolescents in decisions that affects their lives. The project will increase knowledge, understanding and practical experience in the development and implementation of programmes aimed at fulfilling human rights and meeting the needs of adolescents, make strategic use of existing knowledge and information to raise awareness and stimulate action at all levels. The project will work with youth groups, NGOs and community structures in increasing opportunity for contributing to valid community activities. The project will also increase opportunities of adolescents especially girls to find and create safe spaces that protect them from all forms of gender-based violence and achieve gender equity.

(d) Support to Education Sector Reform

This project will support the establishment and strengthening of policies and institutional capacities especially in areas of planning, information management, supervision and monitoring and address issues of impact of HIV/AIDS on the education system. The project will support policy of decentralisation to accelerate community-focused and community-driven service delivery. The project will mobilise communities for action on HIV/AIDS, girls' education and participation, orphans and other disadvantaged children. It will promote sectoral co-ordination within the framework of SIPS and SWAPS.

(e) Coverage: *National* for Youth participation and Development, Quality Primary education and HIV/AIDS prevention, Support to Education Sector Reforms.
Selected Districts: Participation and retention of girls and disadvantaged children in Primary Education.

(f)Linkages:

WES: Hygiene and Sanitation : WES, Health
SPAC; Policy Development, Advocacy and Social mobilisation, Community Capacity Development
Health: Hygiene and Sanitation, Life Skills, youth Friendly Services
ECC : PsychoSocial development, Support to orphans.

VII- WATER & ENVIRONMENTAL SANITATION PROGRAMME

The programme will contribute to the national WES programme by strengthening the community-based management, service delivery, and policy development.

VII-1 PROGRAMME OBJECTIVES

To ensure universal effective access to hygiene education in all programme impact areas by the year 2006
To ensure that every family in the target areas has effective access to sanitary facilities by the year 2006
To ensure all schools and health centres in the target have access to adequate sanitation and safe drinking water by the year 2006
To ensure 80% effective access to safe drinking water and effective community-based management of WES facilities for all target areas by the year 2006
To support capacity development at national and district levels for effective sector policy development; sector planning, development, monitoring, and evaluation; and skills development.

VII-2 PROGRAMME STRATEGIES

Based on the need to integrate hygiene, water and sanitation strategies and in consideration of the Mid Term Review recommendations, the following strategies are proposed:

(a) Capacity Development at National, District Assembly and Village Levels

This strategy will focus on capacity development in respect to the legal framework, collaboration, water quality testing, research and development, and hand pump spares supply management.

At National Level

With a view of strengthening the Ministry of Water Development's capacity, the programme will support efforts to improve the legal framework, implementation of the CBM Structure and carryout an assessment of the MOWD water quality testing facilities and capacities. Efforts will be made to develop collaboration between the MOH network and the MOWD Central Water Laboratories to integrate use of the Ministry of Health capacity and facilities for microbiological testing of water points with the MOWD capacity. WHO will be approached for co-operative effort.

Technical support for standardisation of hand pumps will be provided in collaboration with the Swiss Centre for Technology and Development (SKAT) in the critical areas concerned with quality production. The WES programme will ensure replenishment of the revolving fund for Afridev hand pump spares that it helped initially establish, to ensure spares reach the needed districts.

At District and Community Levels

Support will concentrate on sector planning, monitoring and evaluation and development of a CBM support structure. At Village Level, development of a sustainable CBM mechanism; monitoring and evaluation will be supported. The programme will seek enhancement of the Private Sector involvement in local manufacturing, supply and distribution of the spare parts.

(b) Catalytic Support to Expansion of Service Delivery

The programme will support all efforts to improve standards and the overall quality of the national WES programme. The Malawi Bureau of Standards, the National Construction Industry Council and the Ministry of Water Development will be supported to initiate a process of certifying contractor's performance and penalising poor performance. The programme will promote national dialogue with private sector drilling companies on national drilling standards as well as strengthen the borehole and water point construction supervision capacity of the Ministry of Water Development and the Private Sector Consultants.

Despite the government standardization of the Afridev and the MALDA hand pump for deep and shallow well settings respectively; some water points still have non-standard hand pumps, which are difficult to repair for lack of spares. The programme will give top priority to the replacement and repair of such hand pump wherever they exist in the target districts.

(c) Promotion of Intersectoral Linkages and Integration

The programme will continue to advocate for a clear rural sanitation policy, which will be part of an integrated Water and Environmental policy.

Linkages with the Basic Education Sector will be further developed through a school based hygiene education and sanitation project. This follows consultations between UNICEF and the DFID. An expanded UNICEF-assisted school sanitation and hygiene education programme based on the low-cost community-based models implemented in Nestdale project (Nsanje and Chikwawa) has been proposed.

(d) Empowerment of Communities and Households Through Participatory and Gender Sensitive Approaches:

This strategy has the following components: a) promoting gender-balanced community participation and decision making in the planning, implementation, management, operation and maintenance of water and sanitation services; b) sharing and providing access to information, knowledge and skills to communities to facilitate informed decision making; c) saving time for women by making access to water more convenient. Training of extension workers (Health Surveillance Assistants, Water Monitoring Assistants, Community Development Assistants, and others) in participatory methods such as Participatory Rural Appraisal (PRA) and Participatory Hygiene and Sanitation Transformation (PHAST) will be supported to enhance the skills of the various cadres in use of participatory methods. The programme will ensure that all village water and health committee receive the essential Afridev hand pump tools after the hand pump maintenance training.

The Community-based Rural Water Supply, Sanitation and Hygiene Education Implementation manual will be reproduced in an abridged, simplified version in local languages in order to better facilitate informed decision making and monitoring by committee members. The programme will support the orientation of politicians, civic leaders and civil society using partner funding under donor-funded "Governance Programmes" and advocate through, the Ministry of Water Development, for adoption of the manual by all implementers.

(e) Advocacy and Social Mobilisation:

Through the Community Water and Sanitation Advisory Committee (COWASAC), the programme will continue to advocate for a full implementation of the CBM Unit in order to help achieve sustainability and fully integrate water with sanitation projects. A clear sanitation policy for rural and peri-urban areas should also be pursued. UNICEF will continue to coordinate and strengthen its cooperation with the UNDP/WB Water and Sanitation Program for more effective policy dialogue with the GOM and implementation of the national programme. The Ministry of Water Development expressed interest to co-ordinate donors in the sector. UNICEF and UNDP/WB Water and Sanitation Programmes will synegize their support.

(f) Resource Mobilisation:

The programme will continue to leverage resources to support low cost technologies and community-based management of facilities to enable more people access potable water.

(g) Community Management of the "Water Environment":

Protection of water catchments is a critical factor in ensuring sustainable water supplies. Protection of catchments has however been heavily dependent on gazetted forest reserves with little community involvement. Where communities did not see any benefits accruing to them from the reserves, they tended to encroach, leading to destruction (clearing) of forests and unsustainable water catchments. Many piped water schemes have as a result either dried up or have much reduced capacities. The Ministry of Forestry has now embarked on community forestry management. UNICEF need to further promote such collaborative efforts (among the community, the Ministry of Forestry, the Ministry of Water Development and other stakeholders) of managing the water catchment areas (such as forest reserves).

VII- PROGRAMME COMPONENTS

Project	**Components**	**Target Area (Coverage Level)**
Capacity Development for Sustainable Community–based Management and Sector Monitoring	CBM Structure Implementation Sector Monitoring Research and Development Sector Policy Development	National (27 districts)
Integrated Hygiene Education, Sanitation Promotion and Water Supply	Community Hygiene Education & Sanitation Promotion Community Water Supply CBM Training for Communities	Number of Districts to be confirmed (8 proposed)
School Sanitation & Hygiene Education	School Hygiene Education School Sanitation	Numbe of Districts to be Confirmed (8 proposed)

VIII- EARLY CHILD CARE, & FAMILIES AFFECTED BY HIV/AIDS

VIII-1 PROGRAMME OBJECTIVES

1. To improve household and community care practices for all children to achieve child survival, growth and development during the first few years of life (0-3yrs)
2. To strengthen the capacity of all families and communities to seek and provide good quality care for children, pregnant and lactating women
3. To ensure that all families affected by HIV/AIDS and orphans are provided with appropriate care and support to fulfil their rights to survival, development, participation and protection
4. To strengthen the capacity of NGOs, religious groups and community based organizations to provide adequate care and support to orphans and families affected by HIV/AIDS

VIII-2 STRATEGIES

This programme will focus on strengthening capacity of families, communities and facilitators at that level to provide convergent care and support to children aged 0-3 years, pregnant and lactating mothers. The programme will give additional attention to orphans and families affected by HIV/AIDS in order to fulfil their rights. All these will be done by employing the following strategies in the programme districts over a five year period,

(a) Advocacy and social mobilisation for rights,

Participatory focussed group discussions will be promoted involving all groups in the communities in order to have a shared understanding of human rights, focussing on child rights and women's rights. This will be done in collaboration with human rights organisations such as the Human Rights Commission, women and child rights NGOs and community based organisations. Men and boys will be encouraged to particularly take responsibility to give care and support to women to ensure survival, growth and development of their children and to ensure women participation in allocation of household resources. Women and girls will be encouraged to know their rights and ensure that they get appropriate care and support from their households, families and communities to fulfil their rights.
In order to promote a culture of seeking and providing appropriate care, facilitators will work closely with village headmen, TBAs, village health committees and other mobilisers at community level to diffuse fears on health facility care and assure them of the benefits of seeking appropriate care.

(b) **Community capacity development** to address various human, economic and organisational gaps through triple A analysis, transfer of knowledge, skills and support

Developing the capacity of community based facilitators in promotion of key childcare practices through the provision of adequate training (in health, nutrition and psychosocial care practices). These include Health surveillance assistants and other extension workers
Developing the capacity of mobilisers in promoting childcare practices. These include chiefs, TBAs, village committee members for health, HIV/AIDS, childcare, and development.
Appropriate gender education focussing on basic education, household chores and child care for both men and women, boys and girls in schools, out of school youth activities and early child care centres
Community participation and especially involvement of women, children and families affected by HIV/AIDS in developing ways to identify and provide assistance to families and children most in need

(c) Service delivery strategies at community level

Provision of support to TBAs to conduct safe deliveries
Provision of support to ensure access to drugs, TBA kits, vitamin A, bednets, scales and other essential items
Provision of economic support for orphans and families affected by HIV/AIDS
Provision of support for extension workers to visit and communicate with communities.

(d) **Convergence of relevant parts of the country programme:**

All programmes will have an input to make at the community level and it is important to coordinate these efforts in a coherent manner. Coordination at district level will be done through the district assemblies chief executive and the district executive committee. Coordination at central level will be done through the programme workgroup. The programme will build on existing experiences in working with communities and will further develop and consolidate tools for community capacity development in collaboration with all other sections in the Country programme.

VIII-3 PROGRAMME STRUCTURE

Projects:
Early Child Care and Nutrition
Support to Orphans and Families Affected by HIV/AIDS

V-3 Project Description

Early Child Care and Nutrition

The project will build on current work on ECCSGD and community IMCI. A baseline survey on key household and community childcare practices has been carried out and results are being analysed. Modules on care practices for extension workers have been developed and will soon be pre-tested. A communication strategy will be developed in January 2001 focussing on sharing results with communities, planners, policy makers, politicians, and partners. This project will be closely co-ordinated with the health programme to establish necessary linkages with facility based IMCI and the baby friendly hospital initiative.

At community level this project will work with community mobilisers and facilitators and ensure that all pregnant women attend antenatal clinics early and regularly, where they will receive iron supplementation and malaria prophylaxis. In order to ensure that all women are assisted by a skilled worker at birth, all traditional birth attendants will be given necessary skills and support to assist women with normal pregnancies at birth and to detect and refer high risk pregnancies as early as possible. Through breastfeeding support groups all women will be supported to breastfeed their babies exclusively for six months and to continue with breastfeeding with additional foods, well into the second year. Women affected by HIV infection will be referred to PMTCT facilities where they will get further support on appropriate reproductive health care and infant feeding options.

The project will work with village health committees to ensure that all mothers with children aged 0-3 years are supported to monitor growth of their children regularly and to provide stimulation for psychosocial development. This will be an opportunity to ensure that from six months of age they receive vitamin A supplementation twice a year. Village health committee members will be given skills to monitor growth and to maintain simple village record on supplementation, births, deaths and other important information.

The project will strengthen the capacity of families and communities to seek and provide good quality health care for children. Through village health committees and village headmen, all families will be supported to implement key household IMCI practices. These include promotion of good sanitation facilities and personal hygiene practices. Use of treated bednets for all pregnant women and young children will be promoted. All parents will be supported to ensure that they provide adequate health and nutrition care to sick children in the home, to recognise danger symptoms early and to take sick children to health facility promptly.

At the district level the project will work with the district assemblies for convergence and all district offices, NGOs concerned with childcare, health and nutrition. At the central level the project will continue to receive

guidance and leadership of the group that is working on community IMCI and ECCSGD called Family and Community Child Care Work Group.

Support to Orphans and Families Affected by HIV/AIDS

This project will build on current experiences on orphan care and develop further elements to ensure that families affected by HIV/AIDS are supported and given care in a comprehensive manner to mitigate the social impact of HIV/AIDS.

The project will continue to work with District Social Welfare Offices, NGOs, community based organisations and people living with HIV/AIDS in order to reach affected families. The project will strengthen the capacity of these organisations to allow them to respond to the crisis. In collaboration with SPAC section the project will work with rights based organisations to ensure that all duty bearers at all levels have a shared understanding on human rights, rights of children and women. The CBOs, NGOs and affected families will conduct participatory assessments and analyses of the situation of affected families, including orphans and infected individuals in the community, and develop and implement plans to provide them with the necessary care and support.

The CBOs and NGOs will build from their experiences with home based care groups, community AIDS and orphan care committees making sure that affected families are given adequate information and support on nutrition care and treatment of opportunistic infections.

This project will be closely co-ordinated with the PMTCT and VCT projects being implemented through the health and education programmes. The SPAC section will support this project in terms of policy formulation to protect orphans and affected families and programme communication and advocacy on rights and HIV/AIDS. The Water and Sanitation Programme will provide support to this programme in terms of water needs and the package for hygiene and sanitation promotion.

At district level the project will work with the Orphan Care and AIDS co-ordination committees, while at national level the project will work with the National Orphan Care Task Force and the Joint Co-ordinating Committee for HIV/AIDS in the country programme.

COVERAGE

This programme will be implemented in all 27 districts of the country, with increased scale and intensity in converging districts.

Proposed Programme Budget (Thousands US Dollars)
Subject to confirmation by the board

Programme	Regular Resources	Other Resources	Total
Social Policy	3,200	3,080	6,280
Health	7,700	14,960	22,660
Basic Education	4,500	7,940	12,440
Early Child care and Support to families affected by HIV/AIDS	3,300	5,540	8,840
Water and Environmental Sanitation	2,800	3,480	6,280
TOTAL	21,500	35,000	56,500

IX- ANNEXES

Country Programme Main Donors and Partners

	Social Policy	*Basic Education*	*Health*	*Early Child Care*	*Water and Sanitation*
Norway		X			X
UK		X	X		X
USA	X	X	X	X	
Canada	X	X	X	X	X
Germany		X	X	X	
Netherlands	X	X	X		
Japan			X		X
UNFPA		X	X		
UNDP			X		
WFP			X	X	
WHO			X		
UNAIDS		X	X		
World Bank			X		
NGOs	X	X	X	X	X

Annex 1: Capacity Gaps Analysis of Duty Bearers. Health

The duty bearers have strengths as well as gaps in their capacity to fulfil their obligations. In fulfilling the roles identified above, the following capacity gaps are identified for each duty bearer.

Household level.

The primary care giver, the mother, does not have the knowledge to provide basic home-based health care for common childhood illnesses; mothers and siblings do not have the authority to seek help from other health care providers. Parents and young people do not feel the responsibility to seek information on availability of health/reproductive services.

Fathers do not feel that it is their responsibility to take care of the children and provide motivation and support to breastfeeding mothers.

Women do not have the information and knowledge on their reproductive health rights and the availability of reproductive health services and the benefits of family spacing and appropriate timing of child births and have limited authority to make decisions pertaining the utilization of reproductive health services. Youth do not have knowledge on life skills and the authority to make independent decisions.

Women and children do not have the authority to maintain property rights after death of parents.
Parents do not give priority to children in the use of bed nets and do not feel responsible of providing education on hygiene.
Households are too poor to procure adequate health care for their children and women and lack adequate physical access to health care. They also have limited knowledge on HIV/AIDS and do not have the resources to continue expanding the family to accommodate AIDS orphans. Care givers do not always treat biological and orphan children with similar care and standards. Limited resources to mitigate the impact of HIV/AIDS

All duty bearers at this level do not feel the responsibility for sexual behavioural change, the need to openly discuss sexual matters with their children, particularly adolescents. Adults do not recognize that the use of alcohol and other addictive drugs are linked with inappropriate sexual behaviour. Parents have limited authority to control the use of alcohol by their children. Parents do not question their girls children getting money from sexual services. Women have limited authority to negotiate sex and the use of condoms with husbands and young people with sexual partners.

Community level.

Community leaders feel limited responsibility on the support to pregnant women and mothers. Lack of mother-friendly environment and knowledge and understanding of pregnancy as death risk factor and safe motherhood services. TBAs have limited knowledge of reproductive health care and the authority to refer cases to hospitals and often misuse their authority by unduly retaining women at delivery who should have been referred to obstetric emergency services. Inadequate and poor quality of reproductive health services. The promotion of unsafe and inappropriate traditional practices continue. Widow inheritance continue. Parents support early marriage of girls.

Traditional healers and birth attendants do not have the information and knowledge on the prevention, transmission and consequences of HIV/AIDS. They also do not have the knowledge on what to refer and when to refer sick children and women and adequate counseling to the individual and relatives of those being referred.

There is lack of collaboration between traditional and the biomedical systems and community based organisations lack the organizational capacity, financial and trained human resources to carry out disease surveillance.

Extended families, surviving parents and communities are not meeting their obligations to provide care and protection to orphans. High rates of property grabbing.

Not all schools are supporting anti-AIDS clubs and not all the parents are supporting HIV/AIDS education in the schools. Schools do not have the authority to disseminate information and promote the use of condoms. Lack of adequate financial, human and material resources at the health facilities. High attrition rates due to HIV/AIDS.

Limited felt responsibility to encourage young people to access reproductive health services. Absolute lack of responsibility to create "safe" spaces for young people. Young people do not have access to appropriate and relevant information and do not have the authority to provide services by themselves and disseminate information on reproductive health and safe sex practices.

District level.

DHMT provide limited support, training, supply of essential drugs to and supervision of health facilities and community level. District administrations lack the administrative systems to efficiently allocate essential drugs based on real needs.

District lack adequate provision financial, material and human resources. High health personnel attrition rates due to HIV/AIDS.

Health personnel have inappropriate attitudes to deal with pregnant women and adolescents. Limited felt responsibility of health personnel to provide reproductive health services to young people. District health services lack the knowledge and the skills for effective counseling to young people on HIV/AIDS, voluntary counseling and HIV testing as well as HIV counseling and testing for pregnant and lactating women.

Districts do not keep accurate medical records and the use of information form better management is very limited.

Health care providers have limited knowledge about the referral process, the referral priorities and efficient case management of common childhood illnesses and reproductive health, particularly the provision of emergency obstetric care.
people. District health services lack the knowledge and the skills for effective counseling to young people on HIV/AIDS, voluntary counseling and HIV testing as well as HIV counseling and testing for pregnant and lactating women.

Districts do not keep accurate medical records and the use of information form better management is very limited.

Health care providers have limited knowledge about the referral process, the referral priorities and efficient case management of common childhood illnesses and reproductive health, particularly the provision of emergency obstetric care.
District health authorities are not fully aware of the existence of community-based organisations and their activities.

National level.

Limited responsibility to develop, implement and enforce health sector policies as well as to appropriately and rationally allocate resources. Poor management, misallocation and misappropriation of resources. Lack of political commitment for efficient and transparent utilization of financial resources. Limited capacity to share and use of information for health sector planning, allocation of resources, performance based monitoring and programme development.

Lost of key well-qualified health personnel due to HIV/AIDS and felt need to develop workplace strategies to further reduce deaths of health personnel. Limited attention to the mitigation of the impact of HIV/AIDS.
Limited capacity to translate operational research finding into programme formulation and development.

Annexe 2: Capacity Gaps Analysis for Care

Caregivers accept most of these responsibilities. However the extent to which they carry them out depends on availability of human, economic and organisational resources. In focussed group discussions held with communities, some of the reasons for not attending antenatal clinics include long distance to health facility, poor attitude of health staff and the quality of care in health facilities.

On infant feeding the limiting factors included lack of confidence and support in breastfeeding, inadequate knowledge on age of introducing complementary foods, how to enrich the food, frequency and amount of feeds, food taboos and limited availability of food resources in the households. Most households in the country run out of food by November and have to rely on their income to buy food. With 60% living beyond poverty line, this is difficult to achieve, but they still survive through piece jobs in exchange of food and contributions from extended family.

In general the interviewers felt that most of the mothers had little or no education and they needed more information on the benefits of regular clinic attendance during pregnancy and critical issues on infant feeding. As indicated earlier gender issues including high workload, lack of access and control over economic resources prevent many women from fulfilling their responsibilities.

On health the mothers indicated that they also accept the responsibility to provide adequate health care and they do give treatment to minor ailments at home. If they have to go to a health facility they first have to inform spouse or relatives before they go. In most cases they are allowed except for a few who are not allowed by their religious leaders (e.g. Zion). Again the issue of distance to health facility and quality of care came up and they sometimes resort to traditional healers. The interviewers felt that the mothers did not have adequate knowledge on signs and symptoms of common childhood illness, their management and prevention. For instance some mothers did not give correct management for fever and diarrhoea. Others withheld breastfeeding during diarrhoea. The cost of drugs and treated nets is high and moreover treated nets are not readily available, except in project areas. On hygiene practices, not all households have latrines and disposal of child faeces was inappropriate coupled with no hand washing.

Besides providing health and nutrition care, the communities did indicate various ways, in which they play with children, sing songs and respond to their needs. They however indicated that this depends on time the caregiver has. Some caregivers have a practice of punishing a child and is left to cry for so long. Although the potential for local play materials exists, most do not make a deliberate effort to make them available to young children. The major gap here is knowledge of the importance of stimulation and response to the child's brain development particularly in the first two years and throughout the childhood period.

In families affected by HIV AIDS the major gap is in terms of food and economic resources to meet basic needs and health care. The caregiver also needs to know more about human rights and to be skilled in handling infected persons and orphans as they are usually more sensitive on the way they are treated.

On gender issues mothers lack the knowledge and confidence to question gender bias on roles, decision making, control of resources and status in society in general and they just accept the status quo. If this situation is to change men and women, boys and girls need more information on participation rights and gender empowerment.

In conclusion at the level of caregivers and the household there is need to address the following capacity gaps:
Knowledge about human rights and responsibilities on the whole range of care practices. In particular men need to recognise and accept their role in ensuring and provide necessary support to respect and protect child rights and women's rights in their household

Although mothers accept responsibility and have authority to undertake these roles, they have limited knowledge and skills in recommended nutrition, health and psychosocial care practices.
Gender issues around heavy work, little or no basic education, limited access and control of resources, limited knowledge of their rights and lack of confidence in pursuing to achieve their rights further limit their capacity
Gaps in basic services
Gaps in food security and economic resources to meet basic needs for health and nutrition, especially in the context of HIV/AIDS

Family and Community Level

The duty bearers at family and community level include extended family relations, traditional birth attendants, traditional healers and other key people who often influence caregiver practices. Their major role is to support caregivers and household heads to seek and provide appropriate care for their children. There are many factors that inhibit practice of recommended behaviours by caregivers and households that are embedded in culture. It is the role of families and communities to recognise bad practices and support households to be consistent with human rights principles. The major capacity gaps are in terms of limited knowledge and skills in childcare practices and human rights

Institution, NGO and district assemblies

The services that are provided by various institutions and NGOs should dovetail with responsibilities and activities at community level. Their major capacity is in terms of limited numbers of extension workers and other facilitators, inadequate knowledge and skills on critical points in child development and inadequate resources allocated by district assemblies or line ministries to support duty bearers at community level. They have a wide catchment area that is hardly covered because of lack of transport and funding.

Central level

The actors at this level include line ministries of health, gender, youth and community services, national economic council, agriculture and others. Their role is to provide policy leadership and technical guidance. Several policy instruments at national level need to complete the policy formulation process. These include the HIV/AIDS policy, orphan care policy, national code of marketing of breastmilk substitutes and the early child development policy. There is also a need for central level to provide technical support to districts in health, nutrition and psychosocial care. However often the central level team is not able to travel to districts because of limited Government funding.

ANNEX 3: Role and Capacity Analysis for Prevalence of Preventable Water and Sanitation-related Morbidity

Interventions to focus on highlighted areas		Capacity gaps (what they are unable to do)		
Duty bearer	**Roles (what role they must play)**	**Responsibility**	**Authority**	**Human, organisational, economical resources**
Primary Care Provider	Provision of safe drinking water; Provision of hygienic care practices. Provide basic hygiene education and ensure practice of hygienic behaviour .provide precautionary measures against incidence of opportunistic infections in HIV/AIDS infected family members	. primary care giver does not always feel responsible for providing safe water, hygienic care practices and basic hygiene education primary care giver lacks responsibility for adopting preventive measures against opportunistic infections in HIV/AIDS infected family members	.The primary care giver does not always have the authority to use resources for provision of safe water and sanitation facilities .primary care giver has limited authority to decide on course of action regarding management of illness of HIV/AIDS family member .where primary care giver is woman or child, they sometimes have limited authority of resource allocation to care practices	.inadequate knowledge on linkage between hygiene practices and diseases .prohibitive workload of care giver .HIV/AIDS affected and infected caregivers have limited capacity .existing gender disparities place extra burden on women and the girl child . lack of knowledge and awareness of HIV/AIDS and lack of motivation to acquire knowledge on opportunistic infections (affecting HIV/AIDS patient) .social influence due to stigma surrounding HIV/AIDS .
Household	Family planning (child bearing) . provide basic hygiene education . provision of sanitation facilities .provide support to the primary care giver .provide additional care to the infected and preventive measures against transmission of opportunistic diseases and HIV to the other family members	. households do not always feel responsible to use family planning services .households have poor sense of responsibility for practising (good)hygiene .households have poor sense of responsibility for effective environmental management (catchment protection, deforestation, soil erosion, pollution, etc)	.women and adolescent boys and girls have limited authority to choose and use of family planning services .households have limited authority to openly discuss HIV/AIDS infection in their community .	.lack of knowledge or practice . some cultural practices inhibit use of sanitation facilities (by women, children, pregnant mothers) . women are sometimes not empowered to make choices regarding allocation of resources .MTCT of HIV/AIDS is prevalent because of lack of knowledge and use of family planning methods

Interventions to focus on highlighted areas		Capacity gaps (what they are unable to do)		
Duty bearer	Roles (what role they must play)	Responsibility	Authority	Human, organisational, economical resources
		.household members do not acknowledge responsibility to support primary care giver .households sometimes do not acknowledge HIV/AIDS infection . households do not talk openly about HIV/AIDS.		
Village head person	.provision of leadership .role model in hygiene practices and provision of sanitation facilities .dissemination of information of HIV/AIDS transmission and care for the infected and affected	. village head person do not always take responsibility for hygiene practices and safe waste management . some village head persons do not feel responsible for the dissemination of information and leadership for behaviour change	.village head person usually display authority (sometimes without accepting responsibility) .sometimes village head person misuse authority, especially in regard of HIV/AIDS infection in their community (misinformation)	.lack of knowledge, poor leadership skills .there are very few village head women .lack of factual knowledge on HIV/AIDS .lack of information materials on HIV/AIDS .lack of initiative to break the silence on HIV/AIDS
Community (village)	.contribute to the capital cost and maintenance of facilities for water supply and sanitation .demand reproductive health services .reduce stigmatisation and ostracization of HIV/AIDS infected persons (access to water and sanitation facilities)	. communities have poor sense of responsibility for planning, implementation, monitoring and evaluation. .communities are not always acknowledging ownership-hence poor community-based management of existing facilities .communities do not feel	.communities have limited authority to participate in planning, programming and co-ordination	.inadequate knowledge on reproductive health . communities have limited resources for capital costs of facilities .lack of factual information on HIV/AIDS .leadership role in the VW&HC is limited to men .added burden to women in the maintenance of water points

Interventions to focus on highlighted areas		Capacity gaps (what they are unable to do)		
Duty bearer	Roles (what role they must play)	Responsibility	Authority	Human, organisational, economical resources
		responsible for social integration of the HIV/AIDS infected members of the community (leading to inadequate access to water and sanitation facilities)		
Traditional Authority	.social mobilisation for community action for increasing access to safe water and adequate sanitation . role model in providing sanitation facilities, good hygiene practices and environmental protection .local co-ordination of extension support , ESAs . dissemination of information of HIV/AIDS transmission and care for the infected and affected	. Traditional authorities do not always feel responsible for mobilising their communities and in role modelling. .Some TA lack sense of responsibility for monitoring and co-ordination of development initiatives in their area of jurisdiction . some chiefs do not feel responsible for the dissemination of information and leadership for behaviour change	. TA's sometimes do not effectively use their authority to mobilise their communities .weak enforcement of environmental management (catchments protection, deforestation, soil erosion, pollution, etc)	.inconsistent access to logistical support (transport, office, etc) . lack of factual information on HIV/AIDS, . total lack of initiative to lobby for support in the fight against HIV/AIDS .lack of initiative to fight for women's and children's rights .very few women Traditional Authorities
Institutions- private or public (schools, health centres)	. provide hygiene education for pupils, other children and communities . provide information for the prevention and management of opportunistic diseases (related to HIV/AIDS) .ensure maintenance of existing	.all institutions - Have poor understanding of their responsibility in terms of the impact pupils and children could make within the larger community; - Do not acknowledging their responsibility of	. institutions do not exercise authority to monitor hygiene practices, sanitation and water supply in schools and health institutions	.lack of appropriate resources for the provision of reproductive and curative health services .lack of human, financial and material resources to provide hygiene education and maintenance of existing facilities . the institutions are generally gender insensitive, especially schools lack adequate

Interventions to focus on highlighted areas		Capacity gaps (what they are unable to do)		
Duty bearer	Roles (what role they must play)	Responsibility	Authority	Human, organisational, economical resources
	water and sanitation facilities . provision of reproductive health education and services	educating the community through their pupils; - Have poor sense of responsibility in maintenance of existing facilities - do not assume responsibility in the provision of reproduction health services		sanitation for girls . Low appreciation of gender roles in District Assemblies .Few female extension staff in the sector
District Assembly including line ministries at district level	.mobilising communities for hygiene and sanitation education, including HIV/AIDS and gender sensitisation . provide logistical support to facilitate water supply and sanitation activities . ensure monitoring and evaluation of existing water and sanitation facilities for sustainability . co-ordinating various water and sanitation activities by various bodies . provision of reproductive health services	. District Assemblies sometimes lack responsibility to co-ordinate support from the various line ministries and other support agencies. .District Assemblies lack sense of responsibility in monitoring and evaluation of service delivery by line ministries .line ministries lack sense of responsibility in the provision of services (reproductive health, sanitation, water, hygiene education)	. District Assemblies lack clear understanding of authority in ensuring the availability of services to the community . lack of clear definition by central government of the authority of District Assembly in the WES sector	. lack of knowledge and skills . limited knowledge and use of various technologies for water supply and sanitation facilities . inadequate human resources for logistical support, co-ordination, monitoring and evaluation .Low appreciation of gender roles in District Assemblies .Absence of female professional staff in the sector
NGOs	. provide hygiene education for communities, .training extension workers, TOT	. NGO sometimes not fulfilling their responsibility of consulting right holders	. conflicting government rules and regulation regarding NGO operation	. inadequate human , financial resources and appropriate IEC materials on HIV/AIDS and gender

Interventions to focus on highlighted areas		Capacity gaps (what they are unable to do)		
Duty bearer	Roles (what role they must play)	Responsibility	Authority	Human, organisational, economical resources
	.test-piloting communication strategies on WES including HIV/AIDS and gender . provide facilities for water supply and sanitation .Role model in formulating and implementing sector policy in HIV/AIDS and gender	(communities, women, children) i.e. supply driven projects and activities .NGO have limited sense of responsibility in use of various technology options (low cost technologies, gravity piped-fed schemes, water harvesting, solar powered pumping, wind mills)	limit the authority of NGO for providing education and service delivery	.gender imbalance or inequity . loss of qualified and experienced staff to more lucrative jobs . some NGO lack skills in participatory methods
National (training centres, central government)	. developing policy guidelines (water and sanitation), curriculum development (inclusive of HIV/AIDS and gender) and national standards in hygiene education including guidelines for care practice for HIV/AIDS infected persons. .dissemination of the guidelines and policies to all appropriate levels of duty bearers. . ensure national coverage for hygiene education . provide facilities for water supply and sanitation .management of national water resources and the environment	. Training Centres and Central government: - Lack understanding of underlying responsibility as national bodies in developing policy guidelines and their enforcement. - Are indifferent in assuming responsibility in monitoring and evaluation, training and use of appropriate	. inconsistent and uncoordinated use of authority in planning, programming and co-ordination of the management of the water resources, hygiene education and sanitation promotion . government lack policy enforcement mechanisms . lack of clear definition by central government of the authority of District Assembly in the WES sector	. inappropriate use of existing human and financial resources . lack of appropriate skills and expertise . limited resources for dissemination and implementation of the gender policy and HIV/AIDS

Interventions to focus on highlighted areas			Capacity gaps (what they are unable to do)	
Duty bearer	Roles (what role they must play)	Responsibility	Authority	Human, organisational, economical resources
	.regulation and enforcement of pollution control .mainstreaming gender in the sector	technological options		

ANNEX 4: Matrix used for the Development of Objectives (and Strategies) for Prevalence of Preventable Water and Sanitation-related Morbidity

	Objectives (and Strategies)		
Duty bearer	*Responsibility*	*Authority*	*Human, organisational, economical resources*
Primary Care Provider	To provide safe water, hygienic care practices and basic hygiene education Service delivery (hygiene education, sanitation and water supply)	.To empower primary care giver to assume the authority to use resources for provision of safe water and sanitation facilities capacity development	.to provide knowledge on linkage between hygiene practices and diseases education
	. to facilitate adoption of preventive measures against opportunistic infections in HIV/AIDS infected family members communication strategy	.to empower primary care giver to assume authority to decide on course of action regarding management of illness of HIV/AIDS affected family member, and resource allocation to care practices advocacy, communication	.to enhance the capacity of HIV/AIDS affected and infected caregivers communication, service delivery
			.to eliminate gender disparities that place extra burden on women and the girl child advocacy, communication
			. to provide knowledge and awareness of HIV/AIDS and opportunistic infections (affecting HIV/AIDS patients) education
			.to protect the rights of the infected and affected persons advocacy
			Stigma surrounding HIV/AIDS .counselling
Household	. to promote use family planning services communication	to empower women and adolescent boys and girls to assume authority to choose and use family planning services advocacy	.lack of knowledge or practice
	to promote good hygiene practice at households communication	.to promote open and uninhibited discussion of HIV/AIDS infection in community advocacy	.to change cultural practices that inhibit use of sanitation facilities (by women, children, pregnant mothers) advocacy, communication
	to promote the appropriate use of natural resources (catchment protection, deforestation, soil erosion, pollution, etc)	to empower women to assume authority to	.MTCT of HIV/AIDS is prevalent because of lack of knowledge and use of family planning

Duty bearer	*Objectives (and Strategies)*		
	Responsibility	*Authority*	*Human, organisational, economical resources*
	communication, mobilisation	make choices regarding allocation of resources advocacy	methods
	to break the silence on and denial of HIV/AIDS sero-status. Communication.		
	. to encourage village head person to take responsibility for hygiene practices and safe waste management practice communication	.to promote appropriate use of authority of the village head person communication	. to promote knowledge on linkages between hygiene, sanitation, water supply and diseases communication
Village head person	.to encourage village head persons to take responsibility for dissemination of information and leadership for behaviour change communication		.to enhance leadership skills IEC, capacity development
Community (village)	.to promote community's participation in for the project cycle (planning, implementation, monitoring and evaluation). Advocacy, Social mobilisation		.to provide factual information on HIV/AIDS IEC
	.to promote community ownership and partnership in the management of existing facilities capacity development, communication, partnership		.to promote women participation in the leadership of the VW&HC advocacy
	.to encourage openness on HIV/AIDS issues in the community communication		.to promote equitable sharing of workload in the maintenance of water points advocacy
raditional Authority	. to encourage Traditional authorities to assume responsibility for mobilising their communities, role modelling and responsibility for monitoring and co-ordination of development initiatives in their area of jurisdiction communication, community mobilisation	. to encourage TA's to enforce environmental management (catchments protection, deforestation, soil erosion, pollution, etc) communication	.....inconsistent access to logistical support (transport, office, etc) advocacy
	. to encourage chiefs to assume responsibility		. to provide factual information on HIV/AIDS, and lobby for support in the fight against HIV/AIDS IEC

Duty bearer	*Objectives (and Strategies)* *Responsibility*	*Authority*	*Human, organisational, economical resources*
	for the dissemination of information and leadership for behaviour change advocacy, communication		.to promote advocacy for women's and children's rights among TA's .to promote gender awareness among Traditional Authorities communication
Institutions- private or public (schools, health centres)	.to ensure service delivery (hygiene education, sanitation and water supply)at all schools, health centres advocacy and service delivery to promote school hygiene education and sanitation advocacy, communication , social mobilisation, and service delivery	.to promote monitoring of enforcement of hygiene practices and provision of sanitation and water supply in schools and health institutions, capacity building	.to advocate for the allocation of resources for the provision of reproductive and curative health services advocacy .to ensure institutions are gender sensitive, especially that schools provide adequate sanitation for girls advocacy, IEC .to provide support for the recruitment, training and retention of female extension staff in the sector advocacy, affirmative action..
District Assembly including line ministries at district level	.To promote co-ordination by District Assemblies of the line ministries and other ESA for service delivery (hygiene education, sanitation and water supply) advocacy, partnership. To encourage District Assembly to monitor and evaluate service delivery by line ministries Advocacy, capacity development	. to promote the development of clear WES sector operational guidelines for District Assemblies advocacy and capacity development to support institutional strengthening for service delivery and capacity building of communities to go to scale in an efficient cost-effective and sustainable manner capacity development	. to promote use of various technologies for the development of water supply and sanitation facilities including training of women in the use of new technologies capacity development, advocacy, IEC .to encourage enhancement of the allocation of adequate human resources for logistical support, co-ordination, monitoring and evaluation advocacy .to promote gender awareness communication to encourage the recruitment and retention of female professional staff in the sector advocacy

Duty bearer	*Objectives (and Strategies)*		
	Responsibility	*Authority*	*Human, organisational, economical resources*
NGOs	.to encourage consultation between NGO right holders (communities, women, children) in the project cycle (planning, implementation, M&E) capacity building, communication .to encourage use of various technology options (low cost technologies, gravity piped-fed schemes, water harvesting, solar powered pumping, wind mills) partnerships	to promote clear policy and regulation of NGO operation in the sector. Advocacy	. to enhance NGO capacity in participatory methods partnership, capacity development
National (training centres, central government)	To promote the development of national policy guidelines and their enforcement Advocacy, capacity development To promote and support training, monitoring, evaluation, and use of appropriate technological options Capacity building	To encourage consistent co-ordination of planning, programming and management of the water resources, hygiene education and sanitation promotion Advocacy, capacity development .to advocate for the development of policy enforcement mechanisms advocacy to mainstream gender in all WES activities advocacy	. to promote appropriate and efficient use of existing human and financial resources advocacy to support skills development capacity building to support the resource mobilisation for the dissemination and implementation of the gender policy and HIV/AIDS strategic plan advocacy, resource mobilisation

ANNEX 5: Clustered WES Objectives and Strategies (as derived from Annex 2)

Duty Bearer	*Responsibility Gap*	*Authority Gap*	*Resource Gap*
Household	• To provide safe water, hygienic care practices and basic hygiene education Service delivery (hygiene education, sanitation and water supply) • To facilitate adoption of preventive measures against opportunistic infections in HIV/AIDS infected family members communication strategy • to promote good hygiene practice at households communication • to promote the appropriate use of natural resources (catchment protection, deforestation, soil erosion, pollution, etc) communication, mobilisation		• to provide knowledge on linkage between hygiene practices and diseases education • to eliminate gender disparities that place extra burden on women and the girl child advocacy, communication • to change cultural practices that inhibit use of sanitation facilities (by women, children, pregnant mothers) advocacy, communication
Community	• to promote communities participation in the project cycle (planning, implementation, monitoring and evaluation). Advocacy, Social mobilisation • to encourage chiefs to assume responsibility for the dissemination of information and leadership for behaviour change advocacy, communication	• to encourage TA's to enforce environmental management (catchments protection, deforestation, soil erosion, pollution, etc) communication • to promote monitoring of enforcement of hygiene practices and provision of sanitation and water supply in schools and health institutions capacity building	• to promote knowledge on linkages between hygiene, sanitation, water supply and diseases communication • to promote women participation in the leadership of the VW&HC advocacy • to promote equitable sharing of workload in the maintenance of water points advocacy • to ensure institutions are gender sensitive, especially that schools provide adequate sanitation for girls advocacy, IEC
District	• To promote co-ordination by District Assemblies of the line ministries and other ESA for service delivery (hygiene education,	• to promote the development of clear WES sector operational guidelines for District Assemblies	• to promote use of various technologies for the development of water supply and sanitation facilities including training of women in the

Duty Bearer	*Responsibility Gap*	*Authority Gap*	*Resource Gap*
	sanitation and water supply) Advocacy, partnership,	advocacy and capacity development	use of new technologies capacity development, advocacy, IEC
	• to encourage use of various technology options (low cost technologies, gravity piped fed schemes, water harvesting, solar powered pumping, wind mills) partnerships	• to support institutional strengthening for service delivery and capacity building of communities to go to scale in an efficient cost-effective and sustainable manner capacity development	• to enhance NGO capacity in participatory methods partnership, capacity development
National	• To promote the development of national policy guidelines and their enforcement Advocacy, capacity development	• To encourage consistent co-ordination of planning, programming and management of the water resources, hygiene education and sanitation promotion Advocacy, capacity development	• to support skills development capacity building
	• To promote and support training, monitoring, evaluation, and use of appropriate technological options Capacity building	• to advocate for the development of policy enforcement mechanisms advocacy	
		• to mainstream gender in all WES	