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Educational Perspectives Related to the Impact of the HIV-AIDS Pandemic on Child Labour in Malawi

HIV-AIDS and Child Labour paper No. 7

By

Bright B. Sibale and Evans Kachale
Centre for Development Management
Consulting and Learning Facility

October 2004

Research Co-ordinated by
Anita Amorim, IPEC Geneva
Michael Mwasikakata, IPEC Malawi

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Inputs on Education and Child Labour: Geir Myrstad
Authors: Bright Sibale and Evans Kachale
(Centre for Development Management Consulting and Learning Facility; bbsibale@sdnp.org.mw)

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Bright Sibale and Evans Kachale
October 2004

List of abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
BLM	Banja La Mtsogolo
CABUNGO	Capacity Building Unit for Non-Governmental Organisations
CAC	Community AIDS Committee
CADECOM	Catholic Development Commission of Malawi
CBDA	Community Based Distribution Agents
CBO	Community Based Organization
CHAM	Christian Hospital Association of Malawi
COMAG	ILO Project on Commercial Agriculture in Malawi
CSR	Centre for Social Research
DACCs	District AIDS Coordination Committees
DEC	District Executive Committees
DFID	Department for International Development
DHS	Demographic Health Survey
ECM	Episcopal Conference of Malawi
FIGAs	Food and Income Generating Activities
HACI	Hope for the African Child Initiative
HIPC	Highly Indebted Poor Countries
HIV	Human immunodeficiency virus
IGA	Income Generating Activities
ILO	International Labour Organization
IPEC	International Programme of the Elimination of Child Labour
MAHAP	Malawi Association of HIV/AIDS Persons
MBC	Malawi Broadcasting Corporation
MCH	Mother and Child Health
MDHS	Malawi Demographic Health Survey
MPRSP	Malawi Poverty Reduction Strategy Paper
NAC	National AIDS Commission
NAPHAM	National Association of People Living with HIV/AIDS
NGO	Non-Governmental Organization
NSO	National Statistics Office
PLWHAs	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
TEVETA	Tertiary, Entrepreneurial, Vocational Educational Training Authority
TVM	Television Malawi
UNAIDS	United Nations AIDS Programme
UNDP	United Nations Development Programme
UNICEF	United Nations Children Education Fund
USDOL	United States Department of Labour
VAC	Village AIDS Committees
VCT	Voluntary Counselling and Testing

Executive Summary

In the past five years, there has been an increasing awareness of the impact of HIV-AIDS on child labour. Along with the USDOL-funded ILO-IPEC rapid assessments and good practices reports[1], studies undertaken by UNICEF, UNAIDS, and UNESCO, suggest that the link between child labour and AIDS goes far beyond the assumptions held a decade ago. It is estimated that in Sub-Saharan Africa more than 11 million girls and boys are AIDS orphans (UNAIDS, 2003), and that by 2010 an estimated 20 million[2] children will be either single or double orphans[3]. The loss of one or both parents has a strong connection to child labour; different studies show that HIV/AIDS orphans are twice as likely to work than other children[4]. To date, IPEC's work in this area has focused on improving the knowledge base and identifying appropriate responses. The IPEC studies in South Africa, Zambia, Zimbabwe and Tanzania, confirmed the existence of the close link between the loss of one or both parents to child labour; the greater involvement of girls with the "burden of care" following the sickness of parents; the hazards of prevailing patriarchal and male sexual norms and the bottlenecks in the rehabilitation institutions which are not prepared nor qualified for such a great influx of children into their premises. Therefore, this policy paper corresponds to the need of translating research to action, and outlines a clear strategy on educational alternatives for combating and preventing HIV/AIDS induced child labour in Malawi.

This paper examines and gives an analysis of key linkages between HIV/AIDS and child labour. The findings presented in the report were generated from an in depth review of the available literature as well as consultations with some key stakeholders. The primary observations were as follows:

1. Malawi does ***not have a*** clear child labour policy. There are no plans to develop such a policy in the near future.

2. The ***HIV/AIDS policy framework is available and recognises*** the risk that youth have in contracting the HIV virus.

3. ***Child labour and HIV are interrelated***: one leads to the other, therefore strategies to address the two must also be linked.

4. ***Poverty increases HIV/AIDS and child labour:*** the HIV/AIDS pandemic has proved to be one of the major supply factors behind increasing number of child labourers in recent times. There are increasingly more destitute children who must fend for themselves, their siblings and grandparents, as a result of the death of their parents from AIDS. The need for money makes these children vulnerable and easy targets for child labour. The situation is worsened by the poverty in Malawi, with over 65 per cent of the population living below the poverty line.

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[1] Including the following USDOL-funded papers: one good practices study, four rapid assessments in South Africa, Zambia, Zimbabwe, Tanzania, and one synthesis report (2002-2003).
[2] UNAIDS: "AIDS epidemic update." Geneva, 2003.
[3] ILO-IPEC: Participants Strategy Paper, Lusaka Tripartite Workshop, May 2003, in HIV-AIDS and child labour paper N° 6, 2003.
[4] Rosati, F, Unpublished paper for Lusaka tripartite workshop on HIV-AIDS and child labour, May 2003.

5. ***Food insecure households are more prone to HIV/AIDS***: food is the single most important commodity for any household in Malawi. Yet the levels of food insecurity in Malawi are very high. When households become financially and food insecure, they resort to using children to supplement efforts to raise food or money.

6. Child Labour, Care and Support for Orphans and People Living with HIV/AIDS:-the analysis finds that with the death or sickness of one or both parents, ***children take over as either care givers or breadwinners,*** which condemns them to child labour and increases the of risk contracting HIV/AIDS for children working in some sectors.

7. Early marriages, HIV/AIDS and child labour: ***orphanhood makes children withdraw from school and get married early*** to seek support for themselves and/or others and by engaging in activities that constitute child labour.

8. The farming system and its influence on HIV/AIDS and Child labour: another factor that influences HIV/AIDS and child labour is ***the type of farming system that is predominant in an area.*** There are significant regional variations in terms of distribution and severity of child labour that should be considered in designing a welfare program. Rather than being attributed to demographic reasons alone, these differences follow the type of farming system in the area. The plantation and estate-farming sector, which provides the basis for Malawi exports is a major factor in increasing child labour.

9. HIV/AIDS, Social Economic Activities and Child Labour: ***HIV/AIDS is more prevalent where there are economic activities that attract more people, including child labourers,*** **for example, activities** like tourism, farming and cross border trade.

10. HIV/AIDS, Psychosocial Problems and Child Labour: ***HIV/AIDS brings in a range of social and psychological problems that force children to join the labour market***. The HACI study found that orphans and children affected by HIV/AIDS (especially those that live with chronically ill parents) face a myriad of problems that eventually force them to join child labour and the general labour market.

11. Access to information: HIV/AIDS awareness in Malawi is high, with figures above 95 per cent. A study by the Centre for Development to assess needs for HIV/AIDS information centres revealed that 98.7 per cent of all respondents knew what HIV/AIDS was. ***Although awareness is very high, behaviour change is still very low.***

12. Pressure and incapacitation of service providers due to HIV/AIDS: ***HIV/AIDS has reduced capacity for work and increased pressure on service providers, including the government, in all sectors including child labour.*** The impact of the HIV/AIDS pandemic includes, among others, high levels of morbidity and mortality (Malawi Government, 2001). Government departments, non-governmental organisations and the private sector are all experiencing a loss of productivity and increased costs due to absenteeism, medical bills, contribution towards purchase of coffins and transport to the deceased homes for burial and payment of premature death benefits.

13. Orphanhood and child labour: in Malawi, ***the HIV/AIDS pandemic has resulted in large numbers of children losing either one or both parents.*** It is estimated that each year a total of 70,000 orphans are left behind having lost one or both parents due to HIV/AIDS related illnesses. The HIV/AIDS pandemic and the resulting high numbers

of orphans is a worrying development in terms of child labour as well. The traditional informal security nets, like fostering, have been able to take care of some of the orphaned children, but these systems have by now been stretched to their limits. Even with some support from government, as a welfare service to the community, the fostering systems cannot not cope, due to limited resources from central government. As a coping mechanism, m***any children orphaned by HIV/AIDS*** are more likely to work than other orphans because their household assets and income will have been depleted to cover medical expenses during illness and death of parents. Even before one or both parents die of AIDS, the pressures on the household may result in children increasing their workload within the household or taking on work outside it.

14. Voluntary, counselling and testing services in Malawi: ***voluntary counselling and testing services in Malawi are not common;*** as a result, few men, women, boys and girls get an HIV test done.

In terms of networking in the field of HIV-AIDS prevention and child protection, this paper will show that there are a number of interventions being implemented. Most of these, however, are in the HIV/AIDS sector and do not adequately and directly address child labour issues. This is not to say that there aren't programmes that address the issue of child labour; even though a few such programmes are available, they are often constrained due to budget limitations. Numerous NGO, community, and some national programs have emerged to address children affected by HIV/AIDS. Most of these are direct service programs, seeking to fill some of the gaps that have occurred in the children's lives as a result of the death of a parent. As indicated, very few of these go beyond direct service to address the socio-economic factors driving the pandemic. In any case, most of the programs are already under pressure to accommodate the increasing number of children affected by HIV/AIDS.

This study recommends that the following actions be taken at a policy level:

1. Government needs to urgently develop a child labour policy that should be the national framework to guide stakeholders on issues related to child labour.

2. There is need to strengthen the provision of education services at all levels and help communities mobilise their children to remain in school, especially in areas where tobacco, tea and plantation farming framing are most dominant. This is particularly necessary in areas where illiteracy levels are high, which are also areas with high HIV/AIDS prevalence.

3. There is currently no coordinated national public awareness programme on child labour. It is therefore recommended that efforts to raise awareness against child labour should be improved and extended to more areas and sectors. Along these awareness programmes, should be messages that disseminate the interrelatedness of child labour and HIV/AIDS.

4. Child labour is a result of poverty. Efforts that are implemented as part of poverty reduction should therefore mainstream child labour and HIV/AIDS issues so that educational needs of children are not compromised for short term economic benefits.

5. Many stakeholders (public, private as well as civil society) implementing child labour and HIV/AIDS issues, especially at district and community levels, are ill equipped to deal with child labour cases, both in a preventive and curative way. There is need to

develop technical and financial capacity to support implementation of child labour activities, especially among decentralised local institutions.

6. The Government should also consider including child labour issues in teacher and pupil training curriculum, in addition to HIV/AIDS information, which has already been incorporated in the curriculum. This would ensure that the children themselves access information directly from the education system, thereby growing up aware of the dangers of child labour.

7. Most activities being implemented in the child labour sector are not coordinated and do not fall under a coherent national programme. There is need to develop a comprehensive programme to provide support to children most vulnerable to child labour and HIV/AIDS, such as orphans domestic workers and street children. The programme will also be a framework to improve coordination between various stakeholders.

8. Public institutions mandated to implement or monitor child labour programmes are not adequately financed. The Government through the Treasury should ensure that ministries responsible for labour issues and social welfare are adequately funded to enable them support decentralised institutions, NGOs and the private sector to implement child labour issues.

9. Mobilise public finances to support child labour and HIV/AIDS activities. These strategies are related to use, allocation, efficiency and effectiveness of government funds in supporting implementation of child labour activities.

10. Government should ensure and put in place relevant legislation to protect children from being employed to carry out hazardous work.

11. Although youth organisations have programmes on the rights of the child and HIV/AIDS, very few have programmes that directly fight against child labour the civil society therefore needs to improve efforts against child labour, which also include lobbying government for conducive policy and legal framework for children.

PART I:	The impact of HIV-AIDS in Malawi & its direct link to child labour

1.1 Background and rationale

Because of the impact of HIV/AIDS on child labour during the past five years, there has been a lot of awareness and activities related to it. Studies have been undertaken by the USDOL in conjunction with ILO-IPEC using rapid assessments and reviewing good practices reports. Studies that have been undertaken by UNICEF, UNAIDS, and UNESCO, among many others, point to the fact that the link between child labour and AIDS goes far beyond the often anecdotal assumptions held a decade ago[5]. Reports indicate that in Sub-Saharan Africa more than 11 million girls and boys are AIDS orphans[6]and that by 2010 an estimated 20 million children will be either single or double orphans. Orphan-hood has a strong link to child labour, and different studies show that HIV/AIDS orphans are twice as likely to work than other children[7]. To date, IPEC's work in this area has focused on improving the knowledge base and identifying appropriate responses. ILO-IPEC studies in South Africa, Zambia, Zimbabwe and Tanzania have confirmed the existence of a close link between the loss of one or both parents and child labour; the greater involvement of girls with the burden of care following the sickness of parents; the hazards of prevailing patriarchal and male sexual norms; and the bottlenecks in the rehabilitation institutions which are neither prepared nor qualified for such a great influx of children into their premises. Therefore, this policy paper translates the need to move from research to action, and outlines a clear strategy on educational alternatives for combating and preventing HIV/AIDS induced child labour in Malawi.

The purpose of this report is to document the educational and psychosocial impacts of HIV/AIDS on child labour based on literature and consultations done in Malawi. Before progressing, however, it is necessary to understand the economic and social policy factors that influence child labour and HIV/AIDS in the country.

1.2 Economic situation of Malawi and how it influences HIV/AIDS and child labour

The Malawi economy is largely based on agriculture and other agro-related industries. Despite many efforts to diversify the economy, the agricultural sector continues to dominate, supporting 90 per cent of the population and accounting for 40 per cent of the Gross Domestic Product (Forestry Department, 2003)[8]. Malawi's agriculture system is characterised by a dual production system consisting of the small landholder sub-sector and the estate sub-sector. The small landholder sub-sector operates on 4.8 million hectares of customary land and makes up 80 per cent of Malawi's food basket and 10 per cent of exports. The estate sub-sector concentrates on tobacco, tea and sugar, which account for 80 per cent of all agricultural exports (Forestry Department, 2003). The tobacco sector of Malawi, which provides 70 per

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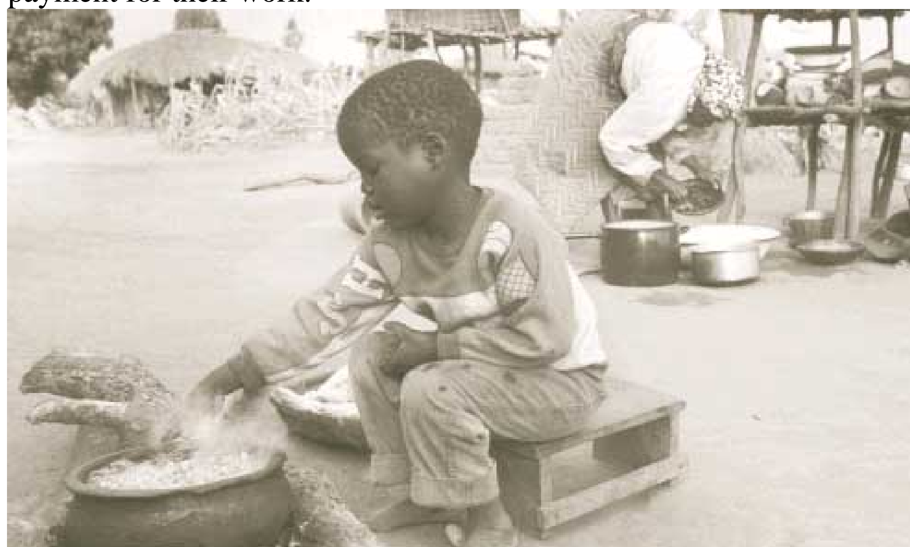
[5] Lusaka Declaration on AIDS and child labour (op cit).
[6] UNAIDS/UNICEF, 2002.
[7] Rosati, F., Unpublished paper for Lusaka tripartite workshop on HIV-AIDS and child labour, May 2003.
[8] Department of Forestry. Forest Law Enforcement and Governance in Malawi, 2003.

cent of Malawi's foreign exchange earnings, is one of the sectors in which child labour is widely found. Little is known about child labour in the tea, forestry and sugar plantations-farming sectors, which are also plantation-style and large scale in nature. Research by the ILO revealed that children between the ages of 5 and 16 are involved in weeding and harvesting the tobacco crop despite the fact that Malawi offers free primary education for children. Local commentators have also reported that despite their active participation in the tobacco production cycle, women and children do not adequately benefit from tobacco income. In most cases it is the men who control the tobacco income, and in many cases they spend the money on commercial sex workers in urban areas, some of them contracting STIs and HIV/AIDS along the way, and passing the diseases on to their wives. Because the peak season in the tobacco growing industry (November to February), which requires intensive labour, coincides with that of the school calendar, some parents instruct their children not to go school so that they can assist in field activities. In addition, the busiest work periods are also times when food security is lowest in most tobacco growing districts; hence many children are forced to engage in child labour including high-risk child labour activities such as commercial sex. During the same time, other parents advise their children to work in the field first, before going to school, which interferes with the performance of such children at school due to exhaustion and fatigue. When children do not perform well in school, they sometimes get frustrated and drop out of school early to continue with child labour, or marry early when they are supposed to be in school.

It is also important to mention at this stage that children younger than 5 years are involved in household work that is not necessarily paid. UNICEF's Malawi office commissioned a study in which most households reported that children help out in doing housework.[9] The type of work mentioned included cleaning dishes, sweeping around the house, gardening, drawing water and cooking (as shown by the boy in the picture below). Some children are employed at an early age and are paid only in kind for their services. For example, there have been reports that some children are given shirts, torn shoes, blankets, food and other things instead of money as pay. Similarly, child street vendors are given what is left from their sales as payment for their work.



[9] Government of Malawi et al. Early Child Development Baseline Study in Selected Districts of Malawi. Lilongwe, Malawi, April 2003.

By the end of 1997, 6 per cent of children under the age of 15 in Malawi were orphans. A boy orphaned by AIDS tends a pot cooking on an open fire.
UNICEF/94- 1 207/Andrew

About 85 per cent of the population lives in rural areas and depends almost entirely on subsistence agriculture with an average annual income of less than US$100 per household. 65.3 per cent of the population (about 6.3 million people) is classified as poor Constraints on the productivity of land include rapid environmental degradation and limited access to land. Constraints on labour include generally low levels of education, poor health status complicated by the high prevalence of HIV/AIDS, lack of or limited off-farm employment, rapid population growth, and gender inequalities. The Malawi Government approved a Decentralisation Policy in 1996, which focuses on the empowerment of the poor through their participation in decision-making. Since the adoption of the decentralisation policy, significant progress has been made, although there are still challenges regarding the capacity of District Assemblies (see section of this paper on social policy). Economic development in the agriculture sector remains weak, input prices are too high, and farmers do not adopt better land husbandry practices, as they do not give immediate outputs. As a result, most of the agricultural system is characterised by extensive and labour intensive farming systems, meaning that households have to use everybody, including children available to produce adequate food.

Malawi, which had an estimated population of 11.2 million at the end of 2002, is one of the worst HIV/AIDS affected countries of Southern Africa. Forty-five per cent of the population of Malawi, which equals 5,350,000, are children less than 15 years of age (UNAIDS/UNICEF, 2003). The Malawi Child Survey Report reports a similar figure of 44.6 per cent being the size of the population below 15 years of age. If the cut-off point is raised to 18 years then the youth population rises to 52 percent. In terms of regional distribution of the population, the majority of people (4,633,968) are found in the Southern Region (46.6 percent), followed by the Central Region with 4,066,340 (40.9 percent) and then the Northern Region, with 1,233,560 (12.4 percent). HIV infection is mainly found in younger age groups, particularly among women, and life expectancy is projected to drop from 57.4 years to 44.1 years by the year 2010, which would have an effect on productivity. According to the 1998 figures, the country's population is mainly rural (86 percent).

1.3 Social and poverty policy

The key development challenges of Malawi have been identified in the Country Development Report (UNDP 2001) as governance, poverty and HIV/AIDS. As indicated above, more than 65 per cent of Malawi's population lived below the poverty line in the year 2000, ranking Malawi among the bottom seven per cent of countries on the United Nations Development Programme's (UNDP) Poverty and Human Development Report[10]. Also, the social indicators related to children in Malawi are very poor. For example, the DHS survey for 2000 shows that 49 percent of children are stunted (height for age) and 25 percent are underweight (weight for age). At the same time, acute malnutrition (or wasting) is estimated at 5 to 6 percent of children under age five and 1 percent are severely wasted (W/H <-3 Z score). Another point that needs to be mentioned is the fact that 56 percent of the adults were literate at of end of

[10] UNICEF: At a glance: Malawi. http://www.unicef.org/infobycountry/malawi.html.

1995[11]. There is a general agreement that the AIDS pandemic is severely affecting households' food security, exacerbating the already poor indicators. Most vulnerable households have been left out of productive systems and have very little resilience to cope with any sort of shock. These social and economic challenges can be directly linked to the political, economic and social conditions that prevail in Malawi, and which, in turn, drive the HIV/AIDS epidemic and facilitate child labour. As a result of these challenges, Government has made poverty reduction its major goal. The Malawi Poverty Reduction Strategy Paper (MPRSP) was established as the main framework for guiding development interventions in the country. The overall goal of the MPRSP, launched in 2002, is to achieve sustainable poverty reduction through empowerment of the poor. Therefore, the MPRSP recognizes that the poor, who also include children involved in child labour, should not just be recipients of development, but be active participants in the development process. It is only then that poverty can be reduced in a sustainable manner. The MPRSP is constructed around four building blocks called the "pillars". These form the strategic framework that groups various priority policies and activities into a coherent plan for poverty reduction. These pillars are:

- *Sustainable pro-poor economic growth;* the poor will be economically empowered by ensuring macro-economic stability, which increases access to credit and product markets for the poor.

- *Human capital development;* increasing poor people's access to health and education, to enable them to empower themselves. In the case of children affected by child labour, this means implementing programmes that enhance access to and retention in educational institutions, improving access to HIV/AIDS information and technology and developing the capacity of local institutions, parents and guardians for prevention of child labour. Support to basic education for improved child development is a key strategy to achieve this.

- *Improving the quality of life of the most vulnerable:* realising that even though the two pillars above will have significant effects in reducing the numbers of poor people, the MPRSP has put in a safety net strategy that will "net" those that will not benefit from the two pillars above due to various underlying factors like age, HIV/AIDS, gender, health and cultural differences. The overall goal of this pillar is to ensure that the living conditions and situation of the most vulnerable groups in society are improved and maintained at an acceptable level by providing moderate support to the transient poor and substantial transfers to the chronically poor. Children involved in labour, those affected by HIV/AIDS and those in the street are classified nationally as among the vulnerable groups who are prone to contracting HIV. These require safe-net programmes in the short-term transfers and need empowerment activities (pillar 2) like education to support their long-term strategic development.

- *Good governance:* no development interventions can thrive and benefit the poor if public institutions and NGOs do not create the enabling environment. This pillar aims to ensure that public and civil society organisations, their structures, systems and policies protect children and the poor from child labour, HIV/AIDS and other forms of violence/abuse against children.

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[11] UNAIDS: Malawi Summary. http://www.unaids.org/en/geographical+area/by+country/malawi.asp.

In the MRSP, the Government recognises the negative role HIV/AIDS is playing in all sectors of the economy. Hence, the MPRSP will focus on reducing the incidence of HIV/AIDS and improving the life of those that are already infected or affected by the disease. In its efforts to implement the MPRSP, the Government is being supported by its donor partners and through the use of funds from programmes such as the Highly Indebted Poor Countries (HIPC).

As a means to implement the MPRSP, the government is implementing a Decentralisation Policy, approved in 1996, following a review of decentralisation related activities in the country. The purpose of the policy is to decentralise political and administrative authority to the district level as a mechanism for 1) consolidating democracy, and 2) realising the country's development goal of poverty reduction. Under the policy, all development decisions and priorities are set and made within each district at the District Assembly level. In total there are 39 District Assemblies (which include City, District, Town and Municipal Assemblies). Each district's development priorities are contained in a District Development Plan (DDP), to which all sectors must be responsive. Child labour activities are among social welfare type of projects. As a sample, when the authors reviewed two DDPs from Mulanje and Phalombe (both districts have several tea estates and have high levels of child labour and HIV/AIDS), it was noted that HIV/AIDS is a high priority for the welfare projects in both districts. Among the major causes of HIV/AIDS are factors that relate directly to child labour. In Mulanje, among the major causes of HIV/AIDS were high rates of promiscuity (due to high population), bad traditional practices, early exposure to sex, lack of openness and awareness on HIV/AIDS, unprotected sex, divorce and remarriages and poverty which forced children to be employed early and engage in sex.[12]

Under the decentralisation policy, HIV/AIDS issues are identified and prioritised through the District AIDS Coordinating Committee (DACCs), which are subcommittees of the District Executive Committees, a technical arm of the District Assembly mandated to advise the District Assembly on all technical matters related to district planning and development. The DACC's main function is to coordinate all HIV/AIDS activities in a particular district. The DACC works with all major players in HIV/AIDS, including government, nongovernmental, civil society and private sector organizations. The DACC is an HIV/AIDS technical sub-committee of the District Executive Committee. At the community level, HIV/AIDS issues are implemented through the Community HIV/AIDS Committee (CAC) and through the Village HIV/AIDS Committee. Child

Box 1: How to allocate resources to District Assemblies

The Local Government Financial Committee of GOM has derived a poverty-based formula, which forms the basis for the allocation of national funds to the DAs. The formula is not a "one size fits all" but comprises 22 factors derived from national statistics which give base data for the country per DA, including population, HIV infection rate, mortality rate, literacy rate. Dependant on the focus of a particular department/programme, different factors can be incorporated within the formula. For instance, if one was doing a HIV/AIDS/ Child Labour programme, one would be interested in the HIV/AIDS, health, infant mortality, population data related factors more than education factors and would then select the "basket" of factors appropriate to the developmental objectives of the programme. (i.e. population, infant mortality rate, no. of hospital beds, etc, would be selected as the factors to use in the formula). The formula includes an entire list of factors which can be selected and used in the formula to derive a poverty score for each district assembly in relation to each factor.

[12] Government of Malawi: Mulanje District Development Plan, 2002-2005. 2002.

labour and HIV/AIDS are discussed in this committee. At the local level, development projects are identified and implemented by the Village Development Committee (VDC), a committee democratically elected by members from a number (5-10) of villages that form a Group Village. Once the VDC identifies a project, a proposal is sent to the Area Development Committee at the Traditional Authority level, which appraises the proposal before sending it to the District Executive Committee for final desk and field appraisal. Once the DEC recommends a project, it advises the DA to provide funding.

The Decentralisation Process offers a new opportunity in terms of implementation and financing HIV/AIDS and child labour projects by creating a funding mechanism called the District Development Fund (DDF). The DDF is the district basket that channels finances from various sources to the poor. The financing can be made open to a sector in a particular district or targeted as "conditional grants". Conditional grants are funds, which largely come from the development (donor) financing sources and are provided to the Assemblies for specified developmental activities[13], which may include child labour and HIV/AIDS activities. A specific tracking or monitoring system can then be developed to manage the finances. The national AIDS Commission will shortly be decentralising its financing to District Assemblies following the process outlined in the preceding sentences. The major issue, however, from many commentators, is lack of capacity at district level to manage large amounts of funds.

1.4 Child labour laws and policies

According to the Child Labour Law study done by the Centre for Social Research[14], Malawi does not have any written labour policy, let alone a child labour policy. According to the report, that the Ministry of Labour maintains that there are no plans to develop one either. CSR indicates that many stakeholders largely depend on the existing legislation as the guiding framework for child labour related programmes as it is reported that there is a good legal framework for the fight against child labour. According to the Department of Labour, the various pieces of labour legislation express the unwritten labour policy[15]. It is however known that legislation that is not supported by a written policy is difficult to implement as many stakeholders find interpreting the law more difficult than interpreting a policy. A Labour Policy to guide programming and implementation of various child labour related interventions various sectors of the economy is therefore an obvious policy gap that needs to be urgently addressed. The need for the policy is even more pertinent now, considering that this paper indicates the serious linkages that child labour has to HIV/AIDS and vice versa. In addition, as CSR recommends, it would assist practitioners very much if a labour policy can be put together by pulling out the various labour aspects embedded in the various pieces of legislation.[16] Additionally, without such a policy, it is uncertain whether the Ministry of Labour and Vocational Training can convince the Treasury that child labour issues are priorities that should be allocated adequate resources. This is also possibly the reason why the MPRSP is not clear on child labour, resulting in very low funding for the Ministry, especially

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[13] Department of Forestry: Report on Decentralisation Study Visit to the Forestry Department in Uganda, 12 – 18 September 2001.
[14] Centre for Social Research: Child Labour Baseline Study, Final Report, ILO/IPEC, University of Malawi, June 2003.
[15] Ibid.
[16] Ibid.

at the district level. In terms of legislation, there are five pieces of legislation that govern labour in the country. These are:

- Labour Relations Act, No. 16 of 1996;
- Occupation Safety, Health and Welfare Act, No. 21 of 1997;
- Technical, Vocational and Entrepreneurship Training Act, No. 6 of 1999;
- Employment Act, No. 6 of 2000; and
- Workers Compensation Act, No. 7 of 2000.

According to the Child Labour Baseline Study, of these five, only the Employment Act has some child labour provisions. The report indicates that section 21 of the Act prohibits the employment of a child below the age of 14 years *"in any public or private agricultural, industrial or non-industrial undertaking, except for work done in the homes that does not attract a wage, vocational technical institution or other training institutions which is supervised and approved by a public authority, or which is part of the curriculum of an educational or vocational training institutions."(CSR, 2003 p7)*

The same report indicates that section 22 of the Act protects children between the ages of 14 to 17 from being employed to carry out hazardous work. Hazardous work is defined as any occupation or activity that is likely to be harmful for the child's health, safety, education, morals or development; or prejudicial to the child's attendance at school or any other vocational training programme. This echoes ILO Conventions 138 and 182. However, this is not in line with the Malawi Constitution. The Constitution defines a child as a person who is 16 years and under, and provides for compulsory primary education for all children as long as they are under seventeen. Thus the CRS Child Labour Survey Report concludes that the Employment Act and the Malawi Constitution need to be aligned.

As with many other Government Departments, it is reported that many District Labour Offices do not have official copies of the full set of the labour legislation. This makes the translation of the legislation and case handling by the district level staff difficult. It makes participation by other role players even more difficult. This is true because most of these stakeholders (especially NGOs and CBOs) may not necessarily have labour related training or experience to support or take part in prevention and mitigation of child labour, especially in rural areas. The result is that stakeholders and the community in general will always be looking at child labour issues as issues pertaining only to the Ministry of Labour, yet they are crosscutting and need a multi-sectoral approach to combat them.

1.5 The HIV/AIDS Policy and Strategic Framework

The overall policy goal of the health sector is to raise the level of health of all Malawians by reducing the incidence of illness and occurrence of death in the population through the development of a delivery system capable of promoting health: preventing, reducing and curing disease, protecting life and fostering the general well being of the people and increasing productivity[17]. The goal of the HIV/AIDS policy intends to support and contribute to the achievement of the overall health policy by preventing HIV infections, reducing vulnerability to HIV, improving the provision of treatment, care and support for people living

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[17] Government of Malawi, 2000: The National HIV/AIDS Strategic Framework for 2000-2005.

with HIV/AIDS and to mitigate the socio-economic impact of HIV/AIDS on individuals, families, communities and the nation. Specific objectives of the HIV/AIDS policy are to:

- Prevent HIV infections.
- Improve delivery of prevention, treatment, care and support services.
- Mitigate the impact of HIV/AIDS on individuals, the family and communities.
- Reduce individual and societal vulnerability to HIV/AIDS through the creation of an enabling environment.
- Strengthen the multi-sectoral and multi-disciplinary institutional framework for co-ordination and implementation of HIV/AIDS programmes in the country.

The HIV/AIDS policy has recently been approved by Government to support and guide efforts to implement the National HIV/AIDS Strategic Framework. The National HIV/AIDS Strategic Framework is the key document to guide planning for responses against the pandemic. The framework aims to reduce incidence of HIV and other sexually transmitted infections and improve the quality of life of those infected and affected by HIV/AIDS. In particular, the framework is guided by four principal methodological approaches, on which any child labour and HIV/AIDS project should be based. These are:

- Expanding and strengthening people's knowledge about the nature of HIV/AIDS and its impact on individuals, families, communities and on national development.
- Expanding and strengthening the capacities of individuals, families, communities and institutions to respond to the epidemic in a more sustained and effective manner.
- Stimulating and sustaining synergistic interaction between individuals and available programmes and services as a basis for collective action.
- Developing and sustaining a dynamic broad-based institutional framework for the planning, delivery and evaluation of HIV/AIDS programmes.

The framework has the following components, which are relevant in the context of child labour:

Culture and HIV/AIDS: This component aims to bring about socio-cultural changes that will help reduce the spread of HIV/AIDS and minimize its impact on individuals, families and communities. These include cultural practices prevalent in Malawi which encourage unprotected sex, prostitution, early marriages, transmission of HIV/AIDS, property grabbing and multi-partner relationships among men, women, boys and girls.

Youth, social change and HIV/AIDS: The major victims of child labour are children and young people who sell their future for unsustainable and short-term gains. This policy element aims to strengthen the authority of and coordination among youth socialization institutions in order to bring about change in the behaviours that predispose the youth to HIV infection. It is the most relevant objective in terms of child labour.

Socio-economic status and HIV/AIDS: With high levels of poverty, children are forced to engage in short-term economic relief activities to maintain their livelihoods. These activities expose children to HIV/AIDS and child labour and may eventually lead them into criminal activities (due to desperation) and death. This element aims to bring about a change in the socio-cultural and economic environment for women and men in order to address gender imbalances and reduce the spread and impact of HIV/AIDS. By targeting women and

children, the assumption is that child labour can be prevented and children can be less exposed to contracting HIV/AIDS.

Despair and hopelessness: Aims to bring about hope, faith and help Malawians come to terms with the reality of HIV/AIDS in order to facilitate prevention and the mitigation of its impact.

HIV/AIDS management: Even with existing and planned interventions, there are close to 1 million Malawians that are living with HIV/AIDS. These are the people who are likely to use children to supplement household labour for food and income and other forms of care and support because they are incapacitated by disease. These people need to be supported and programmes should be implemented to assist them. This section aims to provide adequate and high quality management services to PLWAs, affected individuals, families and communities.

HIV/AIDS and orphans, widows and widowers: Aims to strengthen and support sustainable capacities for the care of orphans, widows and widowers, particularly at family and community levels. Child labour is reportedly common in families with low capacity to generate their own income and food over a year. When a bread-winner (who is in most cases a man in Malawi), dies of HIV/AIDS or any disease, his widow is left with no choice but to involve her children in child labour to support the family. As a result, some children engage in behaviours that predispose them to HIV/AIDS. The problem becomes worse in cases where family members of the deceased husband grab the remaining property from the widow, a very common practice in Malawi.

Prevention of HIV transmission: With the aim of strengthening the effectiveness of HIV prevention programmes and practices and expanding their scope to reduce HIV incidence among Malawians.

HIV/AIDS information, education and communication: To establish a standardized, comprehensive and effective IEC strategy to reduce the spread of HIV and cope with the impact of the epidemic. Many remote areas that are suppliers and employers of children for child labour do not have access to regular and updated information on child labour. Even in urban areas where information is readily available, bosses deny children involved in domestic work access to radio, TV and newspapers; therefore, the information available to these children is as limited as in rural areas. Both rural and urban areas need a strategy to address information gaps on HIV/AIDS.

Voluntary counselling and testing: To strengthen and promote accessible and ethically sound Voluntary Counselling and Testing (VCT) services that offers psychosocial support to men, women, children and youth in order to reduce the transmission of HIV and impact of HIV/AIDS.

The National AIDS Commission is reviewing the National HIV/AIDS Framework this year. Lessons learn during the last four years of implementation are expected inform the review process.

1.6 The situation of HIV/AIDS in Malawi

Like its neighbours in the Sub-Saharan Africa region, the country has been severely affected by the HIV/AIDS epidemic. According to the National AIDS Commission, AIDS was first identified in Malawi in May 1985. Since then, epidemiological data continues to show escalating numbers. Malawi is one of the 15 poorest countries in the world with the highest HIV/AIDS prevalence rate. Many commentators have linked poverty with HIV/AIDS. With the widespread poverty situation, it is not surprising that Malawi has an extremely high prevalence of HIV/AIDS, nationally estimated at 14.4 per cent (National AIDS Commission, 2003). The National AIDS Commission Monitoring Report for 2003 estimates that of the 900,000 HIV-positive people, 60,000 are aged 14 years and less, representing 6.7 per cent of total people infected. Among pregnant women attending antenatal clinics in urban Blantyre, HIV seroprevalence rose from 2.6 per cent in 1986 to over 30 per cent in 1998; it fell a little to 28.5 per cent in 2001. HIV infection rates are lower in rural Malawi (at 12.4 per cent as compared with 23 per cent for the urban areas). Prevalence rates are however on the increase in both rural and urban areas, unlike in Zambia where some evidence suggests that urban infection rates have levelled out and may be falling, especially among women (Rau, 2002)[18]. Other HIV/AIDS experts report that due to lack of VCT services, fear of stigma and other socio-cultural barriers, not many people are tested, therefore it is likely that figures reported by the NAC are underestimates.

The adult (15-49 years) HIV prevalence is estimated at 25 per cent for urban areas and 13 per cent for rural areas.[19] The national adult (15-49) HIV prevalence is 14.4 per cent (see Table 1 below), translating into about 760,000 adults living with HIV/AIDS, 56 per cent of them being women. Women (especially the age group 15-24 years) are at the highest risk of infection due to their biological make up and due to discriminatory cultural beliefs that prevail in Malawi that tend to disfavour women and girls more than men and boys. Traditionally, women are socialised to respect men and therefore they are not expected to demand their sexual rights. Annual deaths due to HIV/AIDS are estimated at 81,000 with a cumulative number of 555,000 deaths since the first HIV case in 1985.[20] The major mode of transmission is unprotected heterosexual activity (88 per cent), and currently about 8 per cent of all new HIV infections occur through mother to child transmission. Since the main cause of transmission is heterosexual intercourse, the most sexually active age group of 15 to 49 years is the major victim of the epidemic. The following table shows the latest HIV/AIDS statistics in Malawi.

Table 1: Estimates of the HIV/AIDS epidemic in Malawi in 2003

Indicator	Value	Low	High
National adult prevalence (15-49)	**14.4%**	**12%**	**17%**
Number of infected adults	760,000	630,000	910,000
Number of infected adult women	440,000	370,000	530,000
Urban adult prevalence	**23.0%**	**19%**	**28%**

[18] Rau, Bill. 2002: "Combating Child Labour and HIV/AIDS in Sub-Saharan Africa: A review of good practices in policies, programmes, and projects in South Africa, Tanzania and Zambia. Paper No. 1," Geneva: ILO-IPEC.
[19] National AIDS Commission. "Estimating National HIV Prevalence in Malawi from Sentinel Surveillance Data: Technical Report." Lilongwe, Malawi. 2001.
[20] Ibid.

Indicator	Value	Low	High
Number of infected urban adults	240,000	200,000	290,000
Rural adult prevalence	**12.4%**	**10%**	**15%**
Number of infected rural adults	530,000	440,000	640,000
Number of infected children (0-14)	70,000	60,000	80,000
Number infected over age 50	60,000	50,000	70,000
Total HIV+ population	900,000	750,000	1,080,000

Source: National AIDS Commission (2003).

The high prevalence of HIV among adults, especially women, and youths in Malawi is primarily due to social and economic factors. Wife inheritance and other deeply entrenched cultural practices often expose widows, married women and girls to HIV. These cultural practices include wife inheritance, (*chokolo*) where widows are married off to the deceased husband's brother, and *kupita kufa* (*kulowa kufwa*) where a widow is made to have sex with her husband's brother immediately after the death of the husband so as to "clean her". Domestic violence is another common practice that results in children being emotionally disturbed and dropping out of school and running away to engage in child labour. A public hearing on domestic violence conducted by the Malawi Human Rights Commission on 26th October 2001 revealed that the practice is on the increase. It noted that this practice emanates from some traditional norms and cultures that do not only degrade the rights of most women and children but also result in serious psychological and health hazards.[21]

Physical violence was also identified as being on the increase and the victims being mostly women and orphaned children. In the case of children, the Malawi Human Rights Commission heard that families take orphans to their homes so as to work them for minimal or no pay at all. A glaring example of such acts was widely reported in the press where a woman in the commercial city of Blantyre allegedly scorched a fourteen-year-old girl worker with hot water for eating sweet potatoes without permission.[22] Some unconfirmed rumours also indicated that the woman scorched the girl because she suspected that the girl had sex with her husband, putting the girl at risk of contracting STIs. The girl worker, originating from one of the poorest district of Nsanje, died of Class A wounds at Queen Elizabeth Central Hospital. The Blantyre High Court sentenced the woman to death [23].

It is reported that in the year 2000 alone, the Malawi Human Rights Commission received more that 52 complaints related to domestic violence involving women and children.[24] In order to reverse these alarming statistics, the Common Country Assessment identifies several factors that contribute to increasing women's access to education and health facilities. These factors include raising awareness of women's reproductive rights, promoting male participation in sexual and reproductive health, strengthening the infrastructure for curbing gender-based violence, enforcing stricter penalties against offenders and curbing sexual harassment at school and the work place.[25] It is believed that changing cultural attitudes about gender would also greatly improve educational possibilities for women and help to prevent

[21] Rule of Law newsletter, Vol. 001, October 2001, p 4.
[22] Ibid.
[23] Malawi News, May 22-28, 2004.
[24] Rule of Law newsletter, Vol. 001, October 2001, p 4.
[25] UN System in Malawi, Common Country Assessment of Malawi, 2001, p 37.

HIV/AIDS, hence improving the security of women in society and the promotion of their rights[26].

1.7 The spread of HIV/AIDS in Malawi

According to the National Strategic Framework, research into the spread of the HIV epidemic shows that it spreads more rapidly in societies and communities which have the following characteristics:

- Where the society is significantly stratified socially and economically with a great disparity between the rich and the poor;
- Where women occupy a low status in society and have little power to make decisions, including on issues of sex and sexuality;
- Where social support systems are inequitable and sometimes oppressive;
- Where social norms and values condone or even encourage extensive sexual networking, perpetrated particularly by men;
- In societies with labour markets characterized by single gender mobility and high levels of unemployment;
- In communities with flourishing local markets and extensive informal trading networks;
- Where strong social sanctions exist for transgression of cultural, social and religious norms, but transgressions occur nonetheless.

Nearly all of these factors explaining the spread of HIV apply to the Malawian situation. There is great disparity between the rich and poor. Social indicators, particularly with respect to women and children, are largely negative. In spite of some gains over the years, equality and equity between men and women still does not exist. Gender issues are still considered women's issues, with the public not supportive of the imperatives of the National Gender Policy. Alcohol consumption and sexual networking are widespread. It is a common phenomenon for men and boys to be working away from home. And recently, mobility stimulated by trade has grown in scale and involves men and women, adults and the youth. Sex with multiple partners is often unprotected due to lack of access to condoms caused by high selling prices, poor distribution, cultural/religious prejudices and lack of behaviour change-in most cases men preferring unprotected sex. According to health officials, continued HIV infection is also due to the high prevalence of sexually transmitted infections (STIs). The high mobility of workers and migrant labour in districts is another cause of HIV infection. The increasing incidence of mother to child transmission of HIV in the country is spurred by the inadequate access of women to voluntary counselling and testing (VCT) so that they can make informed reproductive choices. Anti retroviral drugs are inaccessible to many PLWAs in the districts because of high cost[27], poor distribution and lack of information about their use and where to get them. Currently there are 170,000 people that are in need of anti-retroviral therapy (NAC, 2003). The absence of adequate care, treatment and support services in most parts of the country has led to despair and hopelessness among some people, a situation which

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[26] Centre for Human Rights And Rehabilitation. Community Safety and Empowerment in Malawi, December 2003.

[27] About K2500 (about USD22.7at exchange rate of K110 to USD1) per month.

has led to decreased desire for people to know their sero status. Poor nutrition is also a contributing factor to the high HIV/AIDS related mortality in the country.

1.8 Linkages between and impact of HIV/AIDS on child labour

Article 32 of the United Nations Convention on the Rights of the Child states that children have the right to be protected from "economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or be harmful to the children's health or physical, mental, spiritual, moral or social development." Although child labour is prominent in least developing and developing countries, it is also prevalent in developed countries. For example, child labour is reportedly evident in agricultural regions, like in the USA, where hiring children saves an estimated $3 billion. In warring countries children are used as soldiers. The Renamo forces in Mozambique, in particular, systematically practised forced recruitment of children. Renamo had at least 10,000 boy soldiers, some as young as six years old. During the time of the Mozambican war, a large number of refugees who fled the country to Malawi were children and had to engage in child labour to survive the impact of displacements. Some of these children had lost their parents and had been forced by such circumstances to marry early (Reece, 2003). In Angola, a 1995 survey found that 36 per cent of children had accompanied or supported soldiers, and 7 per cent of Angolan children had fired at another person[28].

Not many of the studies done on Malawi have focused specifically on child labour. Therefore it is difficult to establish the number of children involved in child labour in Malawi. The Malawi Child Labour Survey (NSO, 2002) estimates that there are 3.8 million people aged between 5 and 17. Of these, a total of 1.5 million (representing roughly about 15 per cent of the population and about one-third of the age-group), are involved in some type of economic activity, while 1.7 million are involved in non-economic activities. The remaining 629,000 are idle and not involved in any economic activities. According to the Malawi Child Labour Survey of 2002, child labour is defined as any economic and non-economic activity that employs a child less than the age of 14 years and exploits a child, prevents a child from attending school, or that negatively impacts the health, social, cultural, psychological, moral, religious and related dimensions of the child's upbringing. With children working long hours, not only are they missing out on their childhood but are also at risk of physical injury from workplace hazards. It is reported that children working in industries in other countries are exposed to hazards including skeletal deformities, asthma and byssinosis – a lung disease caused by breathing cotton fumes[29]. Children are often beaten, tortured and not paid the promised wage in many least developing countries. For example, the child sex industry impacts children in several ways. Children engaging in sex work are also more vulnerable to developing a sexually transmitted infection and female sex workers face the possibility of pregnancy. In Malawi, girl sex workers are regularly harassed and fined by the legal authorities, who leave their patrons unharmed.

[28] Reece, Jolene. "An essay on child labour by Jolene Reece." 2003. http://aids.takingitglobal.org/express/article.html?cid=610.
[29] Ibid.

1.8.1 Poverty, HIV/AIDS and child labour

Poverty increases HIV/AIDS and child labour: The HIV/AIDS pandemic has proved to be one of the major supply factors behind the increasing number of child labourers in recent times. There are increasingly more destitute children having to fend for themselves and in some cases look after their siblings and grandparents, as a result of their parents dying of AIDS and making them an easy target for being forced into labour. These factors are worsened by the poverty situation in Malawi, with over 65 per cent of the population living below the poverty line. In such circumstances, many households expect children to sell their labour and earn either food or income to support their parents or guardians/households. Due to this expectation, children engage in various forms of child labour, including sex, either in return for cash, in-kind remuneration, food or even support during examinations[30]. There are many children seen in urban as well rural areas, who are sent to sell eggs, groceries and other petty products to earn money to supplement or wholly support their households. These children stand for long hours in sunshine and walk long distances to and from the market, conditions that are detrimental to their well-being. Although data on this type of child labour is scarce, in most cases these children are orphans, who are either staying with distant relations, aged relatives, guardians or they live alone because they have lost one or both parents due to HIV/AIDS. For example, an ILO Child Labour baseline study done by Centre for Social Research (2003)[31] in Mchinji, Kasungu and Mzimba found that out of the children who worked for pay in the twelve months prior to the survey, 22 per cent worked mostly as temporary employees paid on a daily basis (*ganyu* basis)[32]. From the wages earned, eighteen percent (18 per cent) of the children gave most of the income earned to parents, either in part or full; 41 per cent gave all and 31 per cent gave part of their earnings to parents or guardians, implying and confirming that desperate parents use child labour to earn or supplement their livelihoods from child labour. Most of the income was spent on personal needs (57 per cent) although as many as 14 per cent of the children indicated spending the money on household items, 9 per cent spent on school materials and another 9 per cent bought goods and services. The low expenditure of child labour income on education might be suggestive that such children are actually not going to school or their parents are not interested in the child's education. These findings justify the fact that poverty drives child labour, putting many children at risk of contracting HIV/AIDS.

The involvement of children in income generating business activities also exposes children to HIV/AIDS and risky behaviours by their peers or adults who buy merchandise from them. The common risky behaviours that have been reported by commentators in Malawi include smoking tobacco and Indian hemp, abuse of various types of drugs, womanising, beer drinking and violence. Apart from being involved in such bad behaviours, these children also face various forms of abuse by either their peers or by elders. A survey by Save the Children (Norway) done in 2000[33] reported that in some families, fathers encouraged their daughters to know certain men who have spare cash and materials. Such fathers sent their girl children to shops, owned by the wealthier men, usually with less cash than what they are required to buy.

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[30] Many informal reports indicate girl children are coaxed into sex before exams.

[31] Centre for Social Research, 2003: Child Labour Baseline Study, Final Report, ILO/IPEC, University of Malawi, June 2003.

[32] *Ganyu* in Malawi means temporary or causal labour.

[33] Kaponda, CPN. A Situation Analysis of Child Abuse in Malawi, Study done for the National Task Force on Children and Violence in collaboration with SCF (US), 2000.

Many girls were reported to be caught in such sexual traps, which constitute a form of child labour, and this eventually led to the girls dropping out of school, getting married early and contracting sexually transmitted diseases. Box 2 above illustrates a specific case study of sexual abuse and child labour as quoted in the report above[34].

1.8.2 Food Insecurity and HIV/AIDS

Food insecure households are more prone to HIV/AIDS: The levels of food insecurity in Malawi are very high. The DHS survey 2000 shows: 49 per cent of children are stunted (height for age) and 25 per cent are underweight (weight for age). In the same time, acute malnutrition (or wasting) is estimated at 5 to 6 per cent of children under-age five and 1 per cent are severely wasted (W/H <-3 Z score). Households that are affected by HIV/AIDS spend most of their time and financial resources in the care and support for those with HIV/AIDS, hence reducing investment in agriculture and other productive activities. There is a mutually reinforcing relationship between HIV/AIDS, food security and child labour. Each one leads to the other. Many commentators have agreed that when a household is affected by HIV/AIDS, or when one member is suffering from AIDS, both manpower and financial resources are diverted to care and support. Assets are liquidated to raise money for medical bills, transportation to and from hospitals and to buy food that is not normally consumed in the household. In order to supplement resources required for care and support, children are encouraged or forced to drop out of school and are sent to work for either food and or income. At the community level, the community starts spending more time on care and support activities like communal farms, instead of implementing development programmes for their area.

Box 2: Example of extreme cases of child labour

There is a family in Ndirande, which has 6 children (3 boys and 3 girls). Neither parents are working and depend on their children to get food and money for the home. The boys go in the streets to beg and the girls go to sell their bodies and get money. The parents noted that the girls brought more money compared to the boys. The parents even commented that boys are useless (*alibe phindu*) as compared to girls because they brought less money.

As reported by the ILO and the Child Survey Report, when the economically active adult population is most affected, children are often forced or drawn into the labour market. Children are therefore often forced to drop out of school, become heads of the household and enter the labour market to contribute to the family income or to take care of their own survival (ILO, 2002b:40). This was found to be a factor, to some extent, in this study. In the Malawi Population and Housing Census Analytical Report of 1998, the proportion of household heads that are under 15 years old is small at 0.5 per cent, but those between 15-19 years is at 2.3 per cent. In both age ranges, there are more young female heads of households (4.4 per cent) compared to 2.0 per cent male heads of households. Most vulnerable households have been left out of productive systems and have very little resilience to cope with any sort of shock. Due to the high demand for care and support services to PLWAs, households do not have alternatives, as they have to send children to work and get some food or income to support their households as a contribution or supplement to parents for care and support.

[34] Ibid.

1.8.3 Child labour, care and support for orphans and people living with HIV/AIDS

The results of the Hope for the African Child Initiative baseline study on the impact of HIV/AIDS on children and their families revealed that close to half the number of respondents, including children aged below 15 years, take care of people living with HIV/AIDS (PLWHA) by engaging in activities that hinder their education. This was reported by 46.5 per cent of the respondents on average for all districts. Across the 6 study districts of Balaka, Dedza, Lilongwe, Mchinji, Salima and Mzimba, it was revealed that Mchinji had the highest proportion of children with 50 per cent of all child respondents taking care of PLWHAs, followed by Mzimba (43.7 per cent), Salima (38.6 per cent), Dedza (33.3 per cent), Lilongwe (32.4 per cent) and Balaka at 25.6 per cent In addition to these alarming statistics, Mchinji is also known for high incidences of child labour due to tobacco estates and high incidence of HIV/AIDS. Mchinji district borders Zambia and lies between the two urban areas of Lilongwe (Malawi) and Chipata (Zambia). The figures reported above in a way relate to the other finding from the same study where respondents in Mzimba, Salima and Mchinji reported the highest prevalence of PLWHA in their households. The main activities that the community is doing about PLWHAs were reported to be: providing resources to the PLWHAs (15.0 per cent), taking them to the hospital when sick (10.9 per cent), forming community organisations (6.5per cent), community was assisting these people in household chores (5.8 per cent), giving them moral support (5.4 per cent), and giving them food and drugs (5.4 per cent).

Although the above care and support services are provided as part of the normal inter and intra family support in most parts of the country, these activities disrupt children's performance at school and expose them to risk of contracting diseases. A good proportion of this support is derived from home-based care (HBC) programmes, which are under implementation in most districts. Players in HBC programmes are (in rank order) relatives, religious groups/organisations, communities at large and CBOs. The extended family system, where relatives are involved, has again been shown to be the most important community-based support mechanism for the chronically ill. It is also reported that the strength of the extended family is weakening due to the severity of the HIV/AIDS problem and the worsening economic situation, which is a potential problem for Malawi.

1.8.4 Coping mechanisms for household living with PLWHAs

Many children enter or increase their participation in the workforce to compensate for changes in household earnings or labour supply. Children orphaned as a result of HIV/AIDS are even more likely to work. Even before one or both parents die of AIDS, the pressures on the household may result in children increasing their workload within the household or taking on work outside it. Quite often, households experiencing prolonged periods of illness with HIV and related conditions and eventual death, suffer dramatic cuts in income, severe strains on cash flow and likely loss of assets. To make up for these economic losses, children may be withdrawn from school and/or told to work. Not just that, the impact of HIV/AIDS can go full circle, from affecting a child indirectly to the child becoming infected.[35]

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[35] Choudhry, Upasana. "HIV/AIDS and child labour: Intersecting risks" May 2004. http://www.oneworld.net /article/view/85411/1/.

There are also clear gender dimensions to this link, especially for girls but also for boys in certain circumstances. For girls, early marriage and sexual abuse by older men carry major HIV risks, while gender roles often prioritize work over education in families affected by HIV/AIDS. For boys, the increase in poverty as a result of HIV/AIDS also creates pressures to work, and earning an income and social expectations bring both pressures and opportunities for sex. The HACI study found out that child labour is a form of coping mechanism for orphans who have been left behind by parents who died of HIV/AIDS. The study found out that a range of coping mechanisms are employed by orphans and their families during critical periods of their survival. Key mechanisms employed in order of ranking included: seeking casual labour (ganyu); seeking alms; involvement in IGAs; beer brewing; farming; selling firewood; petty trading and selling livestock. The HACI study also showed that 53.7 per cent of the orphan respondents were male while 46.3 per cent were female and both genders are involved in the activities above. Mchinji has the highest number of male orphans with 61.5 per cent, and the lowest was in Mzimba with only 44.6 per cent. A large number (51.6 per cent) of orphans were between 10-14 years old. The youngest group of orphans was reported in Mzimba where 58.4 per cent of the respondents were of the age between 5 and 9 years. The study further revealed that the average age at which the respondents became orphans was 9.0 years distributed as follows across the six districts: 8.7 years for Balaka, 9.7 years in Dedza, 9.0 years in Lilongwe, 9.6 years in Mchinji, 8.4 years in Mzimba and 8.8 years in Salima.

1.8.5 Early marriages, HIV/AIDS and child labour

Many commentators reported that orphans tend to drop out of school and marry early. Orphanhood makes children get married early to seek support for themselves and/or support others and makes them engage in activities that constitute child labour. The HACI study interviewed orphans between ages of 10 and 18 years and found that up to 9.6 per cent of them had married, 1.5 per cent divorced, .5 per cent separated and 9.6 per cent already widowed. This is despite the fact that the legal marriage age in Malawi is 18 years. This indicates that people in the study areas start getting married at a very young age. Lilongwe (20.4 per cent) and Salima (12.8 per cent) were the districts where the largest proportion of orphans was married. However, 70.7 per cent of them were still unmarried, but 3.6 per cent were single with a boyfriend and 3.9 per cent were single with a girlfriend. A study by McAuliffe's (1994)[36] supported this fact, finding that 46 per cent of primary school students and 66 per cent of secondary school students who were surveyed were sexually active and most of them had the first sex intercourse between 10 and 14 years old.

1.8.6 Farming system and their influence on HIV/AIDS and child labour

The other linkage between HIV/AIDS and child labour is related to the type of farming system that is predominant in an area. There are significant regional variations in terms of distribution and severity of child labour that should be considered in programming. Rather than being attributed to demographic reasons alone, these differences follow the type of farming system in the area. Plantation and estate farming, which provides the basis for Malawi exports, are the main culprits for child labour. Unfortunately, most of the children

[36] Kadzamira, E.C. et al. "The Impact of HIV/AIDS on Primary and Secondary Schooling in Malawi: Developing a Comprehensive Strategic Response." 2001.

that work in these estates do not have access to education, HIV/AIDS information, condoms and many other social services. Thus, they are not aware of how to prevent HIV/AIDS and become very vulnerable to HIV/AIDS. The Child Labour Survey reports that most of the economically active children were found in the Central Region of Malawi, with an estimate of 627,000 children. The Southern Region came second with 625,000 children and was followed by the Northern Region, which had 200,000 children. Many reasons account for these variations, but the most important one is that the Central Region has been the hub of tobacco production since the early 1970s when the Government reformed the agricultural sector and introduced tobacco farming through leasehold tenure systems. Of all the tobacco estate land, over half is located in the Central Region of Malawi (GoM/UNDP, 1994)[37]. Evidence is already available that the tobacco estate sector is a main culprit for using child labour.

1.8.7 HIV/AIDS, social economic activities and child labour

HIV/AIDS is more prevalent where there are economic activities that attract more people including child labour. There seems to be a relationship between areas with economic activities like tourism, farming and cross border trade. According to the National AIDS Commission Sentinel Survey for 2003, the HIV/AIDS prevalence is quite high in the urban sites as well as the semi-urban sites. In the areas that were surveyed during the 2003 sentinel surveys, there were five urban areas that showed prevalence above 20 per cent. All urban and semi-urban sites are above 13 per cent. Areas in the semi urban and rural areas with high numbers of tobacco and tea estates like Mchinji, Mulanje, Nkhata Bay and areas close to the Malawi's international border like Kaporo, Mchinji, Mulanje, Nsanje and Ntcheu and areas along the lake like Mangochi, Salima, Kaporo, Nkhatabay and Rumphi have prevalence rates higher than the national average of 14.4 per cent. These relationships suggest that where there are more economic activities, there is a higher prevalence of HIV/AIDS, which then leads to more deaths and more orphans who engage in child labour. The flip side, that more children are attracted due to high economic activities, and end up dropping out from school to engage in child labour, is also true.

1.8.8 HIV/AIDS and levels of education

Literacy levels have direct linkages to child labour. According to the Child Survey Report, the illiteracy level for the Central Region is 33.2 per cent, which is higher than for the Southern Region (31.5 per cent) and much higher than the North (17 percent). It is only the Northern Region that has an illiteracy level that is lower than the national average of 30.4 per cent (Annex 2). HIV/AIDS prevalence rates follow regional literacy level patterns as well (presented in Annex 15) with more infections and high prevalence in areas with high population density and more economic activities.

1.8.9 HIV/AIDS, socio-psychological problems and child labour

HIV/AIDS brings in a range of social and psychological problems that force children to join the labour market. It was learnt during the HACI study that orphans and children affected by HIV/AIDS (especially those that live with chronically ill parents) face a myriad of problems, which eventually force them to join child labour and the general labour market. According to

[37] Government of Malawi/UNDP. The Situations Analysis of Poverty in Malawi, 1994.

the HACI report, the reasons or factors that influence this situation include lack of food (43.2 per cent), lack of clothes (33.8 per cent), lack of school fees (4.1 per cent) mainly for those in secondary school and above, lack of money (2.1 per cent), poor medication (1.5 per cent) and lack of proper shelter (0.7 per cent). These problems result in children leaving under serious stress and trauma, and eventually being forced to engage either in child labour or other risky behaviour "to forget problems". The study (Table 2 below) also showed that about 32per cent of all orphans interviewed were abused in some way. The survey did not gender-disaggregate the victims, but there were reports in the field that the majority of those abused were girl orphans. The vacuum created by the loss of a parent or both cannot be filled in by another person. Hence, it can be concluded that orphans become vulnerable despite the fact that guardians may be assigned through the extended family or by the parents before their death. This is worsened by the fact that the community plays a very minor role in ensuring that children remain in school or in providing any type of support.

Table 2: Whether orphan or family member experienced abuse

Whether abused or not	District													
	Lilongwe		Dedza		Balaka		Salima		Mzimba		Mchinji		Total	
	n	%	n	%	n	%	n	%	N	%	n	%	n	%
Yes	39	42	32	32	28	33.3	35	32.1	28	27.2	24	25	186	31.9
No	49	53	60	60	55	65.5	71	65.1	68	67.3	62	64.6	364	62.4
Missing	5	5.4	8	8	1	1.2	3	2.8	4	4	10	10.4	31	5.3

Source: HACI Field Survey, January 2003

1.8.10 Access to information on HIV/AIDS and child labour

Over the past decade, the HIV/AIDS prevalence rate has continued to grow with some stabilisation experienced over the past 3 to 5 years (annex 21). As result the HIV/AIDS pandemic continues to spread despite the fact that awareness levels in Malawi are generally very high, with figures above 95 per cent. A study by the Centre for Development to assess needs for HIV/AIDS information centres revealed that 98.7 per cent of all respondents knew what HIV/AIDS was. Although awareness is very high, behaviour change is still very low.[38] The Centre for Development Management study referred to at the beginning of this section reported that there are limited materials in information centres that can influence behaviour change among users. For the materials to be relevant to users, they must contain information on prevention, spread, causes and effects of HIV/AIDS, sexual abstinence, HIV/AIDS counselling, condom use and VCT. These are basic behavioural related issues pertaining to HIV/AIDS prevention and mitigation in the country and their absence in information centres may support the fact that awareness is not a problem, but rather behaviour change. The table below suggests the content that HIV/AIDS materials should have if they are to influence behaviour change (NAC, 2003)

[38] Kadzamira, E. C. et al. "The Impact of HIV/AIDS on Primary and Secondary Schooling in Malawi: Developing a Comprehensive Strategic Response." 2001.

Table 3: Suggested content of HIV/AIDS materials in IRCs/library centres

Suggested content	Frequency	Percentage
Prevention, spread, causes and effects of HIV/AIDS	82	34.5
HIV/AIDS prevention strategies	46	19.3
Sexual abstinence	21	8.8
Prevention and how HIV/AIDS is spread	21	8.8
Causes and effects of HIV/AIDS	14	5.9
HIV/AIDS prevention and counselling	13	5.5
HIV/AIDS counselling	9	3.8
How HIV is spread	8	3.4
Condom use	5	2.1
HIV prevention & what is HIV and AIDS	5	2.1
HIV/AIDS treatment	4	1.7
What is HIV and AIDS	3	1.3
NA	3	1.3
HIV prevention & its causes and effects	3	1.3
Information on VCT	1	.4
Total	**238**	**100.0**

Source: NAC Resource Centre Needs Assessment Study – October 2003.

To facilitate behaviour change, the Information Center Needs Assessment Study reported that more than 70.2 per cent of respondents would like the HIV/AIDS materials to be in Chichewa and English languages (see Table 4). Chichewa is the legally recognized national language while English is the commercial language. Both languages are taught in primary schools, secondary schools and the university in the country. The study revealed that many people would like to have a more localized approach to development of material in terms of language to effectively cater to their needs. It is undisputable that there are certain parts of the country where people cannot comprehend either written and spoken English or Chichewa. It is therefore important for stakeholders to diversify the language base for IRC/library centre materials to include major dialects like Chitumbuka, Chinkhonde,Chiyao, Chilomwe, Chitonga and Chisena. Apart from these dialects, people would also like to be served through visual learning tools in IRCs/library centres. Visual learning is considered versatile but also very important to those who cannot read. Such diversification will increase IRC/library centre user base as well as increase the impact. Language is a critical factor in any communication process, especially where behaviour change is the ultimate goal. However, it is not practical to produce HIV/AIDS material in all local dialects.

Table 4: Preferred Language for IRC/Library Centre Material

Preferred language	Frequency	Percentage
Chichewa	73	30.7
English and Chichewa	66	27.7
English	28	11.8
Chitumbuka	20	8.4
English, Chichewa and Chitumbuka	13	5.5
English and Chitumbuka	11	4.6
Chichewa and Chitumbuka	6	2.5
English, Chichewa,Chitumbuka & Chinkhonde	6	2.5
NA	3	1.3
Chitumbuka, Chichewa & picture language	3	1.3
Chitumbuka and Chinkhonde	3	1.3

Preferred language	Frequency	Percentage
Chiyao	2	.8
Various languages	2	.8
Chinkhonde	1	.4
Chichewa and Chisena	1	.4
Total	**238**	**100.0**

Source: NAC Resource Centre Needs Assessment Study – October 2003

1.8.11 Incapacitation of service providers due to HIV/AIDS

HIV/AIDS has reduced the capacity of service providers including government in all sectors including child labour. The impact of the HIV/AIDS pandemic includes, among others, high levels of morbidity and mortality (Malawi Government, 2001)[39]. Government departments, non-governmental organisations and the private sector are all experiencing a loss of productivity and increased costs due to absenteeism, medical bills, funeral costs and payment of premature death benefits.[40] A survey on the impacts of HIV/AIDS in the civil services revealed that the pandemic is a major cause of attrition due to deaths and is responsible for the high rates of absenteeism, morbidity and low performance (Malawi Institute of Management, 2002). Attrition rates due to HIV/AIDS are high, and experienced staff, who are in many cases trained by employing organisations, have to be replaced by less experienced staff with consequent results on productivity. This problem has been more evident in the education and agricultural sectors, where teachers and extension workers are dying at a faster rate than they can be trained. For example, although primary school enrolment has risen by over 50 per cent over the last decade, largely due to the abolition of school fees in 1994, it is reported that there are very high rates of dropout and repetition especially in low standards and for girls[41]. Among the reasons cited for high dropouts is the lack of qualified teachers (due to HIV/AIDS related deaths) to motivate students and pupils. When teachers die, non-teaching days increase, pupil performance decreases, which frustrates pupils, some of whom drop out and join child labour. Death of extension staff also means that extension services on social services such as health, child labour, education, agriculture and community development cannot be effective, which perpetuates the problem of child labour at the field level.

Consultations with stakeholders also revealed that in households where one or both parents have died, or where parents are chronically ill due to HIV/AIDS, the family household head does not participate in extension or other community development programmes. Instead, they delegate that responsibility to underage children who are available. Under the decentralisation policy in Malawi, community participation in development includes the provision of labour, such as carrying sand, stones, digging roads, moulding bricks and construction (also called the sweat equity), all totalling to cash equivalent of about 20-25 per cent of the cost of the project proposed. These types of jobs are labour intensive and have disastrous long-term effects on children. Such children begin parental responsibility at very tender age and normally drop out of school to care of the parents or sick relatives. Also due to HIV/AIDS, the older orphans drop out of school to support younger orphans. With limited employment opportunities, such

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[39] Government of Malawi: "Analysis of the Situation of Children and Women in Malawi, Final Report" 2001.
[40] Ibid.
[41]Government of Malawi: "Summary of performance and expenditure review for the education sector from 1993 to 2000" 2003.

children often migrate to districts or areas, which have plantation agriculture (tobacco, sugar, tea and forestry), where they are employed as tenant labourers or unskilled labour, or they migrate to urban areas where they are employed as domestic workers.

1.8.12 Voluntary Counselling and Testing services in Malawi

Voluntary Counselling and Testing services in Malawi are not common. As a result, the rate at which men, women, boys and girls go for an HIV test is generally very low. A study conducted by the Hope for the African Child Initiative in Malawi (HACI)[42] in 2003 in the districts of Lilongwe, Dedza, Balaka, Salima, Mzimba and Mchinji indicated that only 17 per cent of the sample had gone for a test. Mzimba district in Northern Region registered the lowest rate at 14.3 per cent while Salima, Dedza and Mchinji have registered the highest rate above 18 per cent. It is believed that Mzimba has a very entrenched and deep patrilineal society, therefore, they are less likely to get tested for HIV. Apart from inadequate awareness, the cultural factors and stigma related to HIV/AIDS, the low rate might be explained by inadequate access to VCT services, which are only confined to MACRO, district and mission hospitals in all the six study districts. As indicated in the earlier sections, many children who are victims of child labour cannot access VCT services because most of the children are working in estates in rural areas while VCT services are more common in urban areas. Increased access to quality VCT services through health facilities at health centres, NGOs, and clinic levels should provide the local communities, especially tenants and child labourers, with the necessary care, treatment and support services needed to prevent and mitigate the effects of HIV/AIDS. An opportunity exists, however, because the same report indicates that there is a high level of willingness among people to go for an HIV test as demonstrated in the table below.

Table 5: Willingness to go for an HIV test

District	Responses		Total no. of responses	% yes response	% no response
	Yes	No			
Lilongwe	94	48	142	66.2	33.8
Dedza	79	38	117	67.5	32.5
Balaka	75	42	117	64.1	35.9
Salima	92	35	127	72.4	27.6
Mzimba	88	31	119	73.9	26.1
Mchinji	81	39	120	67.5	32.5

Source: HACI Field Survey, January 2003.

In the table above, Mzimba and Salima districts have registered the highest rate of willingness to go for an HIV test at a combined average of 73 per cent. It is also interesting to note from other statistics that an average of 51 per cent (against 9 per cent) of respondents would be willing to ask their spouses to take an HIV test. The impact of HIV/AIDS awareness programmes mounted by NGOs and CBOs, particularly in the two districts, might have contributed a lot to the creation of interest in VCT services in the local communities. In terms of preferences for VCT services, the HACI survey showed that most people would prefer to patronize VCT services if administered in hospitals. This is probably because health facilities of this nature, including health centres and clinics, are the most accessible to a greater

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[42] Phiri, A., Jere, P. and Sibale, B: "A Baseline study on the Impact of HIV/AIDS on Children and their families" 2003.

proportion of the Malawian population. Health facilities also provide adequate and proper room space conducive to administration of VCT services. The biggest challenge in hospitals however is that they do not have personnel who could be assigned to VCT services on full time basis. There are also many reports that have indicated that youth, who are also the main victims of HIV/AIDS, do not prefer hospitals because they not youth-friendly in terms of privacy, approaches and staff attitude. Therefore there is need to include youth-friendly VCT services in programme development. Additionally, hospitals lack necessary equipment for rapid tests, CD4 count and liver function testing, which are important for decision making, particularly affecting PLWHAs. Deliberate involvement of lay people in counselling, promotion of rapid tests, CD4 count and liver function tests in health facilities should make them even more attractive and accessible to local communities as VCT centres.

1.8.13 Care of orphans and vulnerable children

In order to take care of the needs of children orphaned by HIV/AIDS Malawi developed a policy that provides guidelines for all orphan care activities. By the end of 1997, 6 per cent of the population in Malawi was composed of orphans.[43] Malawi believed that communities and households are the most appropriate for caring for children left by members in the community. This resulted from the perception that communities are in the best position to assess the problems that orphans face and as a community they would be in a better position to find means to address the AIDS orphan crisis. One of the Government's main strategies, therefore, has been to promote and support community-based programmes. See box below.

Box 3: Malawi's National Orphan Care Guidelines

- The first line of approach in orphan care must be community-based programmes. The Government will coordinate the activities of service providers.
- Formal foster care will be expanded as the second most preferred type of care.
- Institutional care should be the last resort, though temporary care may be required for children awaiting placement.
- Hospitals should record next of kin, so that relatives can be traced if children are abandoned.
- The registration of births and deaths should be improved, to assist the monitoring of orphans.
- The Government will protect the property rights of orphans, and these rights should be widely publicized.
- Self-help groups should be developed to help affected families with counselling and other needs. NGOs are encouraged to set up programmes of community-based care, in consultation with the Government.
- The needs of all orphans should be considered on an equal basis, regardless of the cause of death of the parent or parents, or their gender or religion.
- The National Orphan Care Task Force will continuously plan, monitor and revise programmes and policies.
- The Government will encourage donor support for resources to help orphan programmes.
- The lead government body on orphan issues will be the Ministry of Gender, Youth and Community Services.

In 1992, with advisers from the Uganda Government and NGOs, Malawi's National Orphan Care Task Force developed the sub-region's first guidelines for the care of orphans. The main points of these guidelines are:

[43] UNICEF: Early Childhood Care and Development. 2003.

- What the table means is that each community that intends to start a project for assisting orphans and other vulnerable children has to follow the guidelines set by the Malawi Government.
- There is a strong need to improve our knowledge of their needs and to include them in program planning.
- Rights of orphans are frequently violated, so programs should be "rights minded."
- Female orphans are especially vulnerable, and their input should be solicited when planning for their welfare.

The basic steps that need to be taken for the project to be successful include those in the box below.

Box 4: Conditions for successful OVC programmes

Programs for the care and support of orphans and vulnerable children (OVC) are most likely to succeed if they:

- Recognize and meet the psychosocial needs, in addition to the biomedical and material needs, of orphans and other vulnerable children.
- Adequately provide for other vulnerable children (and not just orphans).
- Aim to retain orphans in their home communities – either with relatives or in foster homes – to the extent possible, while ensuring that institutional care is available to orphans without any other form of support.
- Devote time and resources to strengthening the economic and psychosocial capabilities of the extended families that are attempting to care for orphans.
- Develop strategies to protect children (especially female children) who are without parental protection from sexual exploitation, forced labour or other violations of the rights of the child.
- Carefully balance a child's need to learn a profit-making vocational skill with his/her right to formal education, realizing that putting a lot of emphasis on vocational skills at the expense of education might force the child out of school.
- Ensure that voices of orphans and other vulnerable children are heard when plans are being developed to meet their needs.

1.8.14 Processes for community mobilization against child labour and HIV/AIDS

Community mobilization is a process of bringing people together to discuss common problems relating to HIV/AIDS. This may often lead to networks and public lobbying for the recognition of critical selected issues. In this way, the community members become empowered, using mobilization to deal with problems that they face in their communities. Important elements for any community to carry out a successful mobilization campaign should include some of the following issues:

- To be successful, community-based programs must be community owned.
- Community volunteers require psychosocial support if their involvement is to be sustainable.
- It will be necessary to decentralize HIV/AIDS care as the management of the public sector decentralizes.
- Empowerment of the DACCs and establishment of district-level networks are a possible means of achieving effective and functional decentralized structures.

1.8.15 The role of the media in HIV/AIDS awareness

There are two types of media that can potentially be or are being used to disseminate child labour and HIV/AIDS issues in Malawi. The Nation Newspapers/Weekend Nation and the Daily Times/Malawi News publications dominate the print media with both daily and weekend circulation. Their coverage is mainly urban although some rural areas of the central and Southern Region receive late copies. The Northern Region is least served in terms of circulation. Both these papers regularly carry out articles and commentary on HIV/AIDS, but rarely carry out articles on child labour issues, and less still on how the two are interrelated. There are also a number of organisations whose newsletters carry out articles on HIV/AIDS. For example, the National AIDS Commission has a monthly newsletter, which is published en-masse. However the distribution system has not been adequately established and rural areas are not adequately served. The proposed project can link up with NAC to distribute the newsletter and other IEC materials to impact areas. The Journalists Against AIDS in Malawi also run a newsletter, which is disseminated to the rural masses.

The second type of media is electronic. After changing to the multiparty system of government in 1994, there has been an increase in the number of electronic media houses. The main ones are Malawi Broadcasting Corporation (MBC) Radio 1 and Radio 2 FM, Capital Radio, Power FM 101, Radio Maria and Radio Islam. There are also a few more Christian based radio stations. The MBC Radio 1 is the only one with a national coverage, although it has some signal problems in hill areas in the north. This is a potential radio station that can be used to disseminate HIV/AIDS and child labour messages in rural areas, tobacco and tea estates and in remote areas. The Ministry of Agriculture uses the same radio for tobacco and other extension services “Za Ulimi Programme”, hence there is potential for linkages with child labour and HIV/AIDS. The rest of the radio stations are frequency modulation (FM) signals and have urban-based type of coverage. They are very popular among the youth in urban and semi urban areas, because of their type and style of presentation. Music and entertainment occupy the most predominant time. Almost all radio stations have programmes on HIV/AIDS and youth related issues, but none has a specific programme on child labour issues. They could and are playing a very critical role in dissemination of HIV/AIDS/child labour in semi/urban areas.

Malawi has one television station, Television Malawi (TVM). The TVM is a public station and its coverage is also limited to urban and semi urban areas. The TVM is also popular among the urban poor because it is free, unlike Digital Satellite Television, which is expensive at a subscription of $50 a month. The TVM has HIV/AIDS programmes and can feature any programmes produced privately upon arrangement with the management. It also has very popular youth and music programmes, which can be used as channels for disseminating messages on HIV/AIDS/child labour.

In summary, the media is very open with HIV/AIDS issues, but current programs do not address child labour issues. A strategy for media sensitisation on child labour issues seems a potential activity for the proposed project. In addition, the media is mainly conversant with actions to promote HIV/AIDS awareness, but less so with activities to promote behaviour change. This is a potential area that needs intervention. In addition, while most of the information is available in urban areas, the rural areas are underserved and distribution of materials is a serious problem. The national Library Services, which is legally mandated to distribute reading materials to the rural areas through information centres, does not have capacity to carry out that mandate.

PART II:	Mapping of existing interventions and good practices on policies and programmes on HIV-AIDS and child labour in Malawi

2.1 Response to the HIV/AIDS epidemic in Malawi

Malawi has been attempting to deal with the HIV/AIDS problem since 1986. While using different and uncoordinated approaches to deal with the epidemic, little success was registered. As HIV incidence continued to increase, serious psychosocial and economic impacts were felt throughout Malawi. To deal with the HIV/AIDS problems, Malawi launched the National HIV/AIDS Strategic Framework in October 1999 to "reduce incidence of HIV and other sexually transmitted infections and improve the quality of life of those infected and affected by HIV/AIDS".[44] The National AIDS Control Programmes, later changed to the National AIDS Commission, was established to coordinate National HIV/AIDS activities using the NSF as the guiding document for stakeholders. The NAC reports to a Cabinet Committee on HIV/AIDS. The Committee includes the Ministry of Health and Population and the newly established Ministry of HIV/AIDS in the Office of the President and Cabinet. The main role of NAC is to coordinate the national response to the HIV/AIDS epidemic and to provide financial and technical assistance to implementing organisations. The NAC has to meet a variety of challenges and must strike a balance between coordination, its core business and implementation functions while mobilizing resources and coping with donor politics. Because of the position of NAC in the HIV/AIDS work, it reaches out to communities who implement projects in their communities.

Across the country, community-based organizations, working closely with district social welfare officers, are setting up child-care centres with the aim of improving the care of children as well as increasing their learning opportunities. The centres, which are for all children in the community, allow children to play, learn, socialize and eat. Caregivers ensure that orphans in their communities attend the centres and benefit from their activities. See Box 5 below for activities being implemented in some villages in Malawi.

Box 5: A village in Malawi and its youngest orphans

In a village in rural Malawi[45], about 30 small children sit in rows, reciting their lesson, singing and clapping their hands. They are assembled in the village's child-care centre, where they are taught and cared for by local volunteers. Some of these children are orphans, cared for by elderly grandparents who are unable to provide them with proper meals. Others are looked after by - or may even themselves be caring for - mothers who are too ill to cope with their children's basic needs. The centre, which takes children up to primary-school age, is run as a cooperative and staffed by trained villagers. The staff is compensated for their time by other villagers who may also look after the staff's fields and provide food for the centre. The village elders stress that it is important to have a safe place where these children can come during the day to learn and be fed and washed. Health care outreach workers also come to the centre to immunize the children and monitor their growth.

Malawi: Striving for Early Childhood Care UNICEF 2003

[44] Government of Malawi. National HIV/AIDS Strategic Framework, 1999-2004.
[45] Possibly for confidentially, the report quoted did not disclose the name of the village and where it is located.

In addressing this pandemic, a number of international and indigenous (local) NGOs have, in collaboration with Government of Malawi (GOM), developed and implemented multi-faceted assistance programs aimed at preventing future cases of HIV and mitigating the impact of HIV/AIDS on affected children and their parents. Most of these projects have been executed as pilot projects at district or community levels in conjunction with overarching interventions and objectives. Many of them have demonstrated successes and achievements. In Malawi, several organisations have been working in the area of HIV/AIDS without proper collaboration, leading to duplication of efforts and minimal impact of the grass-roots interventions. Until recently, implementing organisations realized that their pilot interventions were unlikely to have lasting national impact unless they replicated and scaled up through collaborative partnerships between networks of NGOs, CBOs, donors and Public Sector Organizations. Based on the National Strategic Framework, nine themes were identified, which are being used to guide future implementers to develop proposals. Main activities implemented in the fight against HIV/AIDS include:

a) Advocacy/IEC: Many national activities responding to HIV/AIDS have focused on advocacy and raising awareness to educate the people of Malawi. Public and private organisations, both local and international, have invested a lot in the implementation and evaluation of the HIV/AIDS strategies in the area of Advocacy/IEC. The MDHS 2000[46] has attested to the fact that Malawians are quite knowledgeable on the HIV/AIDS issue and the dangers associated with it. Unfortunately, their very high knowledge about HIV/AIDS has not been translated into actual behaviour change as there are still some risky sexual practices reported. MDHS 2000 reports that condom use is still not as high as expected when compared with the high knowledge on the dangers of HIV and STI.

b) Prevention: The National Strategic Framework has strived to educate Malawians on the value of prevention of transmission of HIV and other sexually transmitted infections. The idea behind this strategy is to halt and/or reverse transmission of sexually transmitted infections including HIV. Specific approaches in the prevention of spreading HIV and other sexually transmitted infections are:

- **Blood Safety:** Malawi has maintained a safe blood supply by screening blood before transfusion. Malawi also has a policy on Blood Safety.
- **Voluntary Counselling and Testing (VCT):** Malawi has 70 sites in 17 district hospitals that can offer HIV counselling and testing services. While the MDHS 2000 indicates a high demand for VCT services, this has not been quite translated on the ground.
- **Prevention of Mother To Child Transmission (PMTCT):** Malawi launched the PMTCT programme in April 2003 whereby policy guidelines on PMTCT and on infant and young child feeding (including options for HIV positive women) were developed. PMTCT services are offered at nine sites and partial services at seven sites[47] throughout Malawi. Of those counselled at Antenatal Clinic sites, a few have accepted to be tested and know their sero-status.

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[46] National Statistical Office, ORC Macro. "Malawi Demographic Health Survey 2000." Zomba, Malawi, 2001.
[47] National AIDS Commission. "Joint Review of the National HIV/AIDS Strategic Framework and Operations of the NAC." March 2003.

c) Treatment, Care and Support: When the NSF was being developed, treatment, care and support were not clearly included in the strategy. The NSF indicated, however, that treatment of opportunistic infections, procurement of protective materials and supplies should be included. As these activities were not well articulated in the NSF, MOH set out to have the treatment, care and support items developed and implemented by MOH. The HIV/AIDS unit started making plans and implementation process arrangements.

- **Clinical Care and Support:** Some districts have started offering a continuum of HIV/AIDS care: Lilongwe Lighthouse, Thyolo, Chiradzulu, Salima and Mzimba districts, and Ekwendeni and Embangweni Mission Hospitals. ARVs are being offered to few patients at the moment but this will be scaled up soon to offer free ARVs to all deserving patients. Clinical care is not without setbacks as most hospitals have few staff to take care of the high numbers of AIDS patients and the attendant problems.
- **Community Home Based Care:** Due to the chronic nature of the AIDS illnesses and the increased burden placed on the health care services in the hospitals, the Government of Malawi has encouraged communities and households to take care of the those suffering from HIV/AIDS and related illnesses in their homes. As a result, there has been a proliferation of community groups offering home-based care. In order for the caregivers to give appropriate help to the sick, basic training has been provided to them.

d) Impact Mitigation: The NSF has identified orphan care and development of livelihood skills for the people living with HIV/AIDS (PLWAs) as areas that Malawi will concentrate on. As citizens of Malawi, the strategy also has built-in mechanisms to protect the rights and freedoms of the PLWAs.

- **Orphans:** People affected by HIV/AIDS including children often have many immediate or priority needs for care and supportive services that are not provided within their communities or as soon as required. In order to deal with the plight of the orphans, many orphan care centres have sprung up all over the country. The policy and guidelines on OVC have assisted many community organisations to establish orphanages under the guidance of the Ministry of Gender, Youth and Community Services. Different organisations, local and international, have assisted in capacity building of personnel in the communities that take care of orphans. There are several problems, including provision of education, health care and nutrition for the children. Other issues that need to be carefully looked into include protection of the orphans from abuse, stigma and discrimination. Therefore, assisting those infected and affected by HIV/AIDS will be crucial for their well-being.

2.2 The context of Best Practices for dealing with HIV/AIDS in Malawi

The concept of best practice refers to the means of accumulating and applying knowledge about what works and does not work in different situations and contexts. It refers to both the lessons learned and the continuing process of learning, feedback, reflection and analysis. Based on the same notion, Malawi held a National HIV/AIDS Best Practices Conference in April 2002. The meeting was organized to "… share best practices with the goal of scaling up

programmes".[48] At its most basic, best practices meet seven criteria, which ILO/IPEC developed. It is not necessary that all the seven criteria be present in order to qualify as a best practice. Any two or more of the criteria may suffice. The box below shows the type of criteria used to assess the best practices in this report.

Box 6: Seven criteria for determining what makes a practice "good"

1. **Innovative or creative**

What is special about the practice in terms of action against child labour and gender mainstreaming that makes it of potential interest to others who wish to mainstream gender into child labour activities?

2. **Effectiveness/Impact**

What evidence is there that the practice actually has made a difference in terms of combating child labour and gender mainstreaming or gender equality? Can the impact of the practice be documented in some way, either through a formal programme evaluation or through other means?

3. **Replicability**

Is this a practice that might in some way help to combat child labour and promote gender-mainstreaming activities in other situations or settings? The practice does not have to "be copied" or cloned to be useful to others; some elements of a practice may in themselves be useful for other programmes.

4. **Sustainability**

Is the practice and/or its benefits likely to continue in some way, and to continue being effective, over the medium to long term? This, for example, could involve continuation of a project or activity after its initial funding is expected to expire. But it could also involve the creation of new attitudes towards gender equality issues in child labour, new ways of mainstreaming child labour considerations (the girl child in particular), or the creation of capacity among partners and ILO staff to address gender issues.

5. **Relevance**

How does the practice contribute, directly or indirectly, to action of some form against child labour? How does the practice contribute or have implications for gender mainstreaming practices elsewhere?

6. **Responsiveness and ethical force**

Is the practice consistent with the needs identified by both girls and boys; has it involved a consensus-building approach; is it respectful of the interests and desires of the participants and others; is it consistent with principles of social and professional conduct; and is it in accordance with ILO Labour Standards and Conventions? Were girls as well as boys given a voice, by increasing their participation to ensure that their interests and perspectives were taken into account?

7. **Efficiency and implementation**

Were resources (human, financial and material) used in a way to maximize impact?

Source: ILO 2003.

People involved in providing services to HIV/AIDS infected and affected people are asked to provide advice on how they care for those who need help. These people are asked about their approaches to providing services because others are interested in applying their methods. According to experts from ILO/IPEC "…without access to existing knowledge and experience from the field of things that work, whether fully or in part, mistakes may be

[48] Save the Children, Hope for the African Child Initiative. "National HIV/AIDS Best Practices Conference." 2002.

repeated and valuable time may be lost."[49] Lessons learned must be widely shared and adapted to local conditions in order to enable an effective response to the epidemic.

For Malawi, the Best Practices Conference was intended to share practices, deliberate on them and agree on which practices to adopt and scale up. The formal objectives of best practice are:

- To strengthen capacity to identify, document, exchange, promote, use and adapt best practice as lessons learned within a country and inter-country as a means to expand the national response to HIV/AIDS.
- To promote the application of the best practice process for policy and strategy definition and formulation.
- To collect, produce, disseminate and promote best practice.

Box 7: Best practices for policy formulation, coordination and networking are found in programmes that:

- Develop a transparent and participatory workplace HIV/AIDS policy that sets a foundation for the organisation's prevention, counselling and assistance activities.
- Share information and insights with other organisations and with government bodies such as the NAC.
- Document their successes and disseminate them to related programs.
- Strengthen the DACCS and utilize them as a district-level focal point for the coordination of programs that originate from different NGOs and donors.
- Establish mentoring relationships between NGOs that can facilitate the replication and/or scaling-up of successful interventions and activities.
- Retain their "core business" and mainstream HIV/AIDS into their normal programs rather than turning into an AIDS service organisation.

2.3 Best practices documented in Malawi

2.3.1 Group therapy for people living with HIV/AIDS

The National Association of People with HIV/AIDS in Malawi NAPHAM was set up by people with HIV/AIDS to assist each other in all aspects of their lives, including positive living. Different donor organisations have assisted and worked with the members in implementing projects developed either by the PLWAs themselves or others. NAPHAM's goals include fighting the stigmatisation of people living with HIV/AIDS (PLWHA) and reducing the transmission of the HIV virus. NAPHAM began with group therapy but expanded to include other activities such as counselling, home based care and HIV education. It is an important conduit for HIV/AIDS education that can easily integrate child labour activities into its activities, especially in urban areas where it is more established. By utilizing a pool of trained volunteers, NAPHAM promotes positive living and provides psychosocial, nutritional and spiritual support to PLWHAs. NAPHAM volunteers help PLWHAs deal with critical issues related to HIV testing such as who should be informed about the result, how to

[49] Rau, Bill: "Combatting Child Labour and HIV/AIDS in Sub-Saharan Africa: A review of good practices in policies, programmes, and projects in South Africa, Tanzania and Zambia. Paper No. 1," Geneva: ILO-IPEC. 2002.

prevent mother-to-child-transmission and offers advice on breastfeeding to women living with HIV/AIDS. The program is now open to all people living with HIV/AIDS, and about 300 people nationwide are now members. As a result, the beneficiaries are now living positively and are empowered to disseminate positive living messages throughout their communities, businesses and schools.

Comments and lesson learned: Based on the resolutions made at the Best Practices Conference (2002), activities that fit into the best practices category have been included in the NAPHAM grouping. The participation of many people living with HIV/AIDS has attracted many more to join, meaning that the NAPHAM approach can be replicated, has positive impact and is sustainable to some extent. This means that the activities of NAPHAM in one district can easily be replicated elsewhere as sub-offices of NAPHAM have been opened in different parts of the country. NAPHAM is also a good example of networking among individuals who live with HIV/AIDS, and together through the association, the PLWHAs have a voice on national issues even beyond the HIV/AIDS pandemic. While information on gender balance has not been included in the report, it can be assumed that involvement of all sexes does occur, but there is need to collect this information in order to have the exact numbers of members involved in NAPHAM's activities. This will assist leaders in deciding whether the activities are gender sensitive or not and plan for gender mainstreaming where necessary. Children can be involved through VCT and linked to NAPHAM so that they participate in activities of the organisation including accessing information about positive living.

2.3.2 Using male volunteers for home based care

Based in the Blantyre area, the program supports the community provision of HBC to PLWHAs referred from the hospital. HBC programs tend to attract a higher proportion of female than male volunteers, but male volunteers are needed to improve communication with male clients by providing nursing care to men, serving as role models to young males and promoting condom use. After an intensive effort to recruit and train men in 1991, about 40 per cent of the programs volunteers are now male. This has led to improved care for men, increased condom use, and a gender-balanced discussion of HIV/AIDS issues in the target communities. A number of challenges need to be addressed, such as the need to find motivating incentives for volunteers and to counter cultural views of care giving as feminine. To meet these challenges, it is important to approach respected men in the community who are motivated by compassion and have flexible working hours. In addition, it is important to involve youth in the program and to make expectations clear from the outset.

Comments and lessons learned: Involvement of males in providing care to the sick, HIV/AIDS, is a complete departure from the norm in Malawian culture, where it is believed that care is a natural activity for women. The involvement of males in providing nursing care is wake-up call and a major lesson to be learnt that care can be provided by anybody in the community. This shows that it is possible to utilize everybody in the community without looking at females as the experts, as it has been in the past. Replication of a project like this is relatively easy as it depends on the good will of the community and their determination to involve all members of the community regardless of sex.

2.3.3 The role of communities in care and support of PLWHAs

Community volunteers have been recruited and trained in rural Thyolo district to provide care for nearly 1,000 AIDS patients. VCT Centres have been instituted at the community level, and a two-way referral and tracing system between the community and hospital has been established. The objectives of the program include building a holistic approach to HIV/AIDS and HBC as well as establishing a continuum of care to improve the quality of life of PLWHA and TB patients. In addition to giving care, volunteers perform advocacy functions and encourage PLWHAs to openly disclose their status as a step toward fighting stigmatisation and discrimination. Besides PLWHA and Tuberculosis (TB) patients, the program also includes an orphan care component with 10 pre-school centres serving 100 orphans. Eighty orphans in the group also receive vocational training in community-operated centres. The program demonstrates that community care is a feasible approach to the care and support of PLWHAs and that it can help reduce hospitalisations and improve the quality of life for those suffering from AIDS and/or TB.

Comments and lessons learned**:** Involvement of the whole community in implementing HIV/AIDS projects is a welcome move, as all issues surrounding the HIV/AIDS will be dealt with together. The advantage of utilizing the community is that participatory approaches are used to plan, process and implement projects as a team. The building of the community structures a team, thus creating a solid foundation which cannot be easily destroyed. Issues of relevance, replicability and sustainability easily fit into the process of strengthening the cohesiveness. As alluded to in earlier sections, Thyolo is among the districts with problems of child labour and high incidences of HIV/AIDS. It is therefore a potential district for linking activities to mitigate child labour and HIV/AIDS. This best practice has already trained volunteers on the ground,a new child labour programme would therefore build on these existing volunteers by providing additional skills in detection, prevention, mitigation and management of victims of child labour.

2.3.4 Targeting behaviour change using the stepping stones approach

This project was implemented in the context of Action Aid's Strategies for Action project. Stepping Stones is a training package to assist trainers and communities in implementing workshops on the topic of HIV/AIDS and improving communication skills. The package, which includes a manual and video, introduces the learner to a variety of teaching methods including games, discussions, role-playing and peer group targeting. Each community selects a particular peer group (based on gender, age, marital status, etc) to take part in a workshop. The Stepping Stones focus upon the ABC rule: abstinence, be faithful, and use of condoms. Stepping Stones is suggested as a best practice because it has had notable success in increasing HIV/AIDS awareness, modifying dangerous traditional practices, promoting condom use and HIV testing, improving husband-wife relationships and mobilizing community-based action groups.

Comments and lessons learned: Behaviour change is a big problem in Malawi. The knowledge and awareness of HIV/AIDS is quite high throughout Malawi, but behaviour change does not reflect the level of knowledge. Perhaps this approach would assist in increasing HIV/AIDS awareness to influence behaviour change. The MDHS 2000 reports results that give the impression that most people, men as well as women, use condoms some of the time but not always.

2.3.5 BLM's adolescent reproductive health initiative

BLM is an NGO operating reproductive health clinics with support from DFID (Department for International Development), which began an adolescent Reproductive Health project in 1997 with funding from UNFPA and SIDA. The project is implemented through young community-based distribution agents (CBDA volunteers) who serve as peer educators and are trained to conduct health education activities such as music festivals, video shows, and counselling sessions on sexual and reproductive health (SRH). The volunteers also make referrals to SRH clinics and carry a supply of condoms for CBDA volunteers, reaching approximately 570,000 beneficiaries. The demand for condoms and other contraceptives have increased as a result of these activities. However, challenges remain, such as the problem of low resources for the procurement of condoms and low participation of girls in the CBDA program. The program, however, successfully demonstrates that youth can be reached at the village level with SRH services and that young Malawians prefer to get information and commodities from young CBDA volunteers rather than nurses.

Comments and lessons learned: Targeting young people for HIV/AIDS messages is a relevant exercise. If the youth can successfully be reached with these messages, Malawi may be on its way to reducing the prevalence of the epidemic. It can be sustainable because once the messages reach the youth for the first time, one assumes that youths will take ownership of the messages, and, as they chat with other youths, they will be able to share them. Thus, each youth will hopefully make use of the messages and change his or her behaviour.

2.3.6 Prevention of mother to child transmission of HIV – Embangweni Mission Experience

Embangweni Hospital is a Christian Hospital Association of Malawi (CHAM) hospital that started a prevention of mother-to-child transmission (PMTCT) program in 2001 with support from UNICEF. The program seeks to reduce MTCT by 50 per cent among HIV positive pregnant women who receive antenatal services from the hospital, with interventions including community awareness promotion, administration of nevirapine at the time of labour and 72 hours after birth, ante- and post-natal care of HIV-positive pregnant woman, advice on infant feeding and counselling to support safer sex practices. Best practices that have emerged from the program include: the training of community volunteers as counsellors, provision of incentives (t-shirts, umbrellas, meals) to volunteers, holding monthly support meetings with volunteers, follow-up of HIV-positive mother and their families and training of faith-based HBC volunteers and raised awareness of PMTCT issues in "catchment area" communities.

Comments and lessons learned: Infection of children with HIV from their mothers is one of the most difficult problems in Malawi. Involvement of community volunteers in raising awareness in the catchment communities is very good approach. This a very effective way of getting messages to people in the community as the messages come through their own members. This approach has high sustainability and can easily be replicated in other hospitals.

2.3.7 Integrated infant feeding, HIV/AIDS and PMTCT counselling in MCH and Community Services: (the AED Linkages Project)

The Linkages Project's integrated strategy includes the following interventions: (1) strengthening maternal and child health (MCH) services; (2) introduction of the mother-baby package during lactation; (3) promotion of VCT; and (4) improving the skills of maternal

counsellors. The project aims to strengthen the links between health facilities and communities in order to improve breastfeeding and HIV prevention practices as well as the key activities of policy/advocacy, formative research and capacity building. Prevention of mother-to-child transmission is being implemented in part through the baby-friendly hospital initiatives and through the provision of essential services during the antenatal, postpartum and lactation periods. Three breastfeeding options – exclusive, modified and replacement – are discussed with HIV-positive pregnant women during antenatal care, so they can be encouraged to make an informed decision.

Comments and lessons learned: In order to prevent transmission of HIV from mothers to their unborn children, the Malawi Government has developed a PMTCT policy and an Infant and Young Child Feeding policy. The PMTCT services are provided at a few hospitals with the intention of scaling up later on. For those women who test positive, free nevirapine is available from Boering and Abbot Companies. Out of 98 per cent of the women tested, 88 per cent received their results. 18 per cent of those who were tested received positive results. After hearing about the advantages, men now attend these services with their wives. For this approach to be helpful, there is a need for assurance from the Government for a steady supply of nevirapine. While this approach is very relevant in that it would lead to the reduction of HIV transmission, its sustainability depends on the availability of free drugs.

2.3.8 Everyone can live longer and stronger with good nutrition

The Peace Corps in Malawi operates four programs, each with an HIV/AIDS component. Programs include health, environment, education and the Crisis Corps. It is widely acknowledged that good nutrition plays a critical role in the well-being of PLWHAs, since it bolsters the immune system and provides needed energy. The key to good nutrition is to eat a wide diversity of foods. The typical Malawian now relies too heavily on the country’s staple food, maize. Eating less nsima (maize porridge) and more side dishes such as vegetables and beans will improve the nutritional status of PLWHAs and Malawians in general. Both agriculture and food aid programs should take into account the need for a fully balanced diet. A booklet entitled “Food for People Living with HIV/AIDS” produced by NAPHAM has been distributed to illustrate the nutrition education being provided through Peace Corps and its partners.

Comments and lessons learned: The importance of proper nutrition for PLWAs cannot be overemphasized. There is great need to change the minds of many Malawians in order for them to eat a fully balanced diet. It is a fact that HIV/AIDS and malnutrition often operate in tandem. Poor nutrition increases the risk and progression of disease. In turn, disease exacerbates malnutrition. HIV/AIDS can be both a cause and a consequence of food insecurity. HIV/AIDS leads to reduced agricultural production, reduced income, increased medical expenses, thus causing reduced capacity to respond to the crisis. Food insecurity may lead to increased high-risk behaviours, for example, labour migration or engaging in transactional sex that increases the likelihood of infection. It is therefore important that organisations dealing in HIV/AIDS become aware that food and nutrition play an important role in prevention, care and mitigation activities in HIV/AIDS-impacted communities.

2.3.9 Administration of ARV drugs to HIV-positive patients in a hospital setting

Although ARVs are the most powerful means of improving survival and quality of life, these drugs are difficult to handle, costly and require experienced personnel. The Ministry of Health

(MoH) launched the National Anti Retroviral Treatment Program in July 2000 with a two-drug combination to supplement the hospital-based program. Eligibility for the hospital-based program is limited to those who are HIV reactive, have a CD4 count below 350 and have financial means. Triamune is currently being administered to 310 patients, but the program has experienced a high dropout rate (41 per cent); some of these are possibly due to financial pressures, but about one third of the dropouts are unexplained. The national scale-up of ARV treatment is the eventual goal of the program but a number of problems must first be addressed, including high costs and the limitations of the current fixed drug combination.

2.3.10 Impact of increasing access to HIV/TB care

The program was created in response to the growth in the number of TB cases from about 5,000 in 1985 to 25,000 in 1999, primarily as a result of the HIV/AIDS epidemic. The aims of the Lilongwe-based project include increasing dialogue and coordination between stakeholders in TB and HIV/AIDS programs, promoting the use of VCT centre and creating a network of services that will meet the needs of TB and HIV/AIDS patients.

2.3.11 HIV/AIDS mainstreaming process for the joint Oxfam program in Malawi

Oxfam Malawi decided to mainstream HIV/AIDS issues into all strategic planning and daily activities. In order to do this, Oxfam carried out the following: (1) raising awareness among staff members; (2) developing a workplace HIV/AIDS policy; (3) researching the local epidemic; and (4) reviewing and modifying the program. The awareness-raising activities resulted in the establishment of condom corners and monthly HIV/AIDS meetings in Oxfam offices, as well as the appointment of HIV/AIDS focal persons. The workplace policy was developed during a two-day workshop in which the draft Malawi code of conduct and Oxfam critical illness policies were reviewed. The workshop also included local communities. The research findings led to the modification of existing objectives, indicators, and work plans. Lessons learned from the process include the fact that mainstreaming is a systematic process, not a series of fixed events. It is helpful to encourage staff to address HIV at the personal level and the process also needs to address tensions that arise due to the competing needs of workers and the interests of managers who are operating under tight budgets.

Comments and lessons learned: The main lessons learned are that there is need for a process approach that includes a situation analysis, awareness raising, and policy development, followed by programming, taking action and monitoring implementation if HIV/AIDS programmes are to be successful. The potential linkage with child labour projects is that Oxfam programmes are implemented in Mulanje, Thyolo and Phalombe, where HIV/AIDS and child labour is also high. Oxfam has an established institutional set-up and capacity, which could be used to support child labour activities in the two districts.

2.4 The Hope for the African Children Initiatives (HACI)

The Hope for the African Children Initiatives (HACI) constitutes a groundbreaking two-tier partnership of this kind. It is aimed at improving the well-being of all Malawian children, families and communities made vulnerable by HIV/AIDS by ensuring that Malawian communities in all districts have effective community-based HIV/AIDS prevention, care and impact mitigation. This will be achieved through the identification of best practices in programs for Malawian children, affected by HIV/AIDS in order to scale up these programs at district, zonal, regional, and national levels. HACI compliments the work of several other

major HIV/AIDS activities and organisations in Malawi. The following are organisations that form HACI-Malawi: Save the Children UK, Save the Children US, Care International, Plan International, Public Affairs Committee and Society of Women Against AIDS in Africa. These agencies work together to increase the capacity of local communities to provide care services and assistance to African children affected by HIV/AIDS and their families. Through this initiative, these organisations have extended the scope of their combined efforts on HIV/AIDS far beyond what each one of them could achieve individually.

2.4.1 HACI Objectives

HACI focuses on four strategic objectives:

- **Building awareness and reducing stigma that surrounds HIV/AIDS:**

  Lack of awareness about HIV/AIDS has resulted in fear, shame and denial. The resulting wall of silence has hindered prevention and care efforts. HACI initiative encourages stakeholders to work together to reduce stigma so that people will support vulnerable children and take advantage of available services without fear.

- **Extending the life of the parent-child relationship:**

  The goal is to decrease the period of vulnerability experienced by the child and to postpone the age at which orphanhood occurs.

- **Preparing the family for transition:**

  Parents who are sick or dying are not often supported as they plan the best possible future for their children. Planning steps including appointing guardians, writing wills and giving clear instructions about the children's future are needed if smooth transition is to be achieved.

- **Ensuring the child's future:**

  Access to education and life skills are the basis for enabling children to attain a better livelihood. As communities come under severe economic stress to care for orphans and vulnerable children, young people become more vulnerable to missing school days and caring for sick parents.

2.5 Tovwirane HIV/AIDS support programme in Mzimba District[50]

Tovwirane HIV/AIDS awareness and resource centre is a community-based initiative aimed at sensitising people on HIV/AIDS, started in 1993. Sister Mary Maleta, a nurse based at Mzimba district hospital, conceived the programme as an attempt to complement hospital efforts towards assisting the community in view of their heightened risk of contracting HIV/AIDS. To market the idea, Sister Mary Maleta consulted Mr. D. Phiri, Hellen Munthali and Mayiness Chisi to join hands to form the CBO on HIV/AIDS education around Mzimba boma. When they agreed on her idea, they were sent to receive training in HIV/AIDS awareness. Following their training, the four formed a group, which became known as Mzimba Anti-AIDS support group. The group mobilised a total of 40 volunteers from

[50] Centre for Development Management: "Assessment of Knowledge-based Initiatives in Malawi," written for the Ministry of Economic Planning and Development. 2003.

different church denominations to disseminate messages on AIDS in their respective local communities. However, while conducting these outreach meetings, the volunteers were overwhelmed by the extent of the problem on the ground. Some of the problems discovered included:

- A big number of chronically ill people as a result of HIV/AIDS which culminated into a home based care programme (HBC).
- A large number of orphans in the communities which led to initiation of an orphan care programme.
- Need for material and financial support for orphans and the chronically ill which resulted in initiation of an IGA support programme.
- Need for increased access to treatment for HIV positive people to treat opportunistic infections.
- Need to provide HIV testing services so that it is possible to determine HIV sero status. The group therefore started an HIV/AIDS counselling programme to encourage people to go for testing at the hospital.
- To sustain material support for orphans, the group initiated a skills development programme for the orphans so that they were economically self-reliant.

Because of these needs, which are obviously beyond sensitising people on HIV/AIDS, it became imperative to change the name of organisation to Tovwirane HIV/AIDS Support Programme to better reflect their new image. The CBO is now running five programmes, namely: orphan care, home based care, HIV/AIDS counselling, IGA promotion and skills development. The programme is currently operational in 52 villages spread in Mzimba District. It has 580 volunteers comprising people living with HIV/AIDS (PLWHAs), church members and general community members. The programme provides support to over 20,000 people. In addition, it has 5 Programme Managers with each one of them trained in training for transformation (TFT) so that they in turn train their caregivers in project management. The managers are supervised by an Executive Secretary, who is an overall authority in management of the programme. Other stakeholders involved in project implementation are church and traditional leaders.

The programme collaborates with a number of donor agencies and NGOs. These include the National Aids Commission (NAC), Action Aid, UNICEF, Africare, Friends of Mzimba, Volunteer Service Organisation (VSO), UMOYO Network and Restored Community Church (RCC). These stakeholders have assisted Tovwirane financially, morally, technically and materially.

In terms of impact and sustainability, the programme has registered a big impact in changing people's sexual knowledge, attitudes and practices. It has led to total abolition of *chokolo* (wife inheritance marriage practice) and most villages no longer encourage *mitala (marrying more than one wife).* There is an increasing level of acceptability of volunteers in communities where they were initially rejected. Cases of stigma and discrimination of orphans and PLWHAs have been minimised. A lot of people visit HIV testing centres as a result of counselling held at the community and centre levels. There are currently 85 registered PLWHAs from the initial number of 19 as a result of the intervention.

People, especially those on HBC and orphans, continue to reap significant benefits from the programme. Such benefits include PLWHAs having access to HIV and opportunistic infections treatment while orphans continue to access skills training and equipment to start

their own IGAs. This has enabled PLWHAs and orphans to continue living a productive and positive life.

HIV/AIDS is one of the priority concerns for the Government of Malawi because of the devastation it causes and continues to cause to the national economy. This programme intervention is therefore a timely intervention towards HIV/AIDS prevention and mitigation. It is contributing in terms of enhancing health services through provision of HIV treatment drugs, HIV testing and counselling, skills development and general public awareness of HIV/AIDS.

The following lessons on sustainability can be drawn from Tovwirane:

- Tovwirane HIV/AIDS programme is community based. It operates based on community needs and aspirations. Implementation ideas are generated locally and implementation is done through a network of community volunteers.
- Programme personnel received a lot of training which significantly enhanced their management capacity.
- The programme is governed by a board of governors at the political level, to which the secretariat is accountable. The board comprises local level leadership.
- The programme is based on community values and beliefs. It also targets people's change in knowledge, attitudes and practices in relation to HIV/AIDS.
- Work is performed voluntarily even at the secretariat level. This has significantly reduced overhead costs.
- The programme can be replicated elsewhere as it is based on community capacity, knowledge, attitudes and practices as related to HIV/AIDS.

Table 6: SWOT analysis of the Tovwirane Centre

Strengths	Weaknesses	Opportunity	Threat
- the programme is run by community based volunteers - the programme has unity of purpose - programme beneficiaries accept the fact that HIV/AIDS is real and it can affect anybody else in the country regardless of location or origin - level of commitment to fight HIV/AIDS in the programme is high - the programme operates on principles of transparency and accountability - donor support to the programme is on the increase - community ownership of the programme is high	- the relationship between the board of directors and the secretariat is not very good because of lack of trust - the board sometimes interferes with the work of the secretariat - donor funding is still channelled through the hospital account and not directly to the CBO, thereby undermining capacity building objectives	- expansion of impact area for the project - donor support - enhanced community custodianship of the programme - enhanced positive living among the infected and affected	- rejection by churches of condom promotion as a strategy to HIV prevention. They prefer abstinence and faithfulness, which are in agreement with their religious faith - the CBO intends to transform itself into an NGO, which may lead to loss of identity and ownership

Tovwirane responds to the three major objectives of the National Strategic Framework on HIV/AIDS in the following ways:

Reduce incidence of HIV/AIDS: Under this objective, Tovwirane uses an approach called Training For Transformation (TFT) that was introduced to them by CABUNGO, where the community identifies its problems and suggests ways of solving them. The communities in the rural Mzimba identified HIV/AIDS as a social problem in their community and they also saw that they were responsible themselves for addressing the problem. In addition, the volunteers for Tovwirane who are HIV positive conduct Group Therapy Sessions and health education meetings in schools, churches and communities where they give testimony to the people that AIDS is real and that they were suffering from it. That way the people are encouraged to change their behaviour so that they do not catch the virus. This approach appears to be working, as Mr. Solomon Harvey Kachali, one of the members of the secretariat said, "Village Headmen come to thank us for the job that we are doing because they have fewer cases of men being involved in sexual relationships with other peoples' wives." This is a direct result of outreach education services that are being conducted by Tovwirane. So, the initiative is having an effect on behaviour change, thereby contributing to the slowing down of the spread of HIV infection. The slowing down in the spread of HIV has a positive effect on poverty reduction efforts.

Improved quality of life: The main strategy under this objective is to improve the management of HIV-related conditions, including putting in place guidelines for treating opportunistic infections to improve care at the community level. Tovwirane HIV/AIDS organisation is achieving this objective by providing herbal therapy to HIV/AIDS infected people. Tovwirane has an herbal garden where they grow garlic and ginger that they use to prepare herbal lotions for treating skin sore for HIV patients and ointment for treating Candidiasis. In addition, with the help of cooperating partners, Tovwirane provides immunity boosters such as vanilla, maize syrup and Stimucare tablets to HIV/AIDS patients so that they can live longer. Tovwirane also provides Home Based Care Support to chronically ill people and people living with HIV/AIDS (PLWHAs). Under this program, Tovwirane provides treatment for opportunistic infections. All the 580 volunteers have HBC kits. They also do counselling and this has tremendously increased the number of people accessing VCT. VCT assists people infected and affected by HIV to cope with their situation and also to access alternative therapies such as immune boosters.

Mitigation against economic and social impacts of HIV/AIDS: The mitigation of the impact of HIV/AIDS is essential if poverty reduction is to become a reality. One of the strategies to lessen the impact of HIV/AIDS is to provide frameworks that support those indirectly affected by the pandemic such as orphans, widows, widowers, and households. In this sector, Tovwirane organisation has a skills development programme. Under this programme orphans are taught skills in carpentry, tailoring and tinsmith. Upon graduation, the orphans are given tools such as tailoring machines and toolboxes as start-up capital for them to stand on their own. The study team visited Lufu Zgobvu who is running a successful carpentry shop in Mvula Village and Wezzie Shawa who is running a tinsmith shop at Chanunkha village; both are graduates of Tovwirane.

2.6 CADECOM's Dedza Integrated HIV/AIDS Home-based Care[51]

Like other Dioceses in Malawi, Dedza Diocese is part of the National Episcopal Conference of Malawi (ECM) Integrated AIDS Home-based Care Program, which is implemented in all the seven Catholic Dioceses in Malawi. The programme in Dedza Diocese started in 1997 and ended in December 1998, when the ECM Program was winding down. The Catholic Relief Services supported the project and provided funding to the level of US$362,334.00 for three years. The aim of the Integrated HIV/AIDS Project is to minimize the impact of the HIV/AIDS epidemic among the 900,000 people living in the Diocese. The goal of the project is to provide care and support to affected and infected persons and reduce HIV/AIDS transmission. The specific objectives of the project are: to provide care and support services to at least 25 per cent of people affected and infected by September 2004, to provide HIV/AIDS education to at least 90 per cent of the youths by September 2004.

The project is being implemented in nine areas in three districts of Dedza, Ntcheu and Salima (Chipoka area). The three districts also represent the 3 deaneries of Dedza Diocese. The total number of villages involved in the 9 project areas is 107. Due to high levels of urbanization, proximity to border areas and increased social activity in the three districts, all the townships have high HIV prevalence rates and accelerating rates of HIV transmission. The HIV prevalence is estimated at 12 per cent. Project management is located at the Diocesan Offices at Dedza Boma. Field officers, providers, care support providers, volunteers and the community, in that order, implement field project activities. The Project Coordinator, who reports to the Director of CADECOM for the Diocese, provides overall project leadership.

The project has established a network of village level institutions in the name of project committees, volunteers and care supporters. These contribute significantly to HIV/AIDS education by disseminating messages. In addition, these institutions are actively supporting the chronically ill and the youth with various types for interventions. However, these institutions lack proper training and incentives that can motivate them to participate in the project on a sustainable basis. It is evident that if adequately provided with skills and information, these institutions have potential to reduce HIV/AIDS transmission, even after CRS funding is over.

2.7 The project intervention method

In the project intervention method the objectives above can be divided into three main categories:

HIV/AIDS prevention: The aim of the first category is to prevent the transmission of HIV by mobilising communities and the youth in HIV/AIDS awareness, education and prevention activities.

Care and support: The second category aims to provide care and support services (curative type of approach) for victims of HIV/AIDS to minimize suffering that the groups undergo.

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[51] Centre for Development Management: "Integrated HIV/AIDS Home Based Care Project, Mid-Term Review, Draft Report for Dedza Diocese." 2003.

Capacity building: The third and last intervention category aims to provide the required skills and capacity for the community and CADECOM to implement the first two intervention methods. The focus is mainly on local leaders, youths and orphans.

Table 7: Summary matrix of good practices contained in the reports

Good Practice	Title	Why is it a Good Practice	The Seven Criteria
Impact Mitigation: Care, Treatment and Nutrition Issues	Group Therapy for People Living with HIV/AIDS: The NAPHAM Experience	Gave a clear example of the approach to working with PLWHAs	Effective, replicable, sustainable and relevant
	Pilot program for the administration of anti-retroviral (ARV) drugs to HIV-positive patients in a hospital setting	Gave an indication that with sufficient funding, it is possible to scale up treatment	Relevant, effective
	Caring for Orphans: The Tovwirane Centre Experience	It is possible to use available resources from within the community to assist orphans	Effective, replicable, sustainable and relevant
	Using Male Volunteers for Home Based Care	Gave an example that HBC can involve everyone in the community, that all sexes can work	Effective, sustainable and relevant
	The Role of Communities in Care and Support for People Living with HIV/AIDS in Thyolo District	That communities can contribute towards improving the lives of PLWHAs	Effective, replicable, sustainable and relevant
Community Mobilization	Targeting Behaviour Change Using the Stepping Stones Change Approach	Gives an alternative approach to changing behaviour as regards HIV/AIDS	Sustainable and relevant
	BLM's Adolescent Reproductive Health Initiative	Concentrates on the youths who can stop the spread of HIV if trained early in their lives	Replicable and relevant
	Scaling up HIV/AIDS Interventions through Community Mobilization Involving Traditional Leaders	Encourages use of available authority leaders in the communities	Effective, replicable, sustainable and relevant
	Integrated Infant feeding, HIV/AIDS and PMTCT counseling in MCH and Community Services	Combined all services for HIV/AIDS infected and affected at one sitting	Effective, replicable, sustainable and relevant
Prevention and Behaviour Change	Prevention Mother to Child Transmission of HIV-The Embangweni Mission Hospital Experience	Gave an initiative that would reduce or stop transmission of HIV	Replicable and relevant
Policy Issues, Coordination and Networking	Developing HIV/AIDS Workplace Policy at the National and Enterprise Level:	Encouraged companies to develop policies of their own	Replicable and relevant
	Hope for the African Child Initiative	Enabled a group of 5 NGOs to work together in a network against HIV/AIDS	Replicable, efficient, relevance, impact

PART III:	Recommendations of actions to be taken in Malawi in the educational, counselling, and awareness raising fronts

Based on the literature review above, the following recommendations are made in relation to the three thematic areas reviewed:

1. Government needs to urgently develop a child labour policy that should be the national framework to guide stakeholders on issues related to child labour.

2. There is need to strengthen the provision of education services at all levels and help communities mobilise their children to remain in school, especially in areas where tobacco, tea and plantation farming framing are most dominant. This is particularly necessary in areas where illiteracy levels are high, which are also areas with high HIV/AIDS prevalence.

3. There is currently no coordinated national public awareness programme on child labour. It is therefore recommended that efforts to raise awareness against child labour should be improved and extended to more areas and sectors. Along these awareness programmes, should be messages that disseminate the interrelatedness of child labour and HIV/AIDS.

4. Child labour is a result of poverty. Efforts that are implemented as part of poverty reduction should therefore mainstream child labour and HIV/AIDS issues so that educational needs of children are not compromised for short term economic benefits.

5. Many stakeholders (public, private as well as civil society) implementing child labour and HIV/AIDS issues, especially at district and community levels, are ill equipped to deal with child labour cases, both in a preventive and curative way. There is need to develop technical and financial capacity to support implementation of child labour activities, especially among decentralised local institutions.

6. The Government should also consider including child labour issues in teacher and pupil training curriculum, in addition to HIV/AIDS information, which has already been incorporated in the curriculum. This would ensure that the children themselves access information directly from the education system, thereby growing up aware of the dangers of child labour.

7. Most activities being implemented in the child labour sector are not coordinated and do not fall under a coherent national programme. There is need to develop a comprehensive programme to provide support to children most vulnerable to child labour and HIV/AIDS, such as orphans domestic workers and street children. The programme will also be a framework to improve coordination between various stakeholders.

8. Public institutions mandated to implement or monitor child labour programmes are not adequately financed. The Government through the Treasury should ensure that ministries responsible for labour issues and social welfare are adequately funded to

enable them support decentralised institutions, NGOs and the private sector to implement child labour issues.

9. Mobilise public finances to support child labour and HIV/AIDS activities. These strategies are related to use, allocation, efficiency and effectiveness of government funds in supporting implementation of child labour activities.

10. Government should ensure and put in place relevant legislation to protect children from being employed to carry out hazardous work.

11. Although youth organisations have programmes on the rights of the child and HIV/AIDS, very few have programmes that directly fight against child labour the civil society therefore needs to improve efforts against child labour, which also include lobbying government for conducive policy and legal framework for children.

PART IV:	Links to other IPEC programmes/projects

4.1 Links directly to other IPEC programmes

Although there are many efforts to mitigate HIV/AIDS, most of them do not have child labour issues mainstreamed in them. Neither do child labour programmes have HIV/AIDS strategies deliberately included in them. Accordingly, there is a need to mainstream HIV/AIDS concerns into all IPEC (and, as appropriate, into IPEC's partners') existing projects and action programmes operational in Sub-Saharan Africa. It is therefore important to raise some potential linkages that can be woven between existing programmes and forthcoming projects.

The Ministry of Labour is the key entry point for labour issues, including child labour issues. The Ministry, through its treasury resources, implements a number of child labour activities, although these programmes have not integrated HIV/AIDS issues. The Ministry established a Child Labour Unit to coordinate all child labour related activities on behalf of the Ministry. Through the Unit, the Ministry implemented awareness campaigns, inspections and law enforcement, labour surveys and capacity building programmes. Discussions with the Ministry officials indicate that Malawians are in general aware of the impacts of child labour, but are not aware of the relationships between child labour and HIV/AIDS. As indicated earlier, there is no child labour policy in Malawi. Reports from the Ministry also indicate that there are no guidelines on detection, prevention and mitigation of child labour. As a result, implementation is only guided by existing legislation, which is difficult for practitioners to comprehend. The main linkage with the forthcoming project is therefore to support the Ministry in developing achild labour policy that includes strategies to address the impacts of child labour on HIV/AIDS. The project can also support translation of the said policy, help in developing guidelines for mainstreaming HIV/AIDS in child labour programmes and be followed by a capacity building programme to ensure that stakeholders, especially at district level, have adequate tools to guide them in the planning, monitoring and implementation of child labour activities.

The ILO is also implementing the Commercial Agricultural Project (COMAG) in four districts of the country including Mchinji and Kasungu in Central Region and Mangochi and Mzimba in the Southern and Northern Region respectively. Literature indicates that the four districts have high incidences of child labour and high prevalence of HIV/AIDS. The COMAG project has three components: preventing children from engaging in child labour, withdrawing those already involved in child labour and providing alternatives to those affected by child labour. Among the major lessons learnt from COMAG is that HIV/AIDS has forced households to use children to support families after the death of parents. In addition, because HIV/AIDS affects the most productive members of a family, the aged and the young are left with no option but to use children to engage in child labour. The forthcoming project will need to develop a strong linkage with COMAG in terms of developing awareness programmes against chid labour and HIV/AIDS. The project can also be integrated into the COMAG project by replicating the approaches COMAG has adopted in the other districts where child labour and HIV/AIDS are a problem. Jointly the two projects can facilitate and support a policy formulation against child labour and HIV/AIDS by the Ministry of Labour and Vocational Training. In the capacity building efforts, the project can use experience gained from the COMAG project to roll-out the process to the remaining districts, in liaison with the Ministry of Local Government and District Administration.

The Together Ensuring Children's Security (TECS) project is another key project that addresses root causes (developmental approach) of child labour, especially poverty, illiteracy and food shortages. The overall goal of the project is to reduce incidences of child labour in the agricultural sector[52]. The project originates from the efforts of the tobacco industry when the industry was sensitised on the seriousness of child labour, especially in the tobacco sector where most of child labour occurs. The project, which is relatively small but strategic, has main four components of food security, water and sanitation, education and health. It is implemented in Dowa and Kasungu districts in the Central Region. The objective of the project is to improve the food security, income levels and the use of natural resources leading to sustainable increases in farm productivity and a better environment for children. This should eventually enable households not to force or encourage their children to engage in child labour and also ensure that children do not take part in child labour activities to raise income or food for their households.

The objective of the education component is to create practical equal opportunity educational services tailored to increase primary school enrolment and retention. The project addresses this objective by mobilising communities to attend school, constructing school blocks to ensure that facilities are available, and encouraging and facilitating formation of preschool play groups and junior primary schools. These efforts directly increase enrolment rates and school attendance in addition to reducing child labour. The objective of the safety water and sanitation programme is to provide a sustainable, clean and safe water supply system so that girl children spend less time drawing water and hence use the saved time for educational purposes. By providing safe water, households suffer less from water borne diseases, some of which are also related to HIV/AIDS. Less morbidity means that households can spend more time in their farms and produce enough food to ensure food security and lower risk of HIV/AIDS. Lastly, the health component of TECS aims to reduce infant, child and maternal mortality.

The main linkages with the forthcoming project will be in the design and implementation of activities that address poverty attributes of child labour such as access to education, food security, water sanitation and health. The TEC programme focused mainly on child labour and has shown a lot of potential for addressing HIV/AIDS. First of all, the TEC has the potential to include HIV/AIDS awareness in its activities. For example, TEC can use the local community, schools and project committees who are already partners for targeting HIV/AIDS messages. It can also open up the school information centres and provide reading and learning materials for children on the HIV/AIDS pandemic. The TEC can also work closely with NGOs providing HIV/AIDS services to reach all households and children affected by child labour and HIV/AIDS. Involving the private sector in such projects as HIV/AIDS and child labour is relatively new in Malawi, due to entrenched feelings that the private sector is solely concerned with profit making. In terms of private sector mobilisation, therefore, the TEC can also link up with the forthcoming project to develop guidelines on mobilising the private sector. These efforts will also need to be done jointly or in liaison with the Malawi Business Coalition Against HIV/AIDS, which is an umbrella initiative to mobilise the private sector against HIV/AIDS.

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[52] Together Ensuring Children's Security: Minutes of the Annual General Meeting held on 16 April 2003 at Capital Hotel.

The UNICEF/NORAD/Government of Malawi Programme: UNICEF, in collaboration with the Ministry of Labour, is executing a child labour project funded by NORAD. The first phase (covering two years) is coming to an end in six months. There will be another phase thereafter. The programme has focused on awareness and advocacy work in 11 pilot districts of Mzuzu, Mzimba, and Rumphi in the Northern Region, Mchinji, Kasungu, Lilongwe and Dedza in the Central Region and Blantyre, Thyolo and Mulanje in the Southern Region, focusing on tobacco and tea as well as domestic workers in the three cities. The project is piloting implementation of IGAs as a long-term strategy to address child labour. At the technical level, there is very close collaboration with IPEC. The project's main outputs that have to be linked to the forthcoming project include developing a Code of Conduct on child labour which is currently in an advanced stage of the drafting process, developing a database on child labour (to draw on the SIMPOC survey) and the review of the labour inspection form.

Another programme is the Association for the Elimination of Child Labour (AECL) in Malawi. It was formed under the leadership of the Tobacco Association of Malawi (TAMA) as an umbrella body on child labour issues in Malawi. Its main project at the moment is the ECLT funded primary school in Nkhotakota. The initial Executive Director resigned and was replaced by a coordinator who is also an MCTU official. However its aim has not been realized due to lack of commitment from the tobacco association of Malawi who housed the programme. The main link with the proposed programme would be to de-link the association with TAMA and develop its capacity, in collaboration with the Ministry of Labour, to enable it to act as an umbrella organisation.

The Malawi Congress of Trade Unions (MCTU) is regarded as the pioneer of advocacy against child labour. They have various advocacy programmes at the national and local levels. The impact of their work at the local level however is constrained by lack of grassroots structures and membership in the agriculture sector. MCTU has formed child labour committees in various areas, which are neither effectual nor union structures. Support to MCTU should therefore focus on capacity building, advocacy and outreach activities to enable them be effective.

4.2 Links to relevant non-IPEC programmes

The Malawi Business Coalition Against HIV/AIDS (MBCA): The Malawi Business Coalition Against HIV/AIDS (MBCA) is a focal point for the response of the private sector's fight against HIV/AIDS. Its main objective is to increase private sector support for HIV/AIDS prevention, care and support services in Malawi thereby contributing to NSF goals which aim at reducing the incidence of HIV and other STIs and improving quality of life for the HIV affected and infected. One of its major tasks is to build the private sector's capacity to develop and implement HIV/AIDS Workplace Programmes to fight and mitigate the impact of HIV/AIDS in the workplace. To achieve this, MBCA engages in a number of activities such as sensitising the private sector on HIV/AIDS mainstreaming, sharing lessons and best practices with its members and networking with other stakeholders in the southern Africa region.

The Malawi Social Action Fund (MASAF): The Malawi Social Action Fund (MASAF) is a Government project largely funded by the World Bank and other donors. The MASAF project is now in its third phase and established a system for project identification and implementation at the community level. Within its district assembly implemented projects,

the MASAF financially supports activities that fight child labour and HIV/AIDS. Such activities include construction of school blocks, building orphanages, supporting capacity building, income generating activities, constructing child care centres and many more. The forthcoming project should work with the MASAF as a means to integrate child labour issues in MASAF. In addition, MASAF has a strong capacity building element, which is also demand driven.

The World Food Programme is involved in supporting Government efforts to address food security through 'food for work' programmes. The WFP is not an implementing agency, and instead works through NGOs. Currently it is working with 14 NGOs who are implementing food for work programmes throughout the country under the second Joint Emergency Food Aid Programme (JEFAP 2). The activities that NGOs are implementing include road rehabilitation and maintenance, reforestation, surface irrigation (mainly stream diversion and canalisation). In return, the community receives food based on work performed. Considering that food is an important need for those families that have been affected by child labour and HIV/AIDS, it is important that the forthcoming project has to work with the WFP and help these victims access food, especially during the September to January season where food insecurity is highest.

The Joint United Nations Programme on HIV/AIDS, UNAIDS[53], is the main advocate for global action on the epidemic. UNAIDS is a collaborative effort between UNICEF, WFP, UNDP, UNFPA, UNODOC, ILO, UNESCO, WHO and the World Bank. It leads, strengthens and supports an expanded response aimed at preventing transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic. UNAIDS supports a more effective global response to AIDS through five key thematic areas (which also form strategic objectives of all country programmes):

a) Leadership and advocacy for effective action on the epidemic,
b) Strategic information to guide efforts against AIDS worldwide,
c) Tracking, monitoring and evaluation of the epidemic and of responses to it,
d) Civil society engagement and partnership development,
e) Mobilisation of resources to support an effective response.

In Malawi, just as in other country programmes throughout the world, UNAIDS represents the collective action of Co-sponsors in support of national responses to HIV/AIDS. It also provides key support to the **United Nations Theme Group on HIV/AIDS**, the joint HIV/AIDS policy and strategy decision-making body for Co-sponsors and other UN system agencies at the country level. The UN Resident Coordinator is responsible for ensuring that an effective UN Theme Group on HIV/AIDS is functioning within the framework of General Assembly resolutions 44/211 and 47/199.

[53] UNAIDS: http//www.unaids.org.

PART V:	Partnerships and networking for effective prevention of child labour and HIV/AIDS

According to the Child Labour Survey, community informants identified the four key players in the fight against child labour as parents, traditional leaders, neighbours, and employers. In the report, the community suggests roles to be played by each of the four players. For instance, parents are requested to send their children to school, assign no chores before a child does her/his homework and studies and not to overwork their children by giving them enough rest time. Traditional leaders are asked to punish parents/guardians who fail to do the above. Neighbours, as part of the traditional leadership, are asked to monitor each other's treatment of children and report non-compliance if need be. Employers are asked never to employ a child below eighteen years. In addition to the four players, it is important to recognise the role of decentralised development institutions like area, village and community level development committees, as well as NGOs and CBOs. These institutions can play an important role in identifying and implementing interventions against child labour. The main advantage of using decentralised institutions is that they can easily integrate child labour issues into the overall district development planning system, which in the long-term ensures sustainability of all interventions.

CBOs and NGOs participate in district development affairs. They should be assisted with the capacity to conduct civic education on child labour; run free food distribution at schools and input credit programmes for the poor households. They should also help to facilitate capacity building of local institutions on prevention and case handling of child labour issues. The roles of the District Assembly cannot be over-emphasised, especially with the advent of decentralisation and participatory development management paradigms. With decentralisation, district labour and social welfare offices, with the responsible parties for child labour issues, report to the District Assembly. The DAs therefore need to ensure that adequate resources from the DDF and other donors are provided to these officers so that these offices discharge their duties diligently. DAs also need to ensure that they attract as many NGOs directly dealing with child labour in their district as possible. The CSR (2003) child labour survey indicates that there are very few NGOs dealing with child labour issues in Malawi.

The Central Government is responsible for national policy and legislation formulation, setting standards and guidelines necessary to guide District Assemblies. Therefore they should put into effect a legislative and policy framework for compulsory education, abolition of child employment and overworking of children in households. This could be followed by production of national guidelines and standards for child labour in Malawi, made in simple formats for use by practitioners. Centrally at the national level, the Government through the Treasury should ensure that ministries responsible for labour and social welfare are adequately funded, to enable them to support DAs at the district level. The National Steering Committee on Child Labour National needs to improve stakeholders' collaboration, sharing experiences and best practices to put child labour issues on the national agenda.

The International Donor Partners should also ensure that Cooperation Frameworks with the Malawi Government mainstream child labour issues. Currently, national infrastructure lacks the ability to deal with child labour issues; more so when decentralisation is put into perspective. There is need for technical and financial assistance on child labour.

The Government of Malawi established the National AIDS Commission (NAC) in July 2001 to respond to the HIV/AIDS epidemic in the country. NAC is the coordinating body for all HIV/AIDS activities in Malawi with a mandate to provide leadership in planning, organising, coordinating and setting standards and guidelines for the prevention and control of HIV/AIDS in Malawi. Activities implemented by the Commission follow the National Health Plan and are part of the government strategy of poverty reduction. The overall goal is to reduce the incidence of HIV and other sexually transmitted infections and improve the life of those infected and affected by HIV/AIDS (NAC Brochure, 2003)

The National AIDS Commission replaced the National AIDS Control Programme, which was in operation from 1987 to 2001. The National AIDS Control programme was transformed and restructured to become a Commission in order to effectively respond to an expanded National HIV/AIDS programme. The Commission came into being after realizing that the response to the HIV/AIDS pandemic required a multisectoral approach and interaction between HIV/AIDS and broader issues of population, economic development, human resources development and management, social service provision, culture, community development and gender. The role of the NAC is to coordinate and facilitate the national response to the HIV/AIDS pandemic. Specific objectives of the NAC are to:

- Manage and coordinate the implementation of government policies on HIV/AIDS;
- Liaise with relevant Ministries as appropriate on all matters relating to HIV/AIDS in order to ensure that there are no legal, medical or regulatory barriers to information on HIV/AIDS;
- Ensure through advocacy that all political, community and traditional leaders play a strong, sustained and visible role in the prevention of HIV/AIDS;
- Develop and maintain an up-to-date information system and establish suitable mechanisms of disseminating and utilizing such information;
- Supervise, monitor and evaluate progress and impact of HIV/AIDS prevention, care and mitigation; and
- Develop and institute guidelines for cooperation among the Commission, Government and other organisations and agencies in Malawi.

The National Aids Commission has produced HIV/AIDS materials, which have been distributed throughout the country. If the NAC is able to support projects related to combating child labour, the affected areas are likely to experience considerable improvement.

Malawi HIV/AIDS Partnership (MAHAP) came into being in September 2001 for implementing PVOs and NGOs working in Malawi. MAHAP's goal is to achieve national coverage with high quality, effective and efficient community-based HIV/AIDS prevention, care, treatment, impact mitigation and advocacy interventions. Its objective is to support the Government of Malawi and especially the National AIDS Commission in implementing activities as outlined in the National AIDS Strategic Framework. MAHAP's aims included achieving 75 per cent coverage of Malawi's population by 2005 with community-based services that assist districts in mobilizing local responses. A monitoring and evaluation system that will monitor partner progress in achieving this goal is now under development. MAHAP will assist the NAC in the future in its task of implementing Malawi's National HIV/AIDS Strategy by instituting community-based programs, developing services, and identifying gaps in the delivery of services and in the resources needed to improve and sustain delivery. So far, eighteen organisations have signed the MAHAP agreement to date and an open invitation is extended to all interested organisations.

PART VI:	Annexes of relevant information

Annex 1: Malawi population distribution by sex, sex ratio and region/district

Region/district	1987				1998			
	Both sexes	Male	Female	Sex ratio	Both sexes	Male	Female	Sex ratio
Malawi	**7,988,507**	**3,867,136**	**4,121,371**	**93.8**	**9,933,868**	**4,867,563**	**5,066,305**	**96.1**
Northern region	**911,787**	**441,290**	**470,497**	**93.8**	**1,233,560**	**601,752**	**631,808**	**95.2**
Chitipa	96,794	45,797	50,997	89.8	126,799	60,682	66,117	91.8
Karonga	148,014	71,304	76,710	93.0	194,572	93,673	100,899	92.8
Nkhata Bay	130,189	63,858	66,331	96.3	164,761	80,107	84,654	94.6
Rumphi	94,902	46,162	48,740	94.7	128,360	63,272	65,088	97.2
Mzimba	433,696	210,427	223,269	94.2	610,994	300,287	310,707	96.6
Likoma	8,192	3,742	4,450	84.1	8,074	3,731	4,343	85.9
Central region	**3,110,986**	**1,521,234**	**1,589,752**	**95.7**	**4,066,340**	**2,016,166**	**2,050,174**	**98.3**
Kasungu	323,453	167,705	155,748	107.7	480,659	247,850	232,809	106.5
Nkhotakota	158,044	79,314	78,730	100.7	229,460	114,847	114,613	100.2
Nchisi	120,860	59,118	61,742	95.8	167,880	83,595	84,285	99.2
Dowa	322,432	157,968	164,464	96.1	411,387	203,828	207,559	98.2
Salima	189,173	91,896	97,277	94.5	248,214	121,994	126,220	96.7
Lilongwe	976,627	482,776	493,851	97.8	1,346,360	673,854	672,506	100.2
Mchinji	249,843	127,637	122,206	104.4	324,941	164,090	160,851	102.0
Dedza	411,787	189,950	221,837	85.6	486,682	230,237	256,445	89.8
Ncheu	358,767	164,870	193,897	85.0	370,757	175,871	194,886	90.2
Southern region	**3,965,734**	**1,904,612**	**2,061,122**	**92.0**	**4,633,968**	**2,249,645**	**2,384,323**	**94.0**
Mangochi	496,578	234,592	261,986	89.5	610,239	293,217	317,022	92.5
Machinga	301,849	141,099	160,750	87.8	369,614	176,853	192,761	91.7
Zomba	441,615	209,578	232,037	90.3	546,661	265,859	280,802	94.7
Chiradzulu	210,912	97,327	113,585	85.7	236,050	111,376	124,674	89.3
Blantyre	589,525	304,148	285,377	106.6	809,397	413,429	395,968	104.4
Mwanza	121,513	57,157	64,356	88.8	138,015	67,087	70,928	94.6
Thyolo	431,157	208,139	223,018	93.3	458,976	218,381	240,595	90.8
Mulanje	419,928	196,630	223,298	88.1	428,322	200,834	227,488	88.3
Phalombe	218,134	100,328	117,806	85.2	231,990	109,229	122,761	89.0
Chikwawa	316,733	156,886	159,847	98.1	356,682	178,217	178,465	99.9
Nsanje	204,374	98,278	106,096	92.6	194,924	94,457	100,467	94.0
Balaka	213,416	100,450	112,966	88.9	253,098	120,706	132,392	91.2

Source: NSO (1998).

Annex 2: Literacy levels in Malawi

Area and literacy status	Both sexes		Male		Female	
Malawi						
Literate	**57.6**	**64.1**	**64.5**	**74.9**	**51.0**	**54.0**
English only	0.1	0.0	0.1	0.0	0.1	0.0
Chichewa only	20.7	18.5	21.3	19.4	20.2	17.7
Other language only	1.6	1.3	1.4	0.9	1.8	1.6
English/Chichewa	22.0	28.0	26.6	35.4	17.6	21.5
English/Chichwea other	13.2	16.1	15.1	19.1	11.3	13.2
Urban						
Literate	**79.4**	**87.1**	**83.3**	**92.2**	**75.1**	**81.3**
English only	0.1	0.0	0.1	0.0	0.1	0.1
Chichewa only	17.5	12.3	15.8	10.7	19.3	14.2
Other language only	0.6	0.4	0.5	0.3	0.7	0.6
English/Chichewa	41.5	50.6	45.7	55.5	37.0	44.8
English/Chichewa/Other	19.6	23.8	21.2	25.6	17.9	21.7
Rural						
Literate	**53.8**	60.	61.0	71.4	47.1	49.7
English only	0.1	0.0	0.1	.00	0.1	0.0
Chichewa only	21.3	19.6	22.3	21.2	20.3	18.2
Other language only	1.8	1.4	1.6	1.1	2.0	1.7
English/Chichewa	18.7	24.2	23.1	31.3	14.5	17.8
English/Chichewa/Other	12.1	14.7	14.0	17.8	10.2	11.9
Northern region						
Literate	**71.7**	**81.7**	**75.7**	**88.6**	**68.0**	**75.4**
English only	0.0	0.0	0.0	0.0	0.0	0.0
Chichewa only	4.0	3.3	3.7	2.9	4.2	3.7
Other language only	7.5	5.0	6.6	3.4	8.3	6.5
English/Chichewa	3.8	4.8	4.0	5.3	3.5	4.4
English/Chichewa/other	56.5	68.5	61.4	77.0	51.9	60.8
Central region						
Literate	**54.5**	**61.7**	**61.3**	**72.3**	**47.9**	**51.3**
English only	0.1	0.1	0.1	0.0	0.1	0.1
Chichewa only	24.0	22.2	24.4	23.2	27.3	24.5
Other language only	0.3	0.3	0.3	0.3	0.4	0.4
English/Chichewa	25.2	32.6	30.3	40.5	23.4	28.7
English/Chichewa/Other	5.0	6.5	6.1	8.3	4.4	5.5
Southern region						
Literate	56.5	61.7	64.3	73.7	49.2	50.8
English only	0.1	0.0	0.1	0.0	0.1	0.1
Chichewa only	22.3	19.3	23.1	20.4	21.6	18.3
Other language only	1.1	1.1	1.0	0.9	1.3	1.3
English/Chichewa	24.1	30.5	29.4	38.6	19.2	23.1
English/Chichewa/Other	8.8	10.7	10.8	13.8	7.0	8.0

Source: NSO (1998).

Annex 3: Household characteristics in Malawi

Area & sex	Married			Widowed			Divorced/separated			Never married		
	Total	Males	Females	Total	Male	Females	Both sexes	Males	Females	Both sexes	Males	Females
Malawi region	**54.8**	**53.9**	**55.9**	**4.0**	**1.1**	**6.7**	**4.7**	**2.3**	**7.0**	**36.5**	**43.0**	**30.4**
Urban	51.5	50.2	53.1	2.7	1.2	4.5	3.0	2.0	4.1	42.7	46.7	38.4
Rural	55.3	54.2	56.4	4.2	1.1	7.1	5.0	2.4	7.4	35.4	42.3	29.1
Northern region	**53.3**	**50.0**	**56.4**	**4.3**	**1.1**	**7.3**	**3.2**	**1.8**	**4.5**	**39.2**	**47.0**	**31.9**
Chitipa	50.7	47.5	53.6	4.1	1.0	6.8	3.2	1.4	4.7	42.0	50.1	34.9
Karonga	51.1	47.8	54.2	4.6	1.1	7.9	4.4	2.6	6.1	39.8	48.6	31.8
Nkhata Bay	50.5	48.3	52.6	5.2	1.4	8.7	5.2	3.1	7.1	38.1	47.2	31.5
Rumphi	53.1	49.8	56.3	3.5	0.9	6.1	3.5	1.9	5.2	39.8	47.5	32.5
Mzimba	55.6	51.9	59.1	4.1	1.1	6.9	2.2	1.4	2.9	38.1	46.6	31.0
Likoma	36.9	37.0	36.9	7.5	1.9	12.9	5.9	2.6	8.6	49.6	58.5	42.3
Central region	**56.0**	**54.4**	**57.5**	**3.6**	**1.1**	**6.0**	**3.9**	**2.2**	**5.5**	**36.6**	**42.3**	**31.0**
Kasungu	56.9	52.8	61.3	2.6	1.0	4.3	3.4	2.9	3,9	37.2	43.3	30.4
Nkhotakota	54.2	51.8	56.6	3.3	1.1	5.6	4.5	2.9	6.2	38.0	44.2	31.7
Ntchisi	55.4	53.4	57.4	3.2	0.9	5.4	3.3	2.0	4.6	38.2	43.8	32.7
Dowa	56.9	54.9	58.9	3.3	1.1	5.4	3.4	2.1	4.8	36.4	41.9	30.9
Salima	57.0	56.3	57.7	4.1	1.2	6.9	4.3	2.3	6.2	34.5	40.2	29.1
Lilongwe	56.3	54.7	57.9	3.1	1.0	5.1	3.5	2.0	4.9	37.2	42.3	32.0
Mchinji	56.3	54.1	58.6	3.1	1.1	5.1	4.1	2.6	5.7	36.5	42.3	30.6
Dedza	57.8	58.7	57.0	4.6	1.1	7.6	4.3	1.8	6.6	33.3	38.4	28.8
Ntcheu	50.7	50.8	50.6	5.9	1.4	9.9	5.3	2.1	8.0	38.2	45.7	31.6
Southern region	**54.1**	**53.7**	**54.5**	**4.3**	**1.2**	**7.1**	**5.8**	**2.5**	**2.9**	**35.8**	**42.5**	**29.5**
Mangochi	57.3	57.0	57.5	4.0	1.0	6.7	6.6	2.9	9.9	32.2	39.1	25.8
Machinga	58.6	58.3	58.8	3.5	0.8	5.9	6.2	2.9	9.5	31.7	38.5	25.7
Zomba	53.0	53.3	52.7	4.4	1.3	7.2	6.7	3.0	10.1	36.0	42.4	29.9
Chiladzulu	49.1	49.6	48.6	5.9	1.4	9.7	7.5	2.9	11.4	37.5	46.0	30.3
Blantyre	51.3	50.6	52.1	3.5	1.3	5.8	4.0	2.4	5.8	41.1	45.8	36.2
Mwanza	53.0	52.8	53.2	4.4	1.1	7.5	5.0	2.1	7.8	37.5	44.0	31.5
Thyolo	53.0	53.0	52.9	4.5	1.3	7.4	6.5	2.7	9.8	36.0	43.0	30.0
Mulanje	52.7	53.5	52.0	4.9	1.3	8.0	7.3	2.6	11.2	35.1	42.5	28.8
Phalombe	56.6	57.3	56.0	4.5	1.0	7.6	6.4	2.0	10.1	32.5	38.7	26.3
Chikwawa	58.2	55.6	60.9	3.8	1.0	6.6	3.6	1.9	5.4	34.3	41.5	27.2
Nsanje	57.5	54.6	60.1	5.0	1.2	8.4	4.0	1.8	6.0	33.6	42.5	25.5
Balaka	51.6	51.7	51.6	5.0	1.3	8.3	6.5	2.9	9.6	36.9	44.2	30.5

Source: NSO (1998).

Annex 4: People's preference in terms of where to get VCT services

District	Responses				Total
	Hospital	Macro	Hospital/macro	BLM	
Lilongwe	59	24	8	1	92
Dedza	66	6	0	1	73
Balaka	47	13	6	9	75
Salima	78	5	8	0	91
Mzimba	56	24	7	0	87
Mchinji	77	5	0	1	83
TOTAL	383	77	29	12	501
Percent preference	76.4	15.4	5.8	2.4	100

Source: HACI Field Survey, January 2003.

Annex 5: HIV prevalence projection (in per cent)

	2003	2004	2005	2006	2007	2008
National	14.41	14.33	14.28	14.26	14.26	14.28
Urban	22.96	22.83	22.76	22.74	22.74	22.75
Rural	12.36	12.24	12.13	12.03	11.96	11.91

Source: National AIDS Commission, 2003: Sentinel Survey Report.

Annex 6: Local definitions of child work and child labour at community level

Child work	Child labour
✓ '*ntchito yoyenera msinkhu wa mwana'* ✓ Work that the child does to help parents ✓ All the chores he or she can carry out easily ✓ Work in own household and farm ✓ Work that a child is supposed to do at his/her own household according to their ages ✓ Running households errands ✓ Work that children do in their own households, after school ✓ Work that children do for free, especially in own households ✓ Work that is assigned to children with the aim of training them ✓ Work that gives room for the child to rest or study/read their school notes and books ✓ Work that children are capable of doing	✓ *'ntchito yopyola msinkhu wa mwana'* ✓ Work that is tough *(ntchito ya thukuta)* - task fit for an adult assigned to a child ✓ work that requires too much effort for the child to carry out ✓ Chores that are heavy on them ✓ Work that is not suitable for a child including child prostitution ✓ Work that is not appropriate for the child redundant ✓ Estate work because they work for long hours without food and without consideration of their ages ✓ Estate work characterized by big tasks and not attending school ✓ Work that children do for pay ✓ Work which they are assigned to do at a time when their friends are attending classes ✓ Work at night like hunting birds with a net ✓ Domestic work for pay ✓ Work that is dangerous ✓ Work for food while parents, especially their fathers, are at home doing nothing ✓ Work that would force a child to overwork in own or another household ✓ Children being sent to do 'ganyu' so as to bring back food or money for buying food and other household needs ✓ Taking care of old people

Source: CSR, 2003: Child Labour Baseline Survey p.21 Table 3.

Annex 7: Major reasons why children are let to work (proportion of households that mentioned this reason in per cent)

Reason	All (n=1753)	District name			
		Mzimba (n=259)	Kasungu (n=514)	Mchinji (n=566)	Mangochi (n=414)
Supplement household income	31.4	59.1	16.7	33.0	30.2
Could not afford school/training fees	17.2	13.1	37.4	6.9	8.7
No apparent reason	14.6	13.1	19.6	17.1	5.8
Food shortage *"ophunzitsi sophikira"*	13.4	2.7	14.2	16.3	15.2
Learn life skills	13.2	2.7	1.4	22.3	22.0
Buy personal needs	3.7	3.5	0.6	2.7	8.9
Child not interested in education	2.9	0.8	4.9	1.2	3.9
Help out in household IGA activities	1.3	1.9	2.1	0.2	1.2
All others*	2.3	3.1	3.1	0.3	4.1
Total	100	100	100	100	100

Source: CSR, 2003: Child Labour Baseline Survey p.21 Table 3.

Annex 8: Reasons why children are employed

Reason	No.	%
Children are cheap labour	34	34.7
Child work ethics - works hard, more, fast, efficently, faithfully, etc	16	16.3
Children are easy to control - no arguments	9	9.2
Children suitable for certain tasks	9	9.2
Children are obedient	7	7.1
Children are trustworthy/honest - low or no theft	6	6.1
Obligation - child poor, needs money/food sent by poor parents	6	6.1
Guard against spouse infedelity	4	4.1
Availability	2	2.0
Children are trainable	2	2.0
Children are stable in employment	1	1.0
Part of training for adulthood - socialisation	1	1.0
So as to cheat them on their pay	1	1.0
All	98	100

Source: CSR, 2003: Child Labour Baseline Survey p.21 Table 3.

Annex 9: Reasons why girls engage in 'sex for money'

Why child prostitution	WFGD	MAFGD	BFGD	MYFGD	KITL	KIHT	Total
Purchase expensive dresses, shoes and hair care products	0.0	9.1	25.0	42.9	0.0	20.0	18.2
Sent by parents to bring in income to the household	20.0	0.0	0.0	14.3	0.0	0.0	6.1
Get money for own and household food	0.0	18.2	0.0	0.0	0.0	20.0	6.1
Get money to buy own needs due to poverty	20.0	27.3	50.0	28.6	100	40.0	33.3
Get money to buy what they admire from friends	20.0	18.2	0.0	0.0	0.0	20.0	12.1
Lust or nature or take after their mothers	40.0	18.2	25.0	14.3	0.0	0.0	12.1
Disobedience	0.0	9.1	0.0	0.0	0.0	0.0	3.0
All reasons	100	100	100	100	100	100	100

Source: CSR Child Labour Survey KII and FGD Field Reports.
WFGD: Women Focus Group Discussion. **MAFGD:** Male Adults Focus Group Discussion. **BFGD:** Boys Focus Group Discussion. **MYFGD:** Male Youths Focus Group Discussion. **KITL:** Key Informant Interview.

Annex 10: Causes of child labour by level

Immediate causes	Underlying causes	Structural causes
Limited or no cash or food stocks; Increase in price of basic goods	Breakdown of extended family and informal social protection systems	Low/declining national income
Family indebtedness	Uneducated parents; high fertility rate	Inequalities between nations and regions; Adverse terms of trade
Households shocks (death or illness of income earner; crop failure)	Cultural expectations regarding children, work and education	Societal shocks, e.g. war, financial and economic crises, transition, HIV/AIDS
No schools; or schools of poor quality or irrelevant	Discriminatory attitudes based on gender, caste, ethnicity, national origin, etc.	Insufficient financial or political commitment for education, basic services and social protection; 'bad' governance
Demand for cheap labour in informal micro enterprises	Perceived poverty; desire for consumer goods and better living standards	Social exclusion of marginal groups and/or lack of legislation and/or effective enforcement
Family business or farm cannot afford hired labour	Sense of obligation of children to their families, and of 'rich' people to the 'poor' (should the rich/poor be the other way around?)	Lack of decent work for adults

Source: CSR, 2003: Child Labour Baseline Survey p.22 Table 4.

Annex 11: Poverty head count data for Malawi

District	Poverty head count (% population)	Ultra poor (% population)
Zomba Urban	78	28.8
Zomba Rural	71.9	10
Thyolo	76.8	18.2
Salima	60.8	11.9
Rumphi	65.8	40.3
Phalombe	83.9	31.8
Ntchisi	76.3	20.5
Ntcheu	84	27.7
Nsanje	51.3	21.4
Nkhotakota	65.3	13.6
Nkhatabay	47.7	26.6
Mzuzu	70.9	10
Mzimba	67.5	28
Mwanza	71.4	20.2
Mulanje	67.2	30.3
Mchinji	68	52.6
Mangochi	69.8	36
Machinga	63.5	38.2
Lilongwe Rural	65.6	24.4
Lilongwe City	37.9	47.3
Kasungu	48.9	33.9
Karonga	42.1	42.9
Dowa	53.6	54.5
Dedza	73.3	27.8
Chitipa	71.3	29.3
Chiradzulu	74	28.6
Chikwawa	54.3	22.8
Blantyre Rural	65.3	9.6
Blantyre City	60.3	10.8

Annex 12: Number of adults infected with HIV in 2003 by region and district

North	**75,000**	**South**	**475,000**
Chitipa	7,000	Mangochi	54,000
Karonga	16,000	Machinga	32,000
Rumphi	6,000	Balaka	22,000
Nkhata Bay	10,000	Zomba Rural	41,000
Mzimba	22,000	Zomba Municipality	13,000
Mzuzu City	13,000	Chiradzulu	18,000
Likoma	1,000	Blantyre Rural	29,000
Centre	**216,000**	Blantyre City	99,000
Kasungu	21,000	Mwanza	12,000
Nkhotakota	10,000	Thyolo	46,000
Ntchisi	9,000	Mulanje	42,000
Dowa	21,000	Phalombe	17,000
Salima	24,000	Chikwawa	33,000
Lilongwe Rural	29,000	Nsanje	17,000
Lilongwe City	63,000		
Mchinji	12,000		
Dedza	16,000		
Ntcheu	12,000		

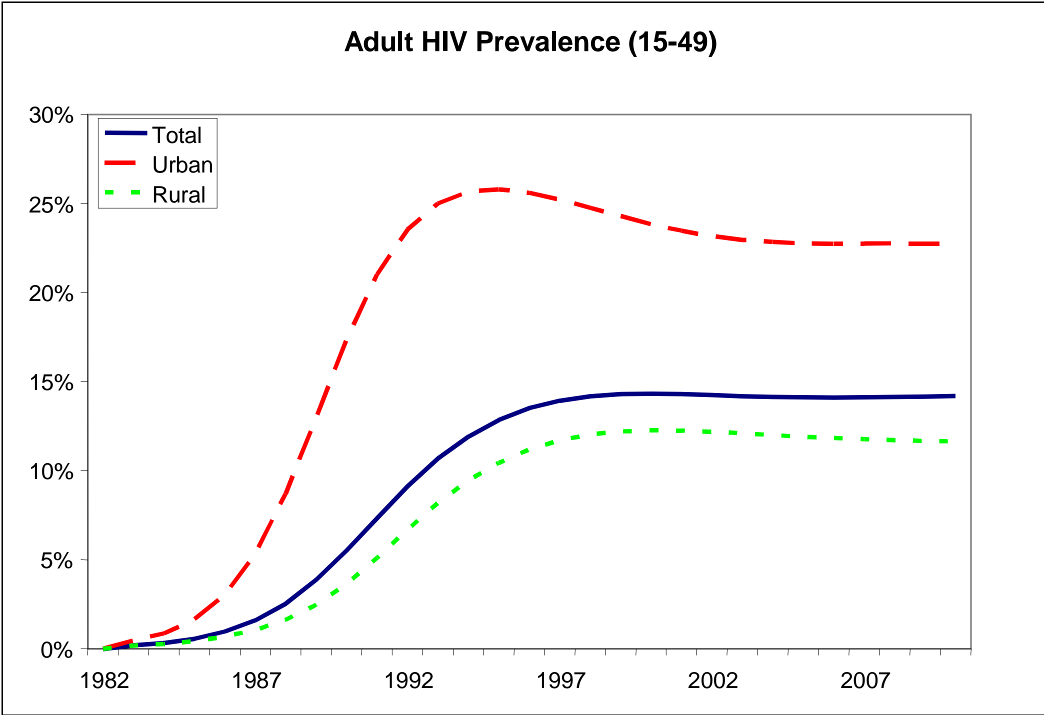
Source: National AIDS Commission 2003.

Annex 13: Estimates of HIV infection in Malawi in 2003

Indicator	Value	Low	High
National adult prevalence (15-49) (%)	14.4	12	17
Number of infected adults	760,000	630,000	910,000
Number of infected adult women	440,000	370,000	530,000
Urban adult prevalence (%)	23.0	19	28
Number of infected urban adults	240,000	200,000	290,000
Rural adult prevalence (%)	12.4	10	15
Number of infected rural adults	530,000	440,000	640,000
Number of infected children (0-14)	70,000	60,000	80,000
Number infected over age 50	60,000	50,000	70,000
Total HIV+ population	900,000	750,000	1,080,000

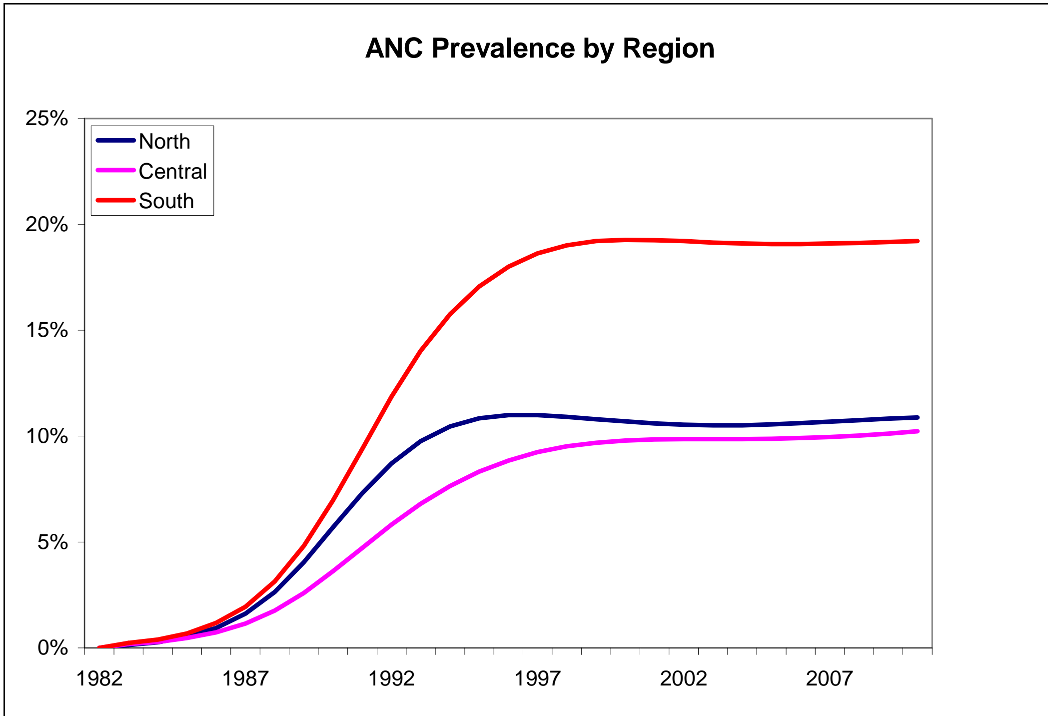
Source: National AIDS Commission 2003.

Annex 14: Estimate of national adult prevalence by place of residence



Source: National AIDS Commission 2003.

Annex 15: Estimate of national HIV/AIDS adult prevalence by region



Source: National AIDS Commission 2003.

Annex 16: Estimates of adults 15-49 infected with HIV by district, 2003

North	75,000	South	475,000
Chitipa	7,000	Mangochi	54,000
Karonga	16,000	Machinga	32,000
Rumphi	6,000	Balaka	22,000
Nkhata Bay	10,000	Zomba Rural	41,000
Mzimba	22,000	Zomba Municipality	13,000
Mzuzu City	13,000	Chiradzulu	18,000
Likoma	1,000	Blantyre Rural	29,000
Centre	**216,000**	Blantyre City	99,000
Kasungu	21,000	Mwanza	12,000
Nkhotakota	10,000	Thyolo	46,000
Ntchisi	9,000	Mulanje	42,000
Dowa	21,000	Phalombe	17,000
Salima	24,000	Chikwawa	33,000
Lilongwe Rural	29,000	Nsanje	17,000
Lilongwe City	63,000		
Mchinji	12,000		
Dedza	16,000		
Ntcheu	12,000		

Annex 17: Indicators of the impact of the epidemic in 2003 and 2010 assuming no reduction in HIV prevalence

Indicator	2003	Projection for 2010 assuming no reduction in prevalence
Annual number of AIDS deaths	87,000	96,000
Increase in the annual number of deaths to adults 15-49 due to AIDS	250%	260%
Increase in the number of tuberculosis cases due to AIDS	190%	18%
Life expectancy with and without AIDS	40/56	43/59

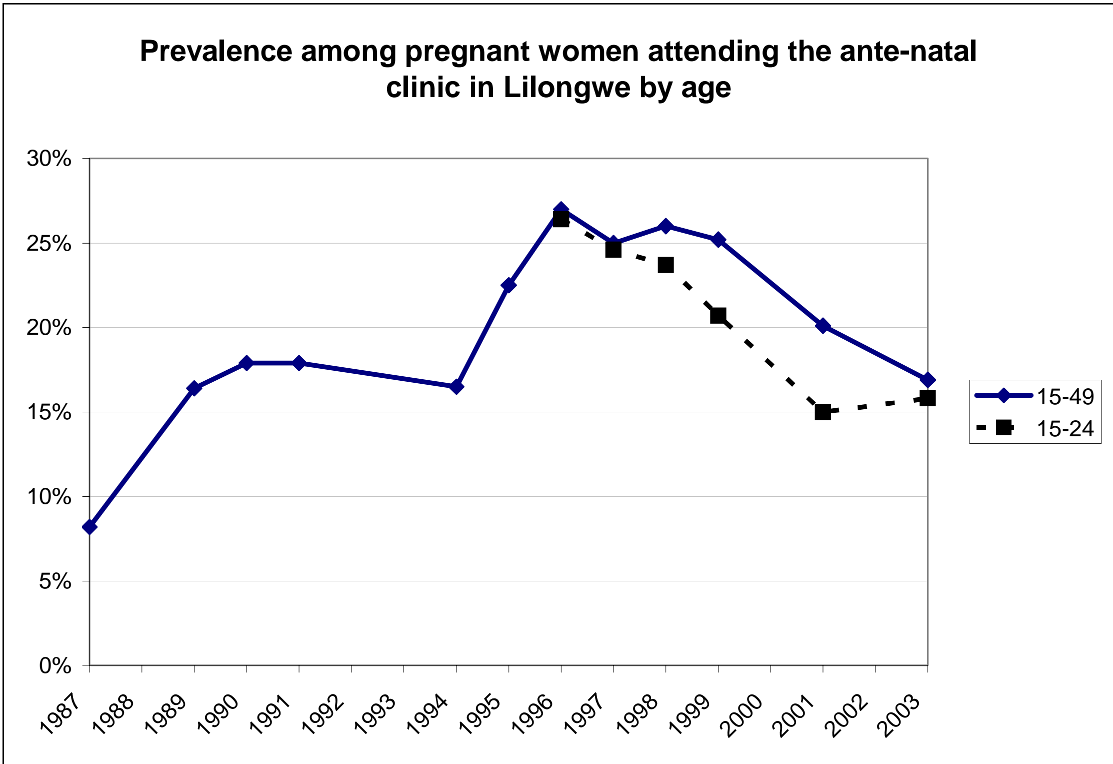
Source: National AIDS Commission 2003.

Annex 18: Indicators of the need for services 2003 and 2010 assuming no reduction in HIV prevalence

Indicator	2003	Projection for 2010 assuming no reduction in prevalence
Number of people needing advanced treatment including anti-retroviral therapy	170,000	190,000
Number of pregnant women in need of HIV counselling and testing	520,000	570,000
Number of HIV+ pregnant women needing anti-retroviral therapy to prevent transmitting HIV to their child	80,000	89,000

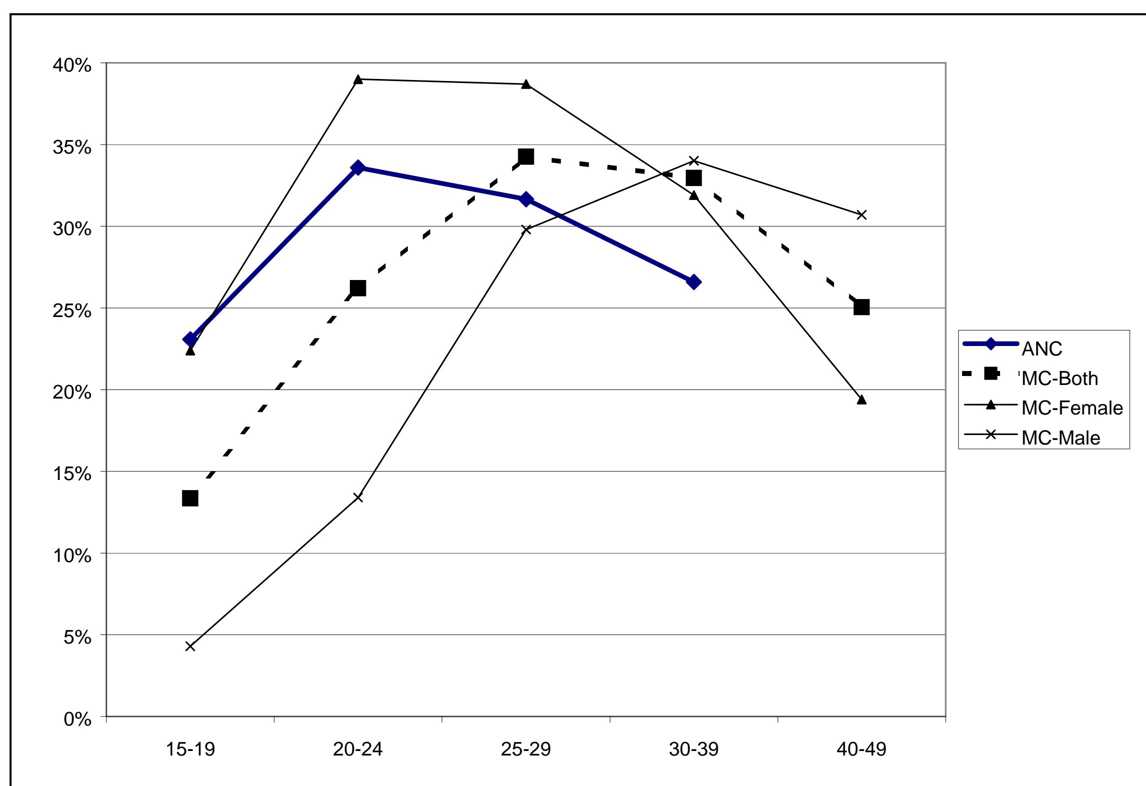
Source: National AIDS Commission 2003.

Annex 19: HIV prevalence among pregnant women attending the ante-natal clinic in Lilongwe



Source: National AIDS Commission 2003.

Annex 20: Comparison of ANC prevalence with general population prevalence for Kisumu, 1998



Annex 21: HIV/AIDS indicators for adults 15-49, 1982-2007

	1982	1987	1992	1997	2002	2007
HIV population						
Total	0	52,251	356,669	649,255	750,108	836,649
Males	0	30,015	163,141	272,798	316,875	355,928
Females	0	22,234	193,527	376,455	433,232	480,722
Prevalence	0.0	1.6%	9.3%	14.3%	14.4%	14.2%
New HIV infections						
Total	0	21,944	88,536	71,491	76,760	90,309
Males	0	11,541	37,494	30,411	34,270	39,368
Females	0	10,401	51,045	41,079	42,490	50,940
Incidence	0.0%	0.8%	3.0%	2.5%	2.4%	2.4%
New AIDS cases						
Total	0	619	9,065	38,344	59,958	64,887
Males	0	412	4,648	16,594	24,415	27,006
Females	0	206	4,419	21,751	35,542	37,884
Annual AIDS deaths						
Total	0	236	5,704	31,258	57,182	63,418
Males	0	159	3,040	13,758	23,211	26,158
Females	0	77	2,664	17,500	33,971	37,260

Source: National AIDS Commission 2003.

Annex 22: HIV/AIDS indicators for children under 15, 1982-2007

	1982	1987	1992	1997	2002	2007
HIV population						
Total	0	2,399	23,552	56,933	72,721	80,468
Males	0	1,198	11,698	28,075	35,633	39,318
Females	0	1,201	11,854	28,857	37,087	41,150
New HIV infections						
Total	0	1,537	12,176	23,041	25,630	27,072
Males	0	773	6,118	11,578	12,879	13,603
Females	0	765	6,058	11,463	12,751	13,469
New AIDS cases						
Total	0	352	4,859	14,941	20,205	21,735
Males	0	174	2,385	7,297	9,840	10,593
Females	0	178	2,474	7,644	10,365	11,142
Annual AIDS deaths						
Total	0	343	4,773	14,760	20,018	21,568
Males	0	169	2,336	7,186	9,722	10,484
Females	0	174	2,437	7,574	10,296	11,084

Source: National AIDS Commission 2003.

Annex 23: Percentage distribution of population age

Area, sex &education level	Age (years)													
	Total	< 10	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Malawi														
Both sexes	**100.**	**100.**	**100.**	**100.**	**100.**	**100.**	**100.**	**100**	**100**	**100**	**100.**	**100.**	**100.**	**100.**
None	32.5	43.4	12.5	15.6	25.6	31.1	34.0	38.4	42.6	45.3	46.9	50.1	57.9	65.6
Primary	59.1	56.6	86.9	71.6	54.7	53.0	53.3	50.8	47.3	46.5	45.5	44.3	38.4	32.6
Secondary	8.1	0.0	0.6	12.8	19.3	15.2	11.9	10.0	9.2	7.5	6.8	5.0	3.3	1.7
University	0.3	0.0	0.0	0.0	0.3	0.7	0.8	0.8	0.9	0.7	0.7	0.5	0.4	0.2
Males	**100.**	**100.**	**100.**	**100.**	**100.**	**100.**	**100.**	**100.**	**100**	**100**	**100.**	**100.**	**100.**	**100.**
None	26.1	44.9	12.7	12.3	17.7	21.8	23.1	25.4	28.7	31.3	32.0	34.5	40.6	49.9
Primary	62.5	55.1	86.5	73.9	54.8	55.7	58.2	58.5	56.1	56.0	55.8	56.3	52.6	46.8
Secondary	10.9	0.0	0.6	13.8	27.0	21.5	17.5	15.0	14.0	11.7	11.0	8.4	6.0	3.0
University	0.5	0.0	0.0	0.0	0.5	1.0	1.2	1.2	1.3	1.1	1.2	0.8	0.6	0.3
Females	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
None	38.6	41.9	12.1	18.7	31.9	40.2	45.0	51.1	56.6	59.3	62.1	66.6	73.2	79.4
Primary	55.8	58.1	87.2	69.4	54.7	50.3	48.3	43.4	38.5	37.1	35.1	31.7	25.8	20.0
Secondary	5.4	0.0	0.7	11.9	13.2	9.1	6.3	5.1	4.5	3.2	2.6	1.4	0.9	0.5
University	0.2	0.0	0.0	0.0	0.2	0.4	0.4	0.4	0.4	0.4	0.3	0.2	0.2	0.1
Northern region														
Both sexes	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
None	15.8	28.4	3.5	4.4	7.7	10.3	12.4	16.3	20.4	24.2	28.2	31.7	37.7	44.2
Primary	72.9	71.6	95.9	79.6	65.7	67.8	70.3	68.2	65.5	63.9	60.9	60.2	56.3	52.5
Secondary	11.0	0.0	0.6	15.9	26.4	21.4	16.8	15.0	13.6	11.4	10.2	7.6	5.6	3.1
University	0.2	0.0	0.0	0.0	0.3	0.5	0.5	0.5	0.5	0.5	0.6	0.5	0.4	0.2
Males	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
None	12.0	29.7	3.6	3.5	5.1	6.7	7.4	8.3	10.4	12.3	14.5	16.7	21.3	27.7
Primary	72.5	70.3	95.8	80.1	58.2	61.1	66.6	66.8	66.6	67.9	66.4	68.8	67.5	66.3
Secondary	15.1	0.0	0.5	16.4	36.2	31.5	25.8	23.9	22.0	18.9	18.0	13.6	10.5	5.6
University	0.4	0.0	0.0	0.0	0.4	0.8	0.8	0.9	0.9	0.9	1.1	0.9	0.7	0.3

Area, sex &education level	Age (years)													
	Total	**< 10**	**10-14**	**15-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65+**
Females	**100.**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
None	19.4	27.0	3.4	5.3	9.7	13.6	34.0	17.4	23.6	29.6	40.6	46.3	52.5	60.2
Primary	73.3	73.0	96.0	79.2	71.7	74.1	53.3	74.5	69.5	64.5	56.0	61.9	46.3	39.0
Secondary S	7.1	0.0	0.6	15.5	18.3	12.1	11.9	8.0	6.7	5.6	3.2	1.7	1.3	0.7
University	0.1	0.0	0.0	0.0	0.2	0.2	0.8	0.2	0.2	0.1	0.2	0.1	0.1	0.1
Central region														
Both sexes	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
None	33.3	44.6	13.0	16.4	27.4	32.3	34.9	38.9	43.5	46.8	50.1	58.4	65.5	65.5
Primary	59.2	55.4	86.5	72.0	55.4	53.6	53.9	51.6	47.7	46.4	45.1	38.5	32.9	32.9
Secondary	7.2	0.0	0.6	11.6	16.9	13.4	10.5	8.8	8.1	6.2	4.4	2.7	1.4	1.4
University	0.3	0.0	0.0	0.0	0.3	0.6	0.7	0.7	0.8	0.7	0.5	0.4	0.2	0.2
Males	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
None	27.5	46.5	13.9	13.7	19.7	23.2	24.6	26.5	30.3	33.1	32.8	36.0	42.3	50.6
Primary	62.6	53.5	85.6	74.1	56.8	57.5	59.4	59.7	56.7	55.5	56.3	56.0	52.2	46.8
Secondary	9.5	0.0	0.5	12.3	23.1	18.4	15.0	12.8	11.8	10.4	9.9	7.2	4.9	2.4
University	0.4	0.0	0.0	0.0	0.4	0.8	1.1	1.1	1.2	1.1	1.1	0.7	0.6	0.3
Females	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
None	39.1	42.3	12.1	19.0	33.7	41.9	46.0	51.7	57.5	59.0	61.5	65.5	72.9	78.8
Primary	55.9	57.2	87.3	70.0	54.3	49.5	47.9	43.2	38.0	37.7	36.0	33.0	26.2	20.6
Secondary	4.9	0.0	0.6	11.0	11.8	8.1	5.6	4.6	4.1	2.9	2.3	1.3	0.7	0.4
University	0.2	0.0	0.0	0.0	0.2	0.4	0.4	0.4	0.4	0.4	0.3	0.2	0.2	0.2
Southern region														
Both sexes	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
None	36.1	46.5	14.6	17.9	28.8	35.1	38.7	43.4	47.7	49.7	52.0	55.2	63.1	69.2
Primary	55.3	53.5	84.7	69.1	51.2	48.8	48.5	45.9	42.2	42.2	40.8	39.4	33.3	28.5
Secondary	8.2	0.0	0.7	12.9	19.6	15.3	11.9	9.8	9.1	7.2	6.5	4.8	3.1	2.0
University	0.4	0.0	0.0	0.0	0.4	0.8	0.9	0.9	1.0	0.8	0.8	0.6	0.4	0.3
Males	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
None	28.5	47.9	14.7	13.5	19.2	24.2	25.9	28.6	31.9	33.9	35.6	37.9	45.1	53.2
Primary	59.6	52.1	84.7	72.1	52.1	52.8	55.2	55.3	52.8	53.8	52.8	53.2	48.6	42.9
Secondary	11.1	0.	0.6	14.3	28.1	21.8	17.6	14.7	13.9	11.2	10.2	8.0	5.7	3.5

Area, sex &education level	Age (years)													
	Total	**< 10**	**10-14**	**15-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65+**
University	0.6	0.0	0.0	0.0	0.6	1.2	1.4	1.4	1.5	1.1	1.3	0.9	0.2	0.4
Females	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
None	43.3	45.2	14.5	22.0	36.1	45.4	51.2	57.3	62.8	65.0	68.4	73.2	79.2	63.1
Primary	51.0	54.8	84.7	66.3	50.5	45.0	41.9	37.1	32.1	31.4	28.6	25.1	19.7	16.1
Secondary	5.4	0.0	0.7	11.6	13.1	9.1	6.4	5.2	4.5	3.2	2.6	1.5	0.9	0.6
University	02	0.0	0.0	0.0	0.3	0.5	0.5	0.4	0.5	0.4	0.4	0.3	0.2	0.2

Annex 24: Percentage distribution of economically active population

Area and Occupation	Total			Urban			Rural		
	Both	Male	Female	Both	Male	Female	Both	Male	Female
Malawi	**100.0**	**100.0**	**100.0**	**100**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Professional and Technical	2.8	3.6	2.0	11.6	9.3	17.4	1.7	2.5	1.0
Administrative and Management	0.2	0.3	0.0	1.2	1.5	0.7	0.0	0.1	0.0
Clerical and related	1.3	1.8	0.8	8.8	8.1	10.5	0.4	0.7	0.1
Sales	5.3	7.1	3.4	23.2	23.0	23.7	3.1	4.2	2.1
Services	2.8	4.6	1.0	15.8	17.7	11.0	1.2	2.3	0.3
Agriculture, Animal and Forestry	82.5	73.3	91.6	17.1	11.5	30.9	90.3	84.5	95.6
Production and Related	4.1	7.1	1.1	15.9	20.7	4.2	2.7	4.7	0.8
Transport and Equipment	0.1	0.2	0.0	0.5	0.6	0.1	0.0	0.1	0.0
Operation and Laboratory	1.1	2.0	0.2	5.8	7.5	1.5	0.5	1.0	0.1
Northern region	**100.0**	**100.0**	**100.**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Professional and Technical	3.6	4.9	2.4	12.2	9.6	17.9	2.7	4.1	1.4
Administrative and Manager	0.1	0.2	0.0	0.6	0.8	0.2	0.0	0.1	0.0
Clerical and Related	1.1	1.7	0.6	7.5	7.3	7.9	0.4	0.7	0.2
Sales	5.3	6.0	4.6	25.4	23.1	30.5	3.1	3.3	3.0
Services	2.6	4.5	0.8	14.8	18.2	7.2	1.3	2.3	0.4
Agriculture, Animal and Forestry	81.8	73.9	89.7	19.2	14.2	29.7	88.7	83.4	93.5
Production and Related	4.6	7.5	1.8	15.7	20.1	5.8	3.4	5.5	1.5
Transport and Equipment	0.1	0.2	0.0	0.2	0.2	0.0	0.1	0.1	0.0
Operation and Laboratory	0.7	1.3	0.1	4.4	6.0	0.8	0.3	0.5	0.0
Central region	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Professional and Technical	2.6	3.3	1.9	11.8	9.4	18.5	1.6	2.2	0.9
Administrative and Manager	0.1	0.2	0.0	1.2	1.4	0.7	0.0	0.0	0.0
Clerical and Related	1.1	1.5	0.6	8.5	7.9	10.1	0.3	0.5	0.1
Sales	4.0	5.9	2.0	23.8	25.1	20.6	1.8	2.7	0.9
Services	2.4	3.8	0.9	15.5	16.9	12.0	0.9	1.6	0.2
Agriculture, Animal and Forestry	86.1	78.7	93.7	18.7	13.1	33.7	93.7	89.8	97.3

Area and Occupation	Total			Urban			Rural		
	Both	Male	Female	Both	Male	Female	Both	Male	Female
Production and Related	2.9	5.0	0.7	15.0	19.2	3.5	1.5	2.6	0.5
Transport and Equipment	0.0	0.1	0.0	0.2	0.3	0.1	0.0	0.0	0.0
Operation and Laboratory	0.8	1.4	0.1	5.1	6.7	0.9	0.3	0.5	0.0
Southern region	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Professional and Technical	2.7	3.5	1.9	11.4	9.2	16.5	1.6	2.4	0.9
Administrative and Manager	0.2	0.3	0.1	1.4	1.6	0.7	0.0	0.1	0.0
Clerical and Related	1.5	2.1	0.9	9.3	8.5	11.4	0.5	0.8	0.2
Sales	6.3	8.4	4.3	22.3	21.4	24.5	4.3	5.9	2.8
Services	3.2	5.4	1.1	16.1	18.3	11.1	1.6	2.9	0.4
Agriculture, Animal and Forestry	79.6	68.4	90.2	15.5	9.7	29.2	87.8	79.9	94.6
Production and Related	4.9	8.9	1.2	16.7	21.9	4.4	3.4	6,3	1.0
Transport and Equipment	0.1	0.2	0.0	0.7	1.0	0.1	0.0	0.1	.0
Operation and Laboratory	1.5	2.7	0.3	6.5	8.5	2.0	0.8	1.6	0.2

Annex 25: Reported average children ever born per woman for Malawi

Age group	1997 CENSUS	1982 DS	1984 FFS	1987 CENSUS	1992 DHS	1998 CENSUS
15-19	0.5	0.4	0.4	0.4	0.3	0.4
20-24	2.0	1.9	1.8	1.9	1.7	1.7
25-29	3.6	3.6	3.4	3.5	3.2	3.1
30-34	5.0	5.1	4.5	4.9	4.9	4.5
35-39	6.1	6.4	5.8	6.0	5.9	5.5
40-44	6.7	7.1	6.6	6.8	6.9	6.3
45-49	6.9	7.3	6.8	7.1	7.3	6.7

Annex 26: Estimated number of births by age of mothers in Malawi

Age group	Number of women	Adjusted ASFR	Estimated number of birth	Percentage of birth in age group
15-19	560,071	0.1	75,781	15.3
20-24	543,922	0.3	164,492	33.1
25-29	398,552	0.3	112,441	22.6
30-34	298,161	0.2	69,330	14.0
35-39	245,784	0.2	44,812	9.0
40-44	180,542	0.1	19,593	3.9
45-49	166,498	0.1	10,075	2.0
TOTAL	2,393,530	1.3036	496,524	100.0
TFR		6.5		

Annex 27: Average household size for Malawi, regions & districts

Area	Average number of persons per household	
	1987	1998
Malawi	**4.0**	**4.3**
Northern	**4.8**	**5.1**
Chitipa	4.9	4.9
Karonga	5.3	4.9
Nkhata Bay	4.7	4.9
Rumphi	4.7	5.0
Mzimba	4.6	5.2
Likoma	5.3	5.2
Central	**4.3**	**4.5**
Kasungu	4.4	4.9
Nkhotakota	4.0	4.6
Ntchisi	4.6	4.7
Dowa	4.5	4.5
Salima	3.9	4.2
Lilongwe	4.3	4.3
Mchinji	4.4	4.6
Dedza	4.3	4.3
Ntcheu	4.4	4.3
Southern	**3.7**	**4.1**
Mangochi	4.0	4.0
Machinga	4.1	4.1
Zomba	4.0	4.0
Chiladzulu	4.2	4.0
Blantyre	4.0	4.1
Mwanza	4.3	4.3
Thyolo	4.2	4.1
Mulanje	4.2	4.1
Phalombe	4.1	3.9
Chikwawa	4.5	4.5
Nsanje	4.3	4.5
Balaka	4.1	4.2

Annex 28: Percentage distribution of heads of households by age and sex

Age group	Total	Female	Male
Total	100	30.7	69.3
Under 15 years	100	47.1	52.9
15-19 years	100	52.1	47.9
20-24 years	100	34.1	65.9
25-29 years	100	24.3	75.7
30-34 years	100	25.5	74.5
35-39 years	100	28.0	72.0
40-44 years	100	29.3	70.7
45-49 years	100	29.6	70.4
50-54 years	100	30.1	69.9
55-59 years	100	29.8	70.2
60-64 years	100	35.3	64.7
65-69 years	100	36.4	63.6
70-74 years	100	39.9	60.1
75-79 years	100	37.8	62.2
80-84 years	100	43.4	56.6
85 years +	100	43.0	57.0

Annex 29: Percentage distribution of persons with at least one radio, one bicycle and one oxcart

	Total persons	With at least one radio	With at least one bicycle	With at least one oxcart
Malawi	**100.0**	**49.9**	**40.7**	**5.2**
Urban	100.0	75.7	30.7	2.5
Rural	100.0	45.6	42.4	5.6
Northern region	**100.0**	**51.1**	**36.8**	**7.5**
Urban	100.0	74.9	42.5	4.8
Rural	100.0	47.6	36.0	7.9
Chitipa	100.0	39.6	30.9	2.6
Karonga	100.0	46.7	44.2	5.7
Nkhata Bay	100.0	50.5	21.3	3.2
Rumphi	100.0	60.5	40.1	7.3
Mzimba	100.0	52.9	39.6	10.4
Likoma	100.0	57.3	4.2	1.6
Central region	**100.0**	**47.6**	**42.7**	**7.3**
Urban	100.0	73.8	31.8	2.4
Rural	100.0	43.4	44.4	8.1
Kasungu	100.0	56.3	52.3	11.8
Nkhotakota	100.0	52.5	38.6	1.5
Ntchisi	100.0	44.7	37.6	9.0
Dowa	100.0	44.3	42.4	10.0
Salima	100.0	41.3	44.2	3.3
Lilongwe	100.0	52.3	41.4	5.5
Mchinji	100.0	46.1	56.0	11.5
Dedza	100.0	35.6	40.4	9.0
Ntcheu	100.0	42.4	30.6	4.6
Southern region	**100.0**	**51.6**	**40.0**	**2.6**
Urban	100.0	77.3	27.1	2.1
Rural	100.0	47.0	42.3	2.7
Mangochi	100.0	42.2	41.4	2.5
Machinga	100.0	48.2	55.8	3.7
Zomba	100.0	53.0	46.3	2.8
Chiladzulu	100.0	46.9	35.1	1.6
Blantyre	100.0	68.2	23.1	2.0
Mwanza	100.0	47.4	32.6	5.1
Thyolo	100.0	49.8	27.0	1.6
Mulanje	100.0	46.3	45.6	1.6
Phalombe	100.0	44.6	55.5	3.2
Chikwawa	100.0	52.2	53.9	3.4
Nsanje	100.0	46.7	39.3	5.6
Balaka	100.0	51.1	44.1	2.6

Annex 30: Facts about Malawi

Indicator	Women	Year	Men	Year
Life Expectancy at Birth	44		40	
Crude Birth Rate (per 1,000 people)	37.9			
% underweight children under 5 severely underweight	5.9			
% severely stunted children under 5	24.4			
% of births with medical prenatal care	91.4			
% of births with medical assistance at delivery	55.6			
Infant Mortality Rate (per 1,000 live births)	103.8			
Under 5 mortality rate (per cent)	188.6			
Total Fertility Rate (births per woman)	6.3	1998		
Adolescent Fertility Rate (births per 1,000 women aged 15-19)	151	1999		
% Children/teenagers (aged 10-14) married	2.3	2000	2	2000
% of children or teenagers (aged 15-19) married	38.2	2000	8.3	2000
Unmet need for family planning	30	1998		
Maternal Mortality Ratio (per 100,000 live births)	1120	1998		
Risk of unintended pregnancy (per cent of married women aged 15-19)	36	1999		
Contraceptive prevalence (all women)	25.0	200		
Contraceptive Prevalence (per cent of married women)	30.6	2000		
Alimi or farmers as per cent	90.2	1998	66.8	1998
Employee	4.8	1998	21.2	1998
Family Business	2.1	1998	2.8	1998
Self Employees	2.8	1998	8.8	1998
Employer	0.1	1998	0.3	1998

Annex 31: Indicators used for HIV/AIDS programming (from the National HIV/AIDS Strategic Framework)

The Framework has suggested broad performance indicators. Specific targets for these indicators are developed by the implementing agency. The following performance indicators have been recommended for each component.

Culture and HIV/AIDS

- Increase in debate and discussion of values, beliefs and practices that influence the course of the epidemic.
- Increase in advocacy for change in sex related values, beliefs and practices.
- Participation of traditional and opinion leaders in HIV/AIDS control and care activities at community levels.
- Participation levels of men and women, boys and girls in the care and support of the chronically ill.
- Changes in negative attitudes towards women and people living with HIV/AIDS.
- Changes in content and practices in traditional education institutions for girls and boys.

Youth, social change and HIV/AIDS

- Increase in and quality of IEC materials and messages addressing youth development issues.
- Programmes and materials on human sexuality education and training for schools, youth organizations and youth communities.
- Participation and leadership of youth in HIV/AIDS activities and related development issues.
- Improved knowledge and changes in attitudes to human rights and freedoms and their exercise.
- Decline in media materials that negatively affect youth character development.
- Increase in dialogue and communication among socialising institutions.
- Policy and legal reforms and enforcement of laws and policies protecting children and the youth.

Socio-economic status and HIV/AIDS

- Increase in advocacy work on issues of gender and the course of the HIV/AIDS epidemic.
- Gender awareness and training programmes within sectors and communities with regard to HIV/AIDS in the family.
- Policy and legal reforms highlighting gender relations and the status of girls and women.
- Increase in access to credit and business training for boys and girls, men and women.
- Increase in knowledge and observance of policy, law and human rights with regard to gender equity and equality.
- Balance in access to education and training opportunities between boys and girls of school-going ages.

Despair and hopelessness

- Improved knowledge and skills in dealing with HIV/AIDS among spiritual leaders, traditional leaders and stakeholders.
- Changes in approaches to HIV/AIDS and attitudes towards PLWHAs among religious leaders and in religious organizations.
- Increase in and quality of materials and messages addressing issues of hope, faith and compassion particularly at community levels.
- Numbers and activities of associations and coalitions of PLWHAs, affected individuals, families and communities.
- Quality and extent of psycho-social support to PLWHAs, orphans, widows and widowers and other affected persons.
- Changes in language and language images that encourage negative attitudes towards the epidemic.

HIV/AIDS management

- Efficiency in referral arrangements for PLWHAs between hospitals and home based care support groups.
- Increase in health provider knowledge of treatment, care and counselling needs of PLWHAs.
- Adequate care and support resources available for programmes and activities.
- Increase in coordination forums and mechanisms for joint planning and exchange of experiences among stakeholders.
- Quality and extent of HIV/AIDS workplace programmes in the public and private sectors, NGOs and religious organisations.
- Changes in human resource management policies, incorporating HIV/AIDS and issues raised by the epidemic.
- Increase in supply of drugs, protective materials and facilities for PLWHAs and care providers.
- Quality and effectiveness in the utilisation of HIV/AIDS management guidelines in hospital and community support groups.
- Changes in health provider attitudes towards PLWHAs, affected individuals and families.
- Availability of adequate and improved data to manage the HIV/AIDS epidemic.

HIV/AIDS and orphans, widows and widowers

- Changes in policy and increase in awareness of policy, laws and human rights affecting orphans, widows and widowers.
- Increase in advocacy and community action in support of orphans, widows and widowers.
- Increase and coverage of training and education programmes for orphans, widows and widowers.
- Number of income generation and resource mobilisation activities targeting orphan support in communities and institutions.
- Decline in cases of property grabbing and abuse of orphans, widows and widowers in both rural and urban communities.

- Availability of adequate and improved data and information on numbers and situations of orphans, widows and widowers nationwide.
- Increase in collaboration and coordination activities among institutions providing care and support to orphans, widows and widowers.

Prevention of HIV transmission

- Increase in counselling services on abstinence and mutual faithfulness among youth and adults.
- Programmes on sexuality and family life education targeting families, communities and educational institutions.
- Counselling programmes for families, educational institutions and communities on behaviour change and HIV/AIDS/STIs.
- Increase in the practice of safer sex behaviours, particularly among young people.
- Decline in STI incidence in sexually active populations.
- Increase in access to condoms by sexually active populations in rural and urban areas and in institutions.
- Increase in access to anti-retroviral therapies by HIV positive pregnant women.
- Increase in the supply of safe blood in health institutions offering blood transfusion services.
- Improved knowledge about and adherence to infection control procedures in health institutions, traditional health clinics, home based care activities and other relevant settings.

HIV/AIDS information, education and communication

- Increase in collaboration and networking forums and related mechanisms in the design of messages and materials.
- Improved quality and distribution of messages and materials: relevance, targeting, content, coverage of social groups.
- Levels of participation of IEC agents and final users in the development of messages and materials.
- Increase in the participation of media personnel and institutions in the preparation and dissemination of HIV/AIDS messages and materials.
- Participation of traditional and opinion leaders in HIV/AIDS education at community levels.
- Levels and quality of knowledge of the nature, transmission modes, risk behaviours and impact of HIV/AIDS at personal, family, community and national levels.
- Increase in access to and utilisation of IEC programmes, particularly by rural populations.
- Increase in the participation of boys and girls in HIV/AIDS education activities as beneficiaries and as agents of change.

Voluntary counselling and testing

- Increase in the numbers and effectiveness of counsellors supporting PLWHAs and promoting VCT at all levels of society.
- Level and extent of involvement of religious leaders and institutions in creating a conducive environment for VCT.

- Quality, distribution and utilisation of IEC messages and materials on the benefits of VCT for various social groups.
- Participation of both HIV positive and negative persons in giving testimonies on the benefits of VCT.
- Increase in and quality of VCT services at all levels of society.
- Numbers of people utilising VCT services and quality and amount of follow up support.
- Effectiveness of integrating clinical services, VCT services and home based care systems.

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