KANENGO AIDS SUPPORT ORGANIZATION-KASO

COMMUNITY EMPOWERMENT FOR THE ELIMINATION OF NEW HIV INFECTIONS AMONG CHILDREN AND WOMEN IN RURAL MALAWI.

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SITUATION ANALYSIS: MALAWI

Maternal and child health

The health indicators for the population of Malawi have remained consistently poor over the last two decades. According to UNICEF, the life expectancy at birth for the Malawi population is now estimated at 40 years having dropped from 45 years in 1995.

The under-five mortality ratio is 118per1, 000 live births in 2009 and infant mortality rate is 69 per 1000 live births (NSO, 2009). Nevertheless, the maternal mortality ratio of 1,120 per 100,000 live births (MoH, 2009), combined with a high neonatal death rate is a clear indicator of inadequate/poor care of women within communities and a lack of integrated HIV prevention, PMTCT and ART and Sexual Reproductive Health-SRH Information and services especially in rural villages.

HIV/AIDS epidemiology

In Malawi, the HIV prevalence among adults 15-49 years old who were tested for HIV between June 2006 and July 2007 varied nationally from 8.2% in Ntchisi to 30.4% in Chiradzulu and 30.6% in Mangochi. The percentages were lower during this period compared to 2005-06 HMIS data when Chitipa reported 8.7% being positive and Phalombe reported 57.0% as positive among those receiving HTC. "This continuing wide variation among the districts may either be a reflection of differences in sero prevalence or attributable to differences in characteristics of persons seeking HIV testing in the districts (MoH, 200b p.30).

Like all other countries in sub-Saharan Africa, the major mode of transmission of HIV is heterosexual intercourse and it accounts for over 75% of transmission in the general population. With respect to pregnant women in Malawi, about 220,935 (33.5%) of the total expected 659,382 pregnant mothers tested for HIV in antenatal clinics between June 2006 –July 2007, which is almost twice the number (110,367 or 17.3%) – "out of the total expected 637,894 pregnant mothers tested during 2005-06 and six-times the percentage reported in 2004-05 when 5.3 % out of the annual expected 617,059 pregnant mothers were HIV tested and received results (MoH, 200b p. 30).

The HIV prevalence in pregnant women varied from 2.7% in Ntchisi District to 24.3% in Thyolo District respectively. In 2006, the data from country wide survey on HIV/AIDS services revealed a total of 137,996 HIV tests were recorded at ANC (equivalent to 56% of booking visits) of which 19,120 tests were positive (13%) (MoH, Lighthouse Trust, CDC, 2006). In 2007, estimates at selected sites indicate HIV prevalence in antenatal women age 15-49 as17.1% in urban areas, 16.4% in semi-urban areas and 12.1% in rural areas -- projected total national prevalence as 12.9% (NAC, 2007). In 2007, the MoH national percentage for HIV prevalence in pregnant women is 11.6 (MoH, 2007b). Expected deliveries between July, 2007and June 2008 are 659,382 and the national HIV prevalence in pregnant women is 11.6% (MoH, 2007b). With no PMTCT interventions, an estimated 30-45%, or 197,815 – 296,722infants will be HIV exposed. This number can only be reduced by half by assuring comprehensive access to quality PMTCT and Sexual Reproductive health-SRH information and services nationwide.

Regarding women, HIV/AIDS data indicate a gender bias in terms of transmission vulnerability and subsequent risk of infection. The prevalence of HIV is 30% higher among women compared to men (13.3% vs. 10.2%). In the younger age groups (15-24 years) prevalence is four times higher among women. For example, the HIV sero prevalence in housewives at selected sites is estimated at 15 –

20.8% compared to men with varied occupations except subsistence farmers who had the highest prevalence.

Kanengo AIDS Support Organization-KASO is implementing this programme as part of a National- Scale up plan in Malawi on PMTCT aimed at eradicating new HIV infections among children and keeping their mothers healthy and alive.

SPECIFIC PROGRAMME INTERVETIONS

KASO is building individual and community capacities to promote and deliver PMTCT and Sexual Reproductive Health-SRH information and services at the community levels. So far, this is being done through the following community focused interventions.

- Building of community structures to educate, promote and advocate for PMTCT, ART and SRH issues at the community level
- Providing bicycles to the PMTCT committees to facilitate their mobility to provide the education, promotion and empowerment on these issues
- Building community capacities to promote and deliver PMTCT, ART and SRH and Life Skills information and services.

OUR VISION

The vision of the PMTCT programme is to have an HIV free generation in Malawi.

THE GOAL OF OUR PROJECT PROGRAMME

The goal of this programme is to reduce pediatric HIV infection and improve the quality of life of parents living with HIV or AIDS.

PARTINERSHIPS

In order to sustainably empower communities and individuals to promote and deliver PMTCT and SRH services, KASO is working with different partnerships in Malawi and beyond. These partnerships are ensuring that the programme will be efficient in bringing PMTCT and SRH services to rural communities, create real empowerment for women and men to actively participate in PMTCT, HIV prevention and SRH and Family planning interventions and services. KASO is working with local hospitals, Health Care Centers, Community Based Organizations and SRH service providers. KASO has also been working with The Elizabeth Glazer Pediatric AIDS Foundation-EGPAF. EGPAF has been providing technical assistance and capacity building to KASO for effective delivering on PMTCT, SRT, ART and HIV prevention strategies.

A. Building of community structures to educate, promote and advocate for PMTCT, ART and SRH issues at the community level

Kanengo AIDS Support Organization aims to leave communities that are equipped to provide PMTCT, SRH and ART education and services in a sustainable way after this project. Based on this quest, this project first phase has consisted of setting up and building the community structures for the capacity

building and delivery of this project. The first activity under this was conducting Orientation meetings with community leaders: This was the very first step in our project implementation. KASO has focused implementation of this project in 2 TAs in Northern Lilongwe district. These are TAs Chitukula and Kabudula. From these geographical areas, KASO is working with 33 villages. The orientation specifically targeted these villages' community leaders. The purpose of the orientations was to provide information and seek community leader's permission to work together with KASO in delivering this project.

The community leaders oriented were chiefs, volunteers, religious leaders and others. After the orientation the community leaders then went back to their villages to mobilize communities for a community awareness and sensitization meetings which then followed. The general sensitization meetings are targeting the community as a whole with information and knowledge to do with the project and PMTCT, ART and SRH as the issues. The women groups on PMTCT were then formed from during and from these sensitization meetings.

Figure 1: During the orientation: Community leaders and volunteers discuss strategies of bringing PMTCT and ART messages to communities.

B. **Providing bicycles to the PMTCT committees to facilitate their mobility to provide the education, promotion and empowerment on PMTCT, ART and SRH and Life Skills.**

After establishing the community structures for the promotion of PMTCT, this programme then provided them with the bicycles for the easy travel in providing the leadership and education on PMTCT. A total of 20 bicycles have been procured and distributed to these communities which they are using to travel to provide education, advocate for more male/husbands involvement in PMTCT and other SRH activities at the family and community levels and also the bicycles are being used to transport pregnant women to ante natal clinics where they are very far from their villages.

C. Building community capacities to promote and deliver PMTCT, ART and SRH information and services

Upon finishing setting up the community structures to bring PMTCT and ART right at the community level, the next phase has been to provide empowerment to communities through training community educators of PMTCT and ART. The training has produced 30 fully trained community educators who are now raising awareness and providing education to the community.

Figure 2: Empowering the most vulnerable with HIV and SRH information and life Skills: A girls' session in progress.

The goal of our community capacity building is to give of the **structure**, **process** and **strategies** of Prevention of Mother to Child Transmission (of HIV).Specifically, we aim to achieve the following objectives:

- To provide information and introductory skills on the essential components of a PMTCT programme, including the prevention of HIV; prevention of transmission from mother-to child; provision of care to HIV-infected women, children and their families
- To facilitate the reduction of HIV-related stigma and discrimination and promote community linkages by empowering the volunteer worker to collaborate with community services
- To increase the capacity of programme managers and healthcare workers in resource limited settings to deliver PMTCT services
- To help develop or strengthen PMTCT training plans

Figure 3: Group discussions: Women from Mwachipha PMTCT committee in a heated discussion during the training.

Figure 4: A community capacity building in PMTCT and SRH in Progress.

Figure 5: Participants demonstrating the use of drama to disseminate information on PMTCT, ART AND SRH at the community level.

Figure 6: Targeting girls of child bearing age with SRH and Life skills empowerment.

3. CHALLENGES OUR PROGRAMMES CURRENTLY FACES

There has been a clear sign that men are more reluctant to partake in the PMTCT activities at the community and family levels. Through the sensitization and monthly meetings we have been conducting, it has clearly been observed that women have been attending in large numbers as compared to men. KASO has learnt from this and we have agreed to work at more advocacy strategies for the involvement and participation of men in the activities at the community levels.

The other thing that this programme has faced is the lack of skilled community educators trained in counseling. It has been vividly shown that counseling MUST part and parcel of providing education and skills in PMTCT and ART. This is clearly more vital when it comes to couple counseling and encouraging families to get tested for HIV, encourage men participation in PMTCT,ART and HTC work and when it come to providing vital information to discordant couples. The counseling skills are also very important when providing information to young peoples either genitive to remain negative or positive so that they can start living positively and avoid infect others with the HIV virus or infect themselves with more strains of HIV. All these initiatives need counselors at the community levels or rather the community educators need more skills and detailed training in counseling for their effective delivery. KASO needs to build capacities for the communities in counseling so that they can conduct couple counseling and increase male involvement at the community level.

Some villages are also very far and hard to reach with the education and are also very far from any health center or hospital. To this end, there are challenges in terms of traveling to these villages and reach families. KASO needs to provide more effective means of transportation for community educators to enable them reach any households with the information and message on PMTCT, ART and SRH information and education.

4. CONCLUSION

Over the past 12 months, it has vividly been shown that successes is possible in bringing PMTCT and ART close to communities and families to reduce the number of HIV infections among children regardless of their locality and remoteness. We have built community structures to deliver and promote PMTCT, HTC, HIV/AIDS and ART information and services, started to generate demand for these services, for more men involvement in PMTCT and related activities at the community and family levels. The change we aim to see has started to be fashioned in the crucible of community work and participation. By orienting community leaders and training 30 participants in PMTCT and ART, this project has started to empower communities so that they are able continue the dialogue, education and promotion of PMTCT.

We also have created linkages with local services providers to all the support groups for women and men living with HIV/AIDS and ensured that communities are not only informed but also that they are able to access PMTCT, ART and SRH services from service providers. We also would like to thank ViiV Health Care/PACF for the Technical Assistance we are undergoing being provided by the Elizabeth Glazer Pediatric AIDS Foundation. This has proved to be very crucial has it has already improved our skills in managing and monitoring PMTCT and other community led projects in a more effective and sustainable way. An HIV free generation is possible in Malawi: It has to start with all of us. It has to start with empowering communities and most vulnerable people and it has to start right now.