UNIVERSITY OF ICELAND

EMERGENCY HEALTH SERVICE LINKAGES FOR STREET CHILDREN FOLLOWING SEXUAL ABUSE IN LILONGWE, BLANTYRE AND ZOMBA CITIES IN MALAWI.

HEALTH LINKAGES FOR STREET CHILDREN

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EXECUTIVE SUMMARY

The “Health Linkages for Street Children” project addresses the long-neglected and proliferating public health problems of human immuno-deficiency virus (HIV) infection and pregnancies among street children in Malawi. The problems largely stem from childhood sexual abuse and marginalized intersectional identities of the street children that make it difficult to access emergency public health services following sexual abuse. The purpose of this project is to improve equitable, inclusive and gender-sensitive access to emergency health services, such as the HIV Post-Exposure Prophylaxis (PEP) and Emergency Contraceptive Pills (ECPs) for street children aged 7 to 17 years, residing in Lilongwe, Blantyre and Zomba cities in Malawi.

By using three interlinked pathways, this project will first aim to understand the experiences and health needs of the street children. Secondary, use this evidence to create survivor-centred and gender-sensitive space and staff for service delivery. Lastly, empower street children, particularly girls, with peer-led influencing to encourage them to make their own decisions on their health. Activities will be implemented over three years and six months of evaluation. The first activity will be baseline assessment, which will guide gender mainstreaming, service providers' capacity building, and integrating emergency health services in three street-based rehabilitation centres in Lilongwe, Blantyre and Zomba. Next, the project will link these services to the street girls who are significantly marginalized by creating segregated girls-only safe spaces within the rehabilitation centres. Additionally, demand for services will be created through mass community awareness campaigns and peer-led influencing.

Using intersectionality and gender mainstreaming at all levels, the project will offer inclusive, value-based, and equitable health care for street girls and boys. Moreover, activities shift beyond biomedical services to address social factors, essentially reducing vulnerability to sexual abuse and associated health problems. Overall, implementation will cost € 287.280 and led by a consortium of two organizations working on street children and adolescent health. Through the consortium and partnership with government ministries, there will be sustained capacity, skills mix of staff and strengthened collaboration to outsource resources for sustainability of the services.

Key words: Street children, sexual abuse, HIV Post Exposure Prophylaxis, Emergency Contraceptive Pills, Intersectionality, Gender Mainstreaming

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ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
ART	Anti-Retroviral Therapy
CRC	Convention on Child Rights
DALYs	Disability Adjusted Life Years
ECPs	Emergency Contraceptive Pills
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
KAP	Knowledge Attitudes and Practices
MoU	Memorandum of Understanding
NPA	National Action Plan
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
SDGs	Sustainable Development Goals
STIs	Sexually Transmitted Infections
UN	United Nations
UNP	United Nations Development Program
USAID	United Staes Agency of International Development
WHO	World Health Organization

INTRODUCTION

1.1 Problem Overview

Sexual abuse is ever-present in the lives of the street children in Malawi. It happens everywhere, takes every form, and almost goes unchallenged. The universality of sexual abuse on the streets proffers its occurrence meaningless and often erased from our collective consciousness, reinforcing the notion that the young, impoverished, and precarious street children are invisible and easily disposable in the cracks of abuse in Malawian societies.

Sexual abuse among street children in Malawi is a long-neglected gendered health problem that renders a double burden of HIV infection and adolescent pregnancies (Ministry of Health, 2018). About 1 in 5 girls and 1 in 7 boys are exposed to sexual abuse before 18 years of age in Malawi, and two-thirds of girl victims experience multiple occurrences of sexual abuse (Ministry of Gender Children Disability and Social welfare, 2014). Evidence has also estimated the prevalence of HIV to be 4.6% among children subjected to sexual abuse and that 33% of girls exposed to sexual abuse become pregnant (Chesshyre & Molyneux, 2009; Ministry of Gender Children Disability and Social welfare, 2014). These alarming health consequences situate sexual abuse as an emergency public health crisis.

In Malawi, public health services such as HIV PEP, which reduce the average risk of HIV transmission by 81% and ECPs, which minimize the risk of pregnancy by 95%, are provided within 72 hours of exposure to sexual abuse (Ellis et al., 2005; World Health Organization, 2016). These emergency health services are available at multiple health facility points, but legal notifications are required before they can be provided (Mulambia et al., 2018). The medical-legal pathways present enormous structural barriers and time-lapse for street children to seek and access emergency health services (Mandalazi et al., 2013). Street girls are particularly vulnerable and are compounded by the intersectional marginalization due to identities on the streets, such as gender, sex, age, and social-economic status (Crenshaw, 1991; Mandalazi et al., 2013).

Pilot projects in Malawi showed that providing integrated medical and legal services in one location significantly increased the accessibility of emergency health services within 72 hours of exposure to sexual abuse (Mulambia et al., 2018). It is also evident that applying Intersectionality (Crenshaw, 1991) and gender mainstreaming (UN Women, 2020) in health care can address the intersectional social determinants of health to promote inclusive and responsive health services (Theobald et al., 2017). Therefore, this project centres on structural

inequalities presented in the pathways to emergency health services among street children following sexual abuse in Malawi; a long-standing problem that stems from the protracted nature of sexual abuse on the streets and the gendered intersectional social factors that exacerbate street children`s vulnerability to HIV infection and adolescent pregnancies.

1.2 Background Information

Malawi is predominantly a young population. As of 2020, Malawi had approximately 19.1 million people (Word Bank Group, 2019), of whom 51% were children under 18 years old (National Statistic Office, 2019). In addition, an estimated 11% of children under 18 years are orphaned by HIV and Acquired Immuno-Deficiency Syndrome (HIV and AIDS), from which 0.4% are street children and 0.1% potential street children (National Statistic Office, 2019).

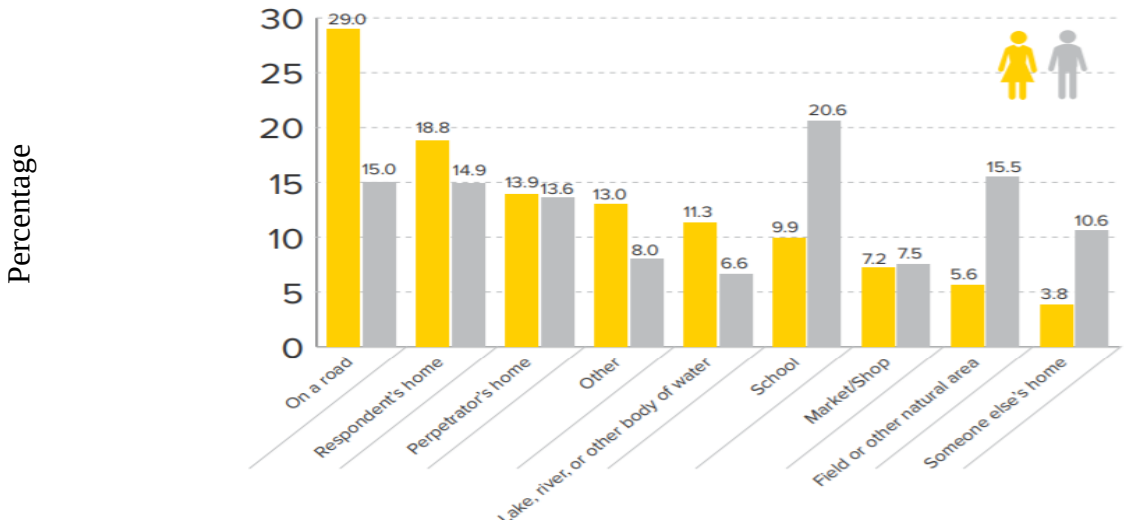
The United Nations (UN) describes street children in relation to their livelihood association of the street. For example, children who live and sleep on the street or work on the street but return to their homes to sleep (United Nations, 2017a). In all these descriptions, the dependability on the street economy for survival is the common denominator, shaping their identities in societies (United Nations, 2017a). In 2013, approximately 8,000 children were predicted on living and working on the street of Malawi's major cities: Lilongwe, Blantyre, Mzuzu, and Zomba (Mandalazi et al., 2013). Over the recent years, these numbers have doubled, although the exact estimates are difficult due to the precarious movements of street children in search of a better livelihood (Crewes et al., 2015)

Nearly 80% of street children were estimated to have lost both parents due to the HIV and AIDS epidemics (Mandalazi et al., 2013). The culminating burden of HIV and AIDS, combined with grinding levels of poverty, breakdown of family structures and domestic violence, contributed to the increase in the number of children resorting to the streets (Crewes et al., 2015). Furthermore, Malawi is among the poorest countries in the world, ranking low on the 2020 Human Development Index (HDI) at 174 out of 189 countries and territories across the globe (UNDP, 2020). In 2020, half of the total population in Malawi (50.7%) were estimated to live below the national poverty line surviving on less than 1.2 US dollars per day (National Statistical Office, 2020). Most of whom belonged to women-headed households in rural and urban slums, who also bear the care burden for orphans and street children (National Statistical Office, 2020).

Correspondingly, the Gender Equality Index of Malawi by 2020 ranked very low, with a value of 0.565, and characterised by significant reproductive health disparities for girls and women (UNDP, 2020). For example, the adolescent birth rate in 2017 was approximately 132 per 1,000 women aged 15 to 19 years (Mgawadere et al., 2017). Adolescent pregnancies were also projected to contribute to 15% of the maternal deaths rate in Malawi, estimated at 439 per 100,000 live births, with significant causes being haemorrhage, obstructed labour, sepsis, and complications of unsafe abortion (Mgawadere et al., 2017).

By 2019, the national prevalence of HIV was 9.2% among those aged 15 to 49 years, with approximately 38,000 new cases of HIV infections recorded that year (UNAIDS, 2019). Although Malawi has implemented several efforts to control the HIV epidemic, significant age and gender disparities in new HIV infections persist. For example, one-third of all new HIV infections (14,000) in 2019 occurred among young people aged 15 to 24 years, of which two-thirds (9,900) occurred among girls (UNAIDS, 2019). Further, the prevalence of HIV and AIDS is more severe in the urban areas, particularly in Malawi`s major cities, such as Blantyre, Zomba and Lilongwe, where most street children rely on their livelihood (Nutor et al., 2020).

The age and gendered disparities in HIV infection and reproductive health have been associated with increased childhood sexual abuse in Malawi (Ministry of Health, 2011). Almost 71.3% of girls and 68.1% of boys who have endured sexual abuse were between 14 and 17 years old when it occurred (Ministry of Gender Children Disability and Social Welfare, 2014). It is common for the abuse to take place on the roads and in schools and perpetrated by romantic partners, peers, or strangers (Ministry of Gender Children Disability and Social Welfare, 2014). The pervasiveness of sexual abuse among children in Malawi has been deeply rooted in our social norms that force young girls to have sex in preparation for marriage (Decker et al., 2018). This positions children (girls) as inevitable victims (Decker et al., 2018).



Locations of sexual abuse incidence among children aged 13-17 years

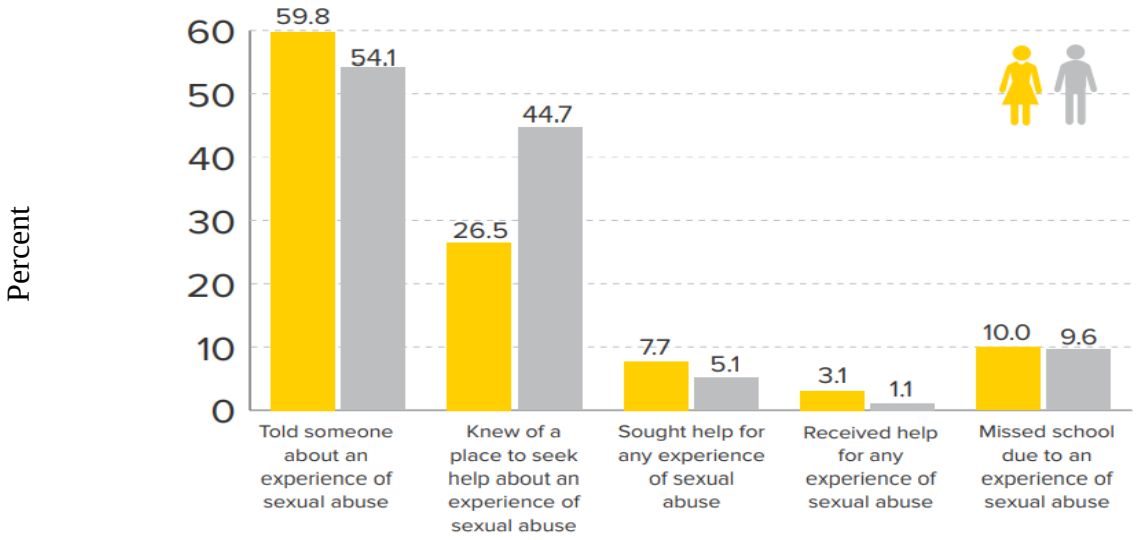
Figure 1: : Locations of exposure to sexual abuse among 13-17 years old in Malawi in the year 2013. (Ministry of Gender Children Disability and Social welfare, 2014) results section, page 70, figure 3.9

Note: "other" includes inside a car, bus, restaurants, clubs, workplace, guesthouse, public gathering places such as weddings, initiation ceremonies and church functions. Source: Violence Against Children and Young Women in Malawi findings from 2013 national survey; by

The higher percentage of children who have experienced sexual abuse on the roads is worrisome and likely to affect the most precarious group of street children (Crewes et al., 2015). A particular concern also relates to access to health services following sexual abuse. Although two-thirds of child victims of sexual abuse report it to their friends, relatives, or authoritative figures, only 10% receive professional services, including health care deemed necessary to reduce the risk of HIV infection and unplanned adolescent pregnancies (Ministry of Gender Children Disability and Social Welfare, 2014).

In most cases, victims of sexual abuse allude to the structural barriers of cost of transportation and time to avail medical-legal services at multiple points, as well as individual barriers such as fear of getting into trouble, fear of abandonment, fear of embarrassment, or fear of threats by the perpetrator for reporting to the police (Mason & Kennedy, 2014).

Further, evidence from Malawi indicates that parents of children who have been sexually abused lack trust in the medical-legal service system due to presumed police negligence and corruption (Mulambia et al., 2018). Although it has not been assessed, the mistrust in medical-legal services is also assumed to impact street children in Malawi (Crewes et al., 2015). While national efforts are in progress to address the barriers in medical-legal services within public health facilities, street children are a minority of the population whose specific gendered needs are often neglected, hence bearing the multifaceted inequities in accessing public health services (Crewes et al., 2015; UNICEF, 2012).



Sexual abuse disclosure, service seeking and usage among children in Malawi, aged 13 to17 years

Figure 2: Disclosure, service seeking and service usage among Malawian child victims of sexual abuse aged 13-17 years in the year 2013

Note: "**Sought help"** include physically availing to access emergency health services, legal and pyschosocial support. Although the percentage of girls who tell someone is high, most have lower knowledge of the available services. **Source:** Violence Against Children and Young Women in Malawi findings from 2013 national survey; by (Ministry of Gender Children Disability and Social welfare, 2014) results section, page 79, figure 3.11

2. CONTEXT ANALYSIS

2.1. Sexual Abuse and Street Children in Malawi

The concept of sexual abuse among children is a complex phenomenon, frequently debated and defined by specific demographic, legal, and social contexts across the globe (Murray et al., 2014). The World Health Organization (WHO) defines child sexual abuse as "the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society" (WHO, 1999). It encompasses sexual activities between an adult or another child, with differing power dynamics involving forced sexual intercourse or coercion, exposure to adult sexual activities, pornography, and child prostitution (WHO, 1999).

Countries have adapted this definition from WHO based on the national legal provisions for an age of consent. For example, in Malawi, chapter XV of the Penal Code depicts the legal age of consent to be 16 years (Government of Malawi, 2011). However, qualifying childhood sexual abuse with legal age of consent contradicts the Constitution of Malawi, which considers a person below 18 years to be a child (Government of Malawi, 2017). Therefore, this project adopts Malawi's constitutional definition of a child when referring to sexual abuse among street children.

In Malawi, the prevalence of sexual abuse among street children has not yet been determined. However, several studies have documented the sexual health risks behaviours that relate to sexual abuse among street children. Street children in Malawi operate in extreme depriving conditions (Mandalazi et al., 2013). The majority come from poor, dilapidated houses headed by older women and single mothers, while others sleep on the on-shop verandas, market benches, video showrooms, and bars (Crewes et al., 2015; Mandalazi et al., 2013). The lack of safer havens to sleep subject’s street children to sexual exploitation, including engagement in group sex or forced transactional sex in exchange for protection and safe shelter from markets security guards, businessmen, and older women in sex work (Mandalazi et al., 2013).

Additionally, the struggle to fit in within the challenging street environment compels children to drugs and substance use as a coping mechanism (Gondwe et al., 2019). The use of

drugs has been reported to increase risky sexual behaviours and increased vulnerability to contracting sexually transmitted infections (STI) by 2.5 times and 2.3 timely likely for HIV among street children (Chimdessa et al., 2017; Mandalazi et al., 2013).

"*I was once told by my friend that he was discharging pus from his genitals, when I asked him what the matter was, he said he was lured by peers to have sex with a strange girl sometime back. Since then, I don't know his whereabouts." Anonymous Street child*

Figure 3: Except from a street child in Malawi in 2013 , Source source (Mandalazi et al., 2013), page 2, paragraph 6

Note: Peer pressure was associated with drug and substance use and sin group sex. Also, girls were compelled to have sex with groups of boys in such circumstances.

Furthermore, street children in Malawi have been associated with ubiquitous sexualities, engaging in vaginal and anal sexual intercourse (Crewes et al., 2015; Mandalazi et al., 2013). Older street boys and security guards forcibly engage younger boys or girls in anal sex without the use of condoms for protection (Mandalazi et al., 2013). Boys exposed to anal sexual abuse have higher odds of engaging in anal transactional sex and having multiple sexual partners of the same or opposite sex (Embleton et al., 2015). This is a huge health concern, as anal sex is four times more likely to transmit HIV infections and other STIs than vaginal sex due to the thin mucosa membranes of the anus that easily tear (Baggaley et al., 2013). Thus, if preventive and emergency health service responses are not provided, this will result in a chain transmission of HIV infection and STIs among street children and the larger urban communities.

"*Watchmen /Guards offer us food and a place to sleep; when we sleep, they advise us to take off our clothes so that we shouldn't feel hot. Then they advise us to face the other side to keep away our bad smell in so doing they. indulge in anal sex with us" – Anonymous Street child*

Figure 4: Except from a street child in Malawi in 2013 , source (Mandalazi et al., 2013), page 3, paragraph 2

Note: young boys were commonly reported to sleep on the shop veranda with Watchmen/Guards, but sometimes young girls also slept in these places

2.2. Gendered Factors Affecting Girls on the Streets

Street girls are a minority group within the Malawian cities. In 2015, an enumeration study in two cities in Malawi indicated that about 2,389 children aged 7 to 15 years old lived and worked on the streets of Lilongwe and 1,776 children on the streets of Blantyre (Crewes et al., 2015). However, only 1 in 5 children were estimated to be girls (Crewes et al., 2015). A correspondence baseline assessment led by Mlambe Health and Social Trust (MhEST) in Zomba in 2019 also reported about 1,000 children living and working on the streets, of whom 96% were boys (Gondwe et al., 2019).

Evidence suggests that the existing age and gender dynamics in livelihood activities play a role in concealing girls (Chikoko, 2014; Crewes et al., 2015; Mandalazi et al., 2013). In all the Malawian cities, almost half of the children are between the ages of 10 and 13 years and most boys are involved in visible scavenging, selling goods, and begging on the streets as a source of livelihood (Crewes et al., 2015). Girls within this age range are transitioning to adulthood and are socially expected to take up caregiving roles such as cooking, selling food, fetching water, and firewood on the streets (Crewes et al., 2015; Gondwe et al., 2019).

Correspondingly, younger girls accompany their brothers and adults with disabilities to beg on the streets (Crewes et al., 2015). The gendered livelihood roles render girls invisible and disposed of power to negotiate access to girls' spaces for work on the streets (Crewes et al., 2015). However, this distinction is worth making because it has reinforced the gender blindness for most organizations doing street children programming in Malawi, with interventions claimed mainly by the majority and visible street boys.

The care-related livelihood jobs in which girls engage do not provide enough income (Crewes et al., 2015). Functionality, of course, many street girls are young, but at the same time are systematised with adulthood gender roles to fulfil the financial support to their families, including supporting their brothers, single mothers, or vulnerable grandmothers in the urban slum communities (Crewes et al., 2015; Kaiser & Sinanan, 2020). This pseudo position compels girls to source extra income through transactional sex with businessmen and older street boys (Chikoko, 2014; Chimdessa & Cheire, 2018; Crewes et al., 2015). In some

cases, girls are forced to transact sex with businessmen through the influence of older women who are usually in sex work and benefit from the young girls' earnings (Gondwe et al., 2019; Mandalazi et al., 2013). The situation subject girls to a vacuum space of negotiating the power dynamics and surrendering to high-risk sexual abuse activities (Asante, 2015; Kaiser & Sinanan, 2020).

Without adequate health services, these vulnerabilities are likely to increase the risk of HIV infection, STIs and adolescent pregnancies. Adolescent pregnancies could eventually subject girls to complications and early childbearing, with their children going through the same circle of poverty, HIV and AIDs, street life and sexual abuse (Asante, 2015; Mandalazi et al., 2013).

Figure 5: Street children at the marketplace in Blantyre city, Malawi; far left are 2 girls, among 11 boys, and one of the girls is pregnant. Source: (Sangala, 2019) pg1

2.3. Child Sexual Abuse and Public Health in Malawi

Sexual abuse among children is “an emergency health crisis”(Veenema et al., 2015). It has devastating consequences on health, including unplanned adolescent pregnancies, the HIV burden, and injuries associated with childbirth (World Health Organization, 2020). These adverse health outcomes are likely to impede the attainment of three cross-cutting targets of the Sustainable Development Goal Three (SDG 3); “Good Health and Wellbeing” (United Nations, 2017b). SGD 3 target 1 (reducing maternal mortality ratio to less than 70 per

100,000 births and neonatal mortality ratio to 12 per 1000 live births), target 3 (ending epidemics, including HIV/AIDs), and target 7 (universal access to sexual and reproductive healthcare services) (United Nations, 2017b)

In Malawi, adolescent pregnancies contribute to 29% of all births (Mgawadere et al., 2017). This is a risk to the lives of young girls who have too underdeveloped reproductive organs to withstand higher risks of childbirth complications, reported as the lead cause of mortality among 15 to 19 years old girls (Geubbels, 2006; Mgawadere et al., 2017). Moreover, adolescent pregnancies are often unintended, and an estimated 30% end in unsafe abortions (Polis et al., 2017). The risk of unsafe abortions among street girls is particularly intensified by inadequate health services, unhygienic environmental conditions, and long-drawn sexual transactional activities (Mandalazi et al., 2013). This is worrisome, and complications of unsafe abortions are among the leading causes of maternal mortality among adolescent girls in Malawi (Polis et al., 2017). In addition, the risks of neonatal complications, such as premature birth, low birth weight, and birth asphyxia, are also higher in girls who are younger than 20 years old than older women (Mgawadere et al., 2017). These neonatal complications are also among the lead causes of neonatal mortality in Malawi, which is estimated at 29 per 1,000 live births as of 12th July 2021 (United State Agency for International Development [USAID], 2021).

The probable risk of new HIV infections related to sexual abuse among street children also alarms the public health sector in Malawi (Ministry of Health, 2018). HIV and AIDs is the culminating cause of mortality and Disability-Adjusted Life Years (DALYs) in the general population and presents substantial economic effects on Malawi, with 95% of the HIV and AIDS budget coming from donors (Oberth & Emma, 2018). For example, from 2017 to 2019, approximately 300 million US dollars was spent treating and caring for HIV and AIDS patients compared to 45 million US dollars spent on prevention (Oberth & Emma, 2018). The large share of the HIV treatment care budget also falls on adolescents and youth. Thus, the consequences of increased new HIV infection among street children pose a considerable economic risk and challenge the sustainability of HIV treatment and care in Malawi (Ministry of Health, 2018).

Globally**,** long term effects of childhood sexual abuse have been associated with subsequent violence in the future, with it being 14 times more likely for men to perpetrate physical and sexual violence and 16 times more likely for women to suffer physical or sexual

violence (World Health Organization, 2020). Sexual abuse has also been associated with interpersonal violence, with both women and men being 30 times more likely to attempt suicide (World Health Organization, 2020). Over half (52.6%) of girls who experience childhood sexual abuse in Malawi experience mental distress, and about 15% have thought of committing suicide (Ministry of Gender Children Disability and Social Welfare, 2014). Correspondingly, two-thirds of boys who experience childhood sexual abuse experience mental distress and report using drugs and substances, which can increase risky sexual behaviors (Ministry of Gender Children Disability and Social Welfare, 2014).

About 1 in 5 boy victims of sexual abuse and 1 in 10 girl victims engage in multiple sexual partners, which increases the risks for HIV transmission, STIs and adolescent pregnancies (Ministry of Gender Children Disability and Social welfare, 2014). These complex health consequences of child sexual abuse cannot be ignored, particularly in a country like Malawi, where young people are most of the population, and its development relies on them (National Statistic Office, 2019).

2.4. Relevant Policies and Programs

Malawi enacted several international and local policy programs to reduce and respond to childhood sexual abuse. At the international level, Malawi ratified the UN Convention on Rights of the Child (CRC) (United Nations, 2017a). Article 19 provides a legal obligation to develop national laws, administrative, social, and educational strategies to protect all children from all forms of violence (United Nations, 2017a). This obligation was translated by enacting the Child Care Protection and Justice Act in 2010 and the 2015 to 2019 National Action Plan (NPA) for orphans and vulnerable children (Government of Malawi, 2015). The NPA focused on improving access to services related to HIV, information on sexual reproductive health and services for 13 to 17 years old children (Government of Malawi, 2015). However, gaps in addressing the specific needs of street children have been documented, and recently the Malawi Ombudsman summoned the government of Malawi for its neglect actions on street children (Chizuma, 2019). As a result, the Ministry of Gender, Children, Disabilities and Social Welfare initiated a process of developing a special NPA for street children for 2021 to 2023 (Chizuma, 2019).

Malawi also adopted the WHO guidelines for providing emergency health services for victims of sexual abuse, including HIV PEP and ECPs within 72 hours of exposure, STI

treatment, and psychosocial services (World Health Organization, 2016). In addition, these services are legally guided by the Prevention of Domestic Violence Act (Government of Malawi, 2006). In response to existing medical-legal barriers, the Government of Malawi piloted the provision of legal, medical, and psychosocial services using the One-Stop Center (OSC) model within a tertiary hospital in Blantyre (Mulambia et al., 2018). This achieved 67.3% of 107 children arriving within 72 hours to initiate HIV PEP and ECPs (Mulambia et al., 2018). Within the model, challenges existed for lack of trust in police, financial resources for sustainability and transportation for follow-up care (Mulambia et al., 2018). The piloting of this model created opportunities to replicate a similar model for targeted population groups such as street children while addressing the presented challenges.

Malawi aligned SGD3 with the recent AIDS 2025 targets to achieve 95% HIV testing and treatment; 95% of women have HIV and sexual reproductive health needs met; and 95% of at-risk populations have combined preventing and treatment care (UNAIDS, 2021). In addition, the government of Malawi, in collaboration with the United States (US) President`s Emergency Plan for AIDs Relief (PEPFAR), implemented multisectoral services for HIV education, prevention, and response, with recently introducing HIV Pre-Exposure Prophylaxis (PrEP) which is highly effective in preventing HIV infection before the potential exposure to the virus (Stelzle et al., 2021).

However, street children have never been considered at-risk populations, and PrEP services have been narrowly targeted for the more visible at-risk groups such as female sex workers and adolescent girls in selected communities (Stelzle et al., 2021). Such intervention and policy gaps are worth noting and call for redefining the targeted interventions to address the needs of street children, who are equally a high-risk population group. Achieving this requires an in-depth understanding of specific needs to first tailor the intervention for continuum health care and generate evidence to inform future policies.

3. PROJECT JUSTIFICATION

3.1. Project Purpose

The overarching aim of this project is to reduce vulnerability to sexual abuse and associated health problems of HIV infection and adolescent pregnancies among street children aged 7 to 17 years by improving access to equitable, inclusive, and quality emergency health services (HIV PEP and ECPs) in Lilongwe, Zomba and Blantyre.

The project builds on Intersectionality (Crenshaw, 1991) school of thought and Gender Mainstreaming (UN Women, 2020) to establish an in-depth understanding of street children`s lived experiences, Knowledge, Attitudes and Practices (KAP) and gendered factors related to accessing emergency health services following sexual abuse. The findings will guide targeted health services, awareness, and empowerment strategies for street children to influence positive social behavioral change.

Further, the findings from the baseline survey that will be conducted will guide the creation of survivor centered and gender-sensitive spaces, to integrate emergency health service within street-based rehabilitation centers across Lilongwe, Blantyre and Zomba. The project will also build the capacity of service providers to deliver need-based, survivor-centered and gender-sensitive emergency health services to street children.

To reach out to more girls on the streets, the project will create girls-only spaces for accessing services within the rehabilitation centers. We believe this will create a safe space to build trust and encourage girls to utilize health services and referral to complementary legal and psychosocial care from partners organizations.

3.2. Problem Analysis

Gender

Gender is socially constructed and inextricable to the social organization between men and women (Bulter, 1990). The central assumptions are that the identity of a woman and a man is learned from repetitive actions or behaviors governed by society's social traditions (Butler, 1988). Traditionally, the identity of “woman” has historically been considered subordinate, insignificant, and sexually objectified to the man in the societies (Bulter, 1990).

These dynamics transcend the social interactions between girls and boys on the streets (Embleton et al., 2015; Mandalazi et al., 2013). Moreover, Malawian streets are predominantly male. The sexism that governs how boys connect with girls conspires to institutionalize and manifest patriarchy on the streets, a hierarchical power of dominance of men over women (Butler, 1988). Thus, reproducing social structures and practices where boys on the streets have the justifiable social power to oppress and exploit girls (Asante, 2015).

The visible biological maturation of girls during adolescence also sets a chronological passage from childhood to womanhood, triggering societal expectations of gender caring roles, marriage, and sexual conformities (Kaiser & Sinanan, 2020). These societal expectations make girls very vulnerable to sexual abuse on the streets (Asante, 2015). Street girls in Malawi have reportedly failed to negotiate working spaces on the streets. Instead, they are compelled to escort their brothers or adults with disabilities in begging activities or participate in forced sexual transactions, for example, with order businessmen to earn income for their families (Crewes et al., 2015; Mandalazi et al., 2013). This gendered disposal of girls in public spaces where they can access opportunities renders them invisible, silenced and with the limited agency to negotiate safe sex, seek and access health services (Kaiser & Sinanan, 2020).

Intersectional Identities of Street Children

The term Intersectionality was coined to understand the multi-layered oppressions and violence that African – American women faced, rooted in the politics of identities, such as race or gender (Crenshaw, 1991). The identities are socially constructed frameworks and allow the social powers to marginalize specific population groups, thereby interlocking systems of oppression that influence access to opportunities and privileges in society (Crenshaw, 1991). Similarly, unveiling the reasons for limited access to public emergency health services among street children is complex. It relates to the intersectional margins of their identities on the streets, including gender, sex, age, social, economic status, and geographical location (Bwambale et al., 2021; Mandalazi et al., 2013).

The Intersectionality of gender and age presents complex power dynamics in Malawian streets, which intentionally creates intersectional subordination of the youngest children and girls (Crewes et al., 2015). Almost 76% of street children in Malawi are within the adolescent age group of 10 to 13 years (Crewes et al., 2015). The younger children are

particularly vulnerable to being influenced by older children or adults to engage in risky sexual behaviors (Chimdessa et al., 2017; Mandalazi et al., 2013). For example, studies have indicated that young children aged 13 years and below are compelled to offer sex to older boys, who have more influence power on the streets (Mandalazi et al., 2013). In other cases, the perpetrators are businessmen or security guards from whom children seek refuge, money, and food (Embleton et al., 2015; Mandalazi et al., 2013). Thus, the age power dynamics may influence decisions to seek and access public health services, especially if children fear the retribution of perpetrators when safety and protection are not guaranteed (Mandalazi et al., 2013).

Girls on the streets face a double jeopardy of ageism (too young) and sexism (too female) to navigate the margins of gender and age powers (Crenshaw, 1991). In addition to serving patriarchy in forced transactional sex and care burden, girls are also positioned in the intertwined matriarchy-age power dynamics from older businesswomen, who have a profitable interest in young girls' sexual activities (Asante, 2015; Gondwe et al., 2019; Mandalazi et al., 2013).

Street children's identities also intersect with their socioeconomic status (Mandalazi et al., 2013). Most street children come from ultra-poor households and are forced to sleep in depriving exploitive conditions on the streets to source money, food, and social protection (Crewes et al., 2015). The need to earn money and food subject them to risky sexual behaviors and makes them unable to control who their sexual partners are (Mandalazi et al., 2013). Moreover, the requirement to avail at multiple points in accessing emergency health services is time-consuming for the children who need to work or beg for food every day. It subjects them to out-of-pocket expenditure for transportation (Bwambale et al., 2021). In addition, being homeless, in conjunction with low social and economic status, means that these children rank at the bottom of society, are mostly abandoned on the streets, and do not benefit equally from public health services (Malawi Ombudsman, 2019).

The syndicate for street children's intersectional marginalization relates to their identification by geographical location (United Nations, 2017a). The Malawian streets are associated with crime and inescapable scenes of violence. This conspires to produce an identity of street children as "hardcore criminals" and "perpetrators of violence" to be arrested by police (Embleton et al., 2015). For example, approximately 285 street children were arrested in Malawian cities from July to August 2021 on allegations of attacking people,

committing abuse, and other crimes (Namangale, 2021). While such crimes are valid, the problem of identifying street children with street activities, such as crimes, shifts away from the view of children as victims to be safeguarded and linked to appropriate services.

Moreover, the pathways to accessing medical services for sexual abuse consider the police the first point of care, presenting a structural barrier of fear of arrest (Crewes et al., 2015). The allegations and frequent arrest of street children also reproduce stigma and discrimination in society and public health facilities (Crewes et al., 2015; Gondwe et al., 2019). Unfortunately, these intersectional experiences are poorly understood in public health. Thus, interventions focus on the assumptions of the general population, in which children live within homes and with legal guardians to support them through the medical-legal processes (Mandalazi et al., 2013). This, although well intended, reinforces the structural exclusion of street children in Malawi.

Problems Analysis Tree

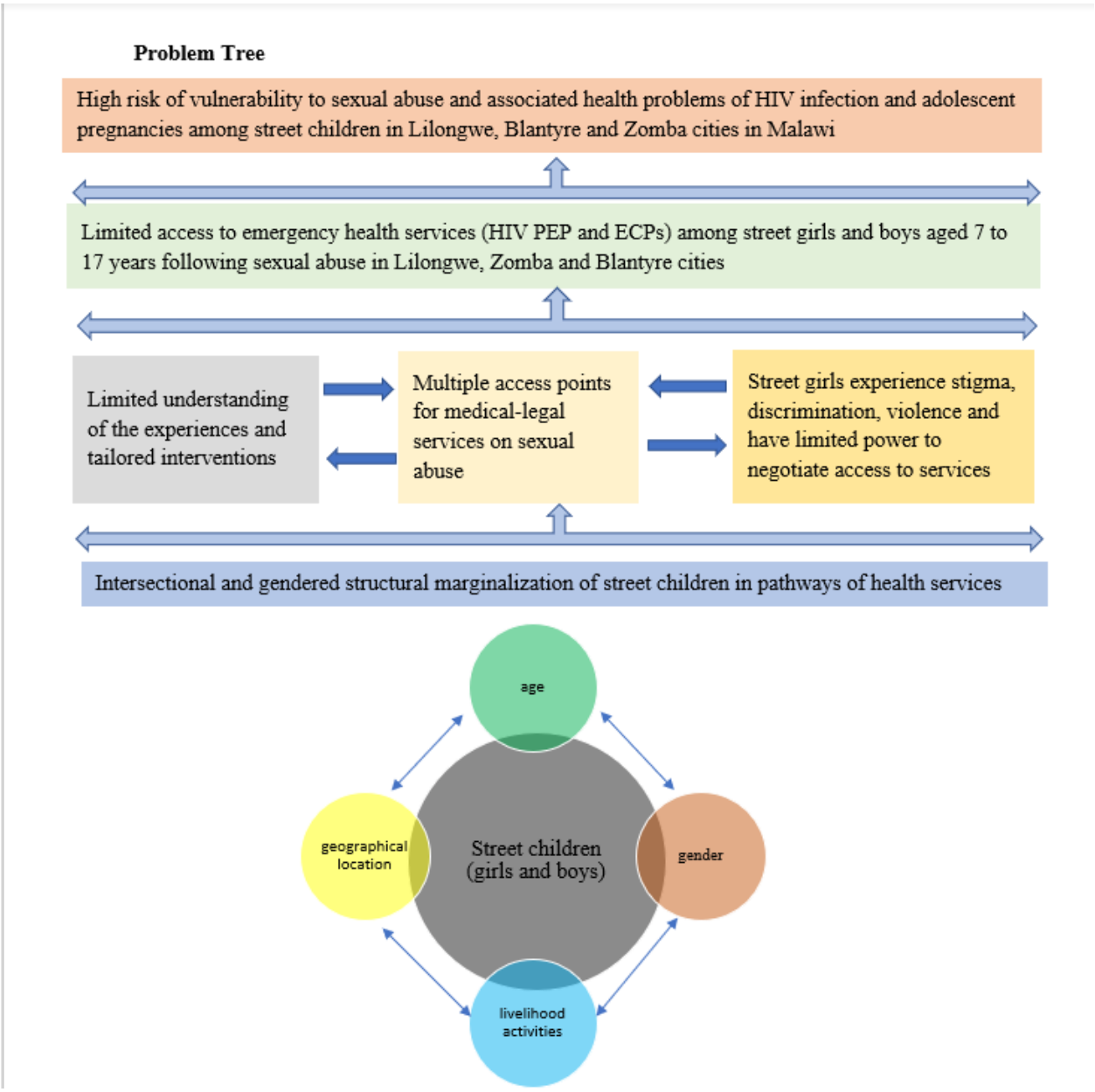


Figure 6: Summary of problems analysis

Note: Street children's vulnerabilities to sexual abuse and associated health problems of HIV infection and adolescent pregnancies result from the structural inequalities presented in the pathways to health services, which stem from the gendered and intersectional social factors that exacerbate street children`s vulnerabilities.

3.3. Project Theory of Change

This project's Theory of Change is premised on dual-track feminist approaches of Intersectionality (Crenshaw, 1991) and gender mainstreaming (UN Women, 2020). These are widely used approaches, effective in breaking through the structures of gender and other societal powers, and will help to provide gender-sensitive data used to improve health services (Theobald et al., 2017). The Theory of Change is also adapted from the One Stop Centre Model for emergency health service delivery following sexual abuse, which maximizes multisectoral services provided in one location (Olson et al., 2020). It is also premised on service provider capacity building and facility-level evaluations to enhance health service accessibility, acceptability and quality delivery for the survivors' wellbeing (Olson et al., 2020). Thus, this project`s Theory of Change encompasses the gender and intersectional lens and areas for implementing integrated emergency health services for street children.

The goal is to reduce sexual abuse vulnerability and associated health problems such as HIV infection and adolescent pregnancies among street children aged 7 to 17 years in Lilongwe, Blantyre and Zomba cities in Malawi (impact).

The goal will be attained by improving access to equitable, inclusive, and quality emergency health services among street children and collecting gender-sensitive data to inform need-based health service delivery (outcomes).

The Theory of Change will achieve the goals through three interlinked pathways of change that focus on: **(1)** understanding the intersectional and gendered needs of street children in accessing health services to map out gaps; **(2)** Creating survivor-centred and gender-sensitive space, segregated for girls, for integrated service delivery of emergency health services and **(3)** empowering street children, particularly girls to influence on social behaviour, attitudes and knowledge of their peers and to make decisions on their health.

Pathway 1: <u>understanding the intersectional and gendered needs of street children in accessing emergency health services</u>

In the first pathway of change, the project will centre on the often-not heard narratives of street children through a baseline assessment, using participatory methodologies. The baseline will assess Knowledge, Attitudes and Practices (KAP) among street children and

experiences around sexual abuse and access to services. Street children be positioned at the core centre to understand their own lived experiences through reflection and be empowered in the process. In addition, the application of Intersectionality in the baseline assessment will substantiate and convey the meaning of those experiences and ways of unlocking the intertwined social identities that reinforce their discrimination, limited agency, and exclusion in accessing public emergency health services (Crenshaw, 1991). Finally, the findings will be adapted for targeted awareness campaigns for demand creation of services, health service delivery and empowerment strategies for street children.

Pathway 2: Creating a survivor centred and gender-sensitive space for integrated service delivery of emergency health services

The project's second pathway will create survivor centered spaces by integrating emergency health services in street-based rehabilitation centres, offered with complimentary legal and psychosocial services from multisectoral stakeholders. In addition, the project will create specific girls-only areas within the rehabilitation centres by segregating the services to provide an enabling and gender-sensitive environment for girls to access services.

Fundamentally, service providers will be capacitated for continuous mentorship and monitoring of service delivery to ensure quality and survivor centred services. In addition, through the strengthened multisectoral partnership, the rehabilitation centres will be supplied with necessary medical supplies from the Ministry of Health and will use coordinated gender-sensitive data management and referral mechanism to other services, including psychosocial support, legal services, and other sexual reproductive health services.

Pathway 3: Empowering Street children to influence social behaviour, attitudes, and knowledge to make decisions on their health.

Leveraging on the project values of inclusion, participation, and equity of street children, the third pathway will focus on empowering street children to be at the forefront of learning about their experiences, contributing to solutions and influencing their social behaviours. Through peer-led education and mentorship initiatives, street children will lead information sharing, and ultimately influence behavioural changes among peers. This will increase participation and acceptability of the services, thereby improving street children's attitudes.

Theory of Change

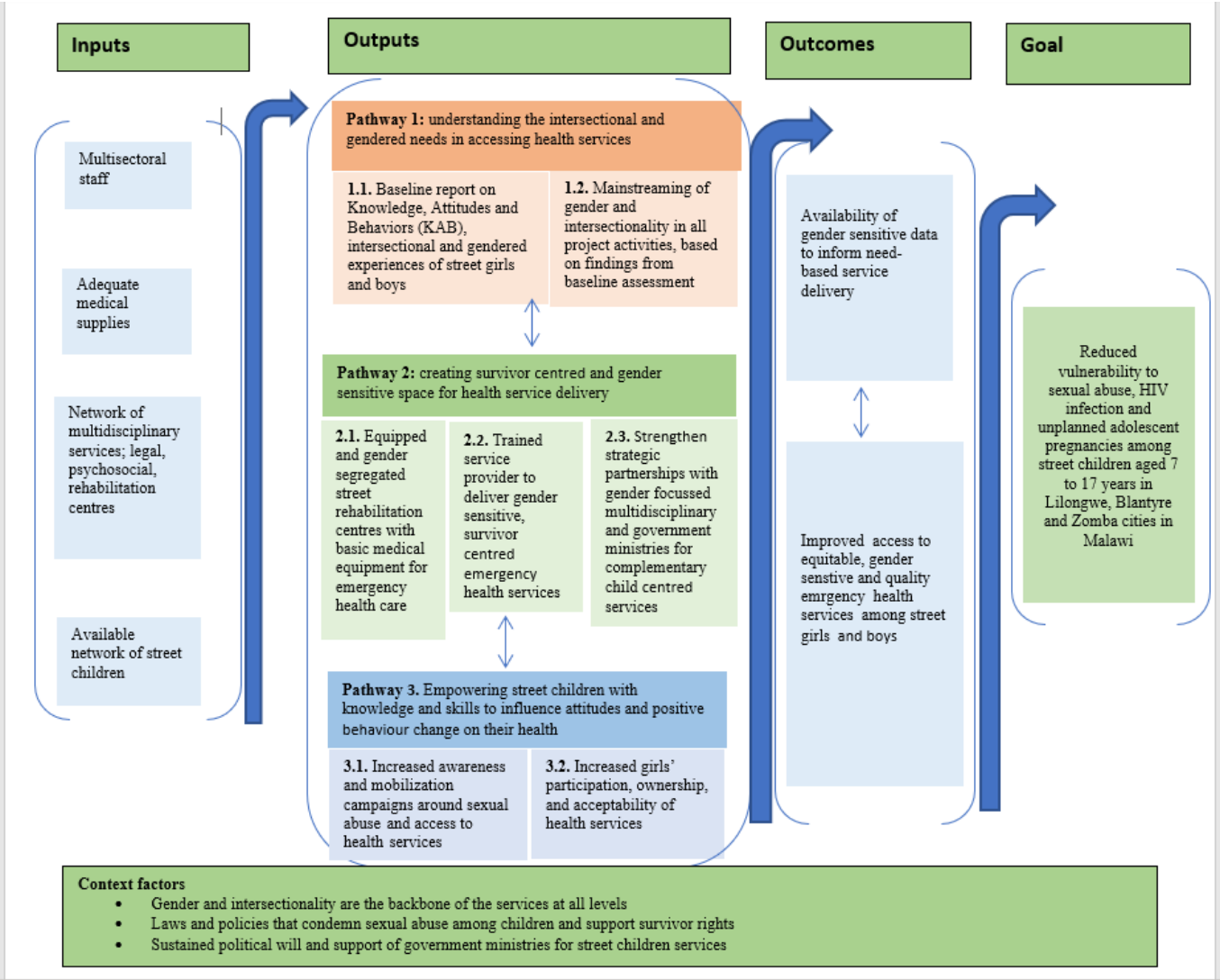


Figure 7: Project`s Theory of Change

Note: The three interlinked pathways of change will collectively contribute to improving accessibility of the emergency health services and generation of gender-sensitive data at all levels to inform service adaptation, essentially contributing to the overall goal of reducing vulnerability to sexual abuse, HIV, and adolescent pregnancies.

Source: adapted from the One Stop Centre Model Theory of Change, "The implementation and effectiveness of the one-stop center model for intimate partner and sexual violence in low- and middle-income countries: a systematic review of barriers and enablers" Pg 3, figure 1; (Olson et al., 2020).

3.4. Implementation Methods

The project will maximise bottom-up learning of service delivery, gender, and intersectionality-oriented health systems, multisectoral collaboration, and a children-friendly environment to deliver the services to street children in Malawi. A combination of these methodologies has been widely documented to promote inclusive, responsive and equitable health service delivery (Olson et al., 2020; Theobald et al., 2017).

Bottom-up learning of service delivery will amplify the power of meaningful participation of street children, learning from their lived experiences, and providing evidence-based services to address specific needs. Fundamental to our bottom-up learning is to position street children at the centre where they understand their experiences, make meaning of problems, co-create interventions and influence decisions concerning their health.

Gender and Intersectionality oriented health system strengthening is the basis for our health service delivery theory and methodologies, mainstreamed in awareness, capacity building and empowerment strategies for street children. Using gender and mainstreaming as methods, the project catalyses gender-segregated services, gender-sensitive data collection, analysis, and continuous adaptation to gendered needs throughout project delivery (Theobald et al., 2017).

Multisectoral participation, collaboration and influencing premises collaborate with multidisciplinary teams to deliver health services and complimentary referral services such as legal and psychosocial services. In addition, we will strengthen our collaborations with the Malawi Police and government ministries for cohesive, continuum care, data management, and reporting of our services for the evidence-based services delivery.

The street child-friendly environment is the primary characteristic of the rehabilitation centres where emergency health services will be integrated and provided. We want to ensure that this space is inclusive, survivor-centred, and values a street child when availing to services. By focusing on medical services as the first point of care, we will unravel the fears associated with legal services and open opportunities to centre on the needs of a child. We are also exceptionally reaching street girls by creating girls-only spaces to ensure an enabling environment to access care.

3.5. Capacity to Implement Project

The project proposes implementation through a consortium involving two local organizations and partnerships with Malawi police, Ministry of Health and Ministry of Gender, Children, Disabilities and Social Welfare. The local implementing organizations will have a track record in working with street children and adolescent health in Malawi, with additional capacity to support services in the rehabilitation centres.

Overall, a Project Technical Advisor (consultant) will manage the project. The Technical Advisor will develop the Terms of Reference (ToR) for organisational nomination, screening and delivery of services based on the framework of the project. Each partner will align the project delivery framework to managerial expertise, advocacy and influencing abilities. Potential local organizations to implement the project have been indicated in the stakeholder analysis with their interest to influence project delivery. Refer to appendix 4.

3.6. Collaboration with other Stakeholders

Organizations such as Youth Net and Counselling (YONECO), based in Zomba, and Mlambe Health and Social Trust are of high priority due to their ongoing work with street children in the targeted cities and previous experiences in delivering health services.

The project will also be implemented in partnership with the Ministry of Health, Ministry of Gender, Children, Disability and Social Welfare and Ministry of Justice, whose current priorities already centered on post violence care for survivors of sexual abuse. The Ministry of Health will be responsible for supplying medical commodities in the rehabilitation centres. The Ministry of Gender, Children, Disability and Social Welfare will be responsible for identifying child protection workers who will provide psychosocial support, referral to reintegration centres and follow-up care. Finally, the Ministry of Justice, through the Malawian police, will be responsible for legal investigation and ensure access to survivor-centred justice.

Further to these main stakeholders, the project will also establish strategic partnerships with organisations that focus on sexual reproductive health, HIV treatment and care, and

empowerment as complementary services to ensure holistic care. The stakeholder interests have been illustrated in the stakeholder analysis attached in Appendix 4.

3.7. Advocacy and Participatory Methods

The project utilizes participatory methodologies throughout, starting with the baseline, which will engage street children and key informant interviews from stakeholders mapped out for this project. The engagement of street children as the project's primary stakeholders provides a strong base for meaningful participation and acceptability of the project services. In addition, through awareness campaigns, advocacy and influencing strategies, other stakeholders on the streets such as women, businessmen or security guards will be targeted to participate, thereby channelling the information to the broader street community.

At the national level, the engagement of ministry departments, gender focused organizations, collaborative service delivery, and implementation. Consortium organizations also present an excellent opportunity for participatory advocacy, service delivery, monitoring and evaluation.

4. PROJECT FRAMEWORK

4.1.Project Goal

The overall goal is to improve access to equitable, inclusive, and quality emergency health services of at least 95% among street children aged 7 to 17 years in Lilongwe, Blantyre, and Zomba by June 2025.

The project's goal is aligned to the newly developed AIDS 2025 targets, in which target number 5 calls for "95% of people at risk of HIV infection use appropriate, prioritized, person-centered and effective combination prevention options by 2025" (UNAIDS, 2021).

4.2.Project Objectives

4.2.1. Explore the Knowledge, Attitudes, and Practices (KAP), and experiences around sexual abuse and emergency health services among street boys and girls aged 7 to 17 years in Lilongwe, Blantyre, and Zomba in Malawi by June 2022.

4.2.2. Establish three gender-sensitive and survivor-centred spaces for integrated emergency health service delivery for street girls and boys in Lilongwe, Blantyre, and Zomba by September 2022 and ongoing.

4.2.3. Empower at least 95% of street girls and boys with knowledge and skills to influence attitudes, health-seeking behaviours and decisions concerning their health by June 2025

4.3. Project Outcome

4.3.1. Improved access to equitable, inclusive, quality emergency health services, including HIV testing, HIV PEP, pregnancy testing, ECPs and condoms among at least 95% of street girls and boys, aged 7 to 17 years old in Lilongwe, Blantyre, and Zomba in Malawi by June 2025

4.3.2. Availability of gender-sensitive data to inform need-based service delivery

4.4.Project Outputs

Output 1: Available baseline assessment data on the level of street children`s knowledge, attitudes and practices, and the intersectional and gendered specific needs of girls and boys

Activity 1: Design and conduct a participatory baseline assessment survey on street children KAP and experiences around sexual abuse and emergency health services

This activity will be in an interview form and will be the first to be implemented. It will engage an external research consultant designing the research protocol, developing participatory methodologies, and ensuring gender and intersectionality questions are mainstreamed in the research tools.

Activity 2: Conduct gender-based and intersectionality analysis on the findings from the baseline assessment

Gender and intersectionality analyses will be conducted concurrently with baseline data analyses to produce a report that will consist of data on KAP levels, gender and intersectionality needs of girls and boys, data triangulation from critical stakeholders that substantiate experiences of street children

Activity 3: Conduct training on gender and intersectionality mainstreaming in project delivery with key implementing organizations, project administrative staff and key multisectoral partners

We will revise the overall project delivery framework using the baseline data, collaboratively with key implementing organizations and stakeholders to develop manuals for gender-sensitive awareness, peer-led education and mentorship programs, capacity building of service providers, and service delivery. Specifically, we will ensure gender-sensitive activities and indicators at all levels of the project and data tools that include intersectional and gendered variables at all levels of service delivery.

Output 2: Establish three survivors centred and gender-sensitive spaces to provide integrated emergency health services and complimentary referral services to legal and psychosocial care to street girls and boys in Lilongwe, Blantyre and Zomba

Activity 4: Identity, equip and create segregated services for girls and boys in three rehabilitation centres for emergency service delivery to street children by September 2022

Three rehabilitation centres will be identified, inspected and approved by the Ministry of Health and Ministry of Gender, Children Disability and Social Welfare to provide emergency health services for street children in Lilongwe, Blantyre and Zomba.

Girls-only spaces will be created within the rehabilitation centres to segregate the services by gender based on the girls' specific needs. In addition, all the rehabilitation centres will be equipped with essential medical equipment, commodities and supplies through the Ministry of Health supply chain system.

Activity 5: Recruit, train, and provide continuous mentorship of 6 Nurse/Midwife Technicians and 6 Community Facilitators on survivor centred, gender-sensitive and intersectionality-oriented health service delivery to street children by September 2022 and ongoing

A total of six nurses will be recruited. Each rehabilitation centre will have two nurses (one for boys and one for girls) and one medical assistant to deliver across the segregated health services. These health care workers will be trained on information related to sexual abuse, the context of street children in Malawi, gender-sensitive and survivor-centred provision of emergency health services and appropriate gender-sensitive data collection and management during service delivery. Further, we will conduct monthly rehabilitation centre monitoring and mentorship support for service providers.

Recognizing that the emergency health services will be provided with complimentary services from legal and psychosocial points of care, we will add a representative from the Malawian Police, child protection workers, and the administrative staff of the project in training.

Activity 6: Provide integrated emergency health services to street boys and girls and referral to complementary legal and psychosocial services

Once the rehabilitation centers have been provided with both equipment and staff skills, provision of emergency health services and referrals to complementary services will start. To ensure the preliminary promotion of the services, we will hold a street launch of service delivery in the three cities and subsequently offer the services within all three rehabilitation centers.

As a starting point, the rehabilitation centres will run health services during the daytime, however, the rehabilitation centres will also offer temporary shelters for street children with the support of child protection workers. Thus, survivors can quickly come at night and be guided to health services during the day opening hours.

Activity 7: Establish and strengthen strategic partnerships with government institutions and gender focussed organizations for complementary legal, psychosocial and other services

We will develop a Memorandum of Understanding (MoU) with key implementing stakeholders for multisectoral and multidisciplinary service provisions for street children. Additionally, we will participate in district quarterly project review meetings, joint advocacy and awareness campaigns, and rehabilitation centre evaluations to strengthen these partnerships.

Output 3: Increased participation of 95% of street girls and boys aged 7 to 17 years in health service awareness campaigns, peer-led education, and mentorship activities by June 2025

Activity 8: Conduct monthly awareness campaigns and mobilisation sessions of street children on information related to sexual abuse and available health services

Gender-sensitive and intersectionality tailored Information Education and Communication (IEC) materials about forms of sexual abuse, available pathways to access emergency health services, and information about the services, including HIV PEP, ECPs and condoms, will be developed. These materials will conduct monthly awareness campaigns in the three cities by targeting street business areas, urban slum communities, and rehabilitation centres where street children access other essentials such as food. In addition, the materials will be distributed in business areas such as shopping malls, market benches, video showrooms, bars and beer drinking clubs through the engagement of

businessmen, women, and security guards. Other IEC materials will also be distributed to partner organisations working with street children.

Activity 9: Conduct Street children peer-led educators training and mentorship to facilitate peer to peer information sharing and influence on attitudes and social behaviours

To empower and provide influencing space for street children, we will train street children to lead peer education and mentorship. In addition to increase girls' visibility and participation, we will ensure equal participation of 50% girls and 50% boys of trained peer educators.

This initiative will create a solid network of street children peer educators who will facilitate weekly focus group discussions around sexual abuse, emergency health services, gender, and intersectional social norms. The initiative will also include motivation competitions through participatory approaches led by the street children themselves. Thus, empowering them with the necessary knowledge, skills, and agency to influence attitudes and social behaviour change.

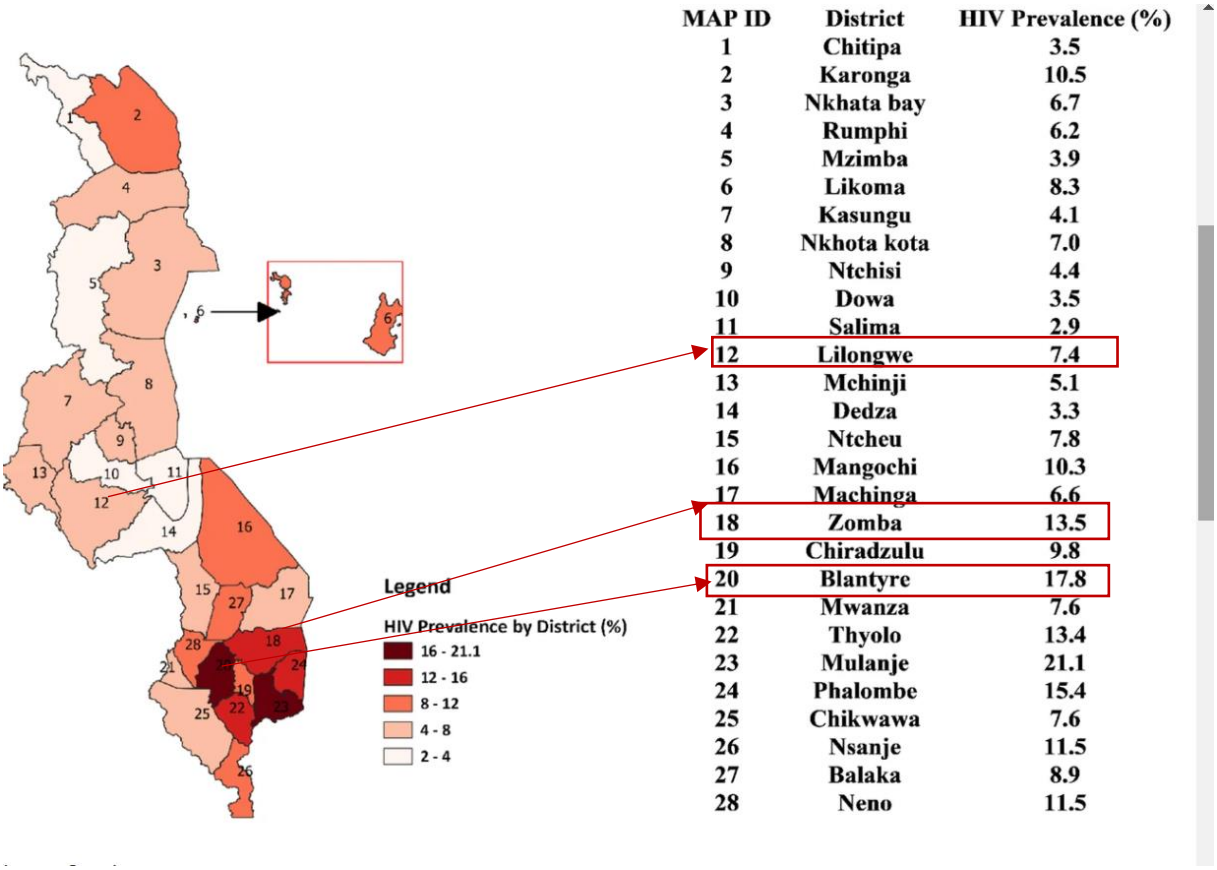
Activity 10: Establish Street community support groups through the engagement of influential people on the street and within urban slum communities

To unpack the social power dynamics within the streets, we will establish three community support groups in each city. The community support groups will include businessmen, security guards, women, and leaders within the urban areas of the cities. These groups will be a source of information sharing and referral for street children. In addition, we will ensure that we motivate by conducting quarterly review meetings of our relationships, providing referral cards, and rewarding community support groups that refer more children for services within a specific period. We aim to sustain these structures to be the catalyst for future programs targeting men's involvement and addressing the effects of male dominance of health services.

5. PROJECT FRAMEWORK

5.1. Description of Project Sites

The project will be implemented in three main cities of Malawi: Lilongwe, Blantyre and Zomba. The three cities have the most street children, collectively having about 6,000 street children (Crewes et al., 2015; Gondwe et al., 2019). In addition, recent analysis marked these cities as endemic areas for HIV infection, highly associated with risky sexual behaviours, including sexual abuse (Nutor et al., 2020).



MAP ID	District	HIV Prevalence (%)
1	Chitipa	3.5
2	Karonga	10.5
3	Nkhata bay	6.7
4	Rumphi	6.2
5	Mzimba	3.9
6	Likoma	8.3
7	Kasungu	4.1
8	Nkhota kota	7.0
9	Ntchisi	4.4
10	Dowa	3.5
11	Salima	2.9
12	Lilongwe	7.4
13	Mchinji	5.1
14	Dedza	3.3
15	Ntcheu	7.8
16	Mangochi	10.3
17	Machinga	6.6
18	Zomba	13.5
19	Chiradzulu	9.8
20	Blantyre	17.8
21	Mwanza	7.6
22	Thyolo	13.4
23	Mulanje	21.1
24	Phalombe	15.4
25	Chikwawa	7.6
26	Nsanje	11.5
27	Balaka	8.9
28	Neno	11.5

Figure 8: Map visualization of district HIV prevalence in Malawi, (Nutor et al., 2020), Page 190, fig 1.

Note: Map showing cities that the project will target. It also indicates how prevalent HIV is in the targeted cities, with Blantyre leading 17.8% prevalence of HIV, Zomba 13.5% prevalence and Lilongwe 7.4%. ; National prevalence estimated at 9.2%. **Source:** "Spatial

analysis of factors associated with HIV infection in Malawi: indicators for effective prevention" (Nutor et al., 2020), Page 190, fig 1.

5.2.Project Beneficiaries

The primary beneficiaries of this project are street children aged 7 to 17 years old living and working on the street of Lilongwe, Blantyre and Zomba cities. The cities have approximately 6,000 street children collectively, of which 1 in 5 are girls (Crewes et al., 2015). However, this number is subject to estimations.

Our project will reach out to all street children in these cities since they are all vulnerable to sexual abuse and associated health consequences. Moreover, girls are invisible, and therefore it is likely that the number could be greater than that projected. We also recognize the mobile nature of this population, which could mask their numbers. Therefore, we will target to reach at least 95% of all children, beginning with the known estimations and expect the number to increase with the implementation of demand creation activities.

Although our primary beneficiaries are street children, we will also indirectly reach out to businessmen, women, security guards within the streets and in urban slums through the mass community awareness and involvement as street children community support groups.

6. PROJECT IMPLEMENTATION

6.1. Project Administration

Overall, the project will be implemented by a multidisciplinary team, including a Project Technical Advisor, Research Consultant, 2 Project Coordinators, 6 Nurses and 6 Community Facilitators. A summary of roles and responsibilities is presented below.

Table 1: Project administrative overview; roles and responsibilities

Role	Responsibilities	Time
Implementing organization 1	• Create demand for services • Lead awareness campaigns and peer-led education and mentorship, influencing strategies for positive behaviour change among street children.	Full time
Implementing organization 2	• Service delivery at rehabilitation centres, training and continuous mentorship of service providers and coordination of referrals to complementary legal and psychosocial care.	Full time
Project Technical Advisor (consultant)	• Lead project initiation • Coordinate baseline research, gender-based and intersectionality analysis and mainstreaming of gender in the project • Build capacity of service providers, and provide technical support, project insight and mentorship to project coordinators to deliver project activities independently	50%; total time in the first two years, part-time in the last year and evaluation year
Research Consultant	• Conduct baseline assessment (Four months of baseline assessment and four months or end line assessment)	20%; baseline and end-line evaluation
Project Coordinators	• Coordinate activity planning, budgeting, monitoring, and reporting	100% full time
Nurses	• Deliver emergency health services and referral to complementary legal, and psychosocial care for street children	100% full time
Community facilitators	• Conduct demand creation and empowering initiative for street children utilization of services	100% full time

6.2. Project Cost-Saving Measures

The project will utilize the established street children rehabilitation centres, as infrastructure costs will be averted. In addition, most medical supplies such as HIV PEP, ECPs and condoms will be provided through the supply chain from the District Health Office, thus reducing the fixed operational cost of medical supplies at the rehabilitation centres.

The Technical Advisor will work part-time from the second year to build the capacity of Project Coordinators to deliver the project activities independently. This will then cut administrative costs sequentially. In addition, the project will recruit lower cadre nurses and community facilitators, from which the nurses are proposed to be integrated into the government system by the third year. This will further cut administrative costs and ensure the sustainability of services when nurses are paid through the government.

Other rehabilitation centre-based supplies, particularly for girl victims, including sanitary pads, will at different times be sourced through fundraising activities during national and international advocacy platforms. As such, costs related to these commodities can be diverted to service delivery.

6.3. Project Activity and Resource Plan

The project will be implemented over three years, from January 2022 to December 2024, and the following six months, from January 2025 to June 2025, will be spent on post evaluation. It will be implemented across three phases: baseline assessment, service delivery and demand creation, and evaluation. The table below shows a summary of activities and resource plans.

Table 2: Activity and resource plan

Ref	Activity	Inputs	Deliverables	Lead	Time Frame			
					Y1	Y2	Y3	Y4
0	Project inception	Office materials and staff	2 implementing organization, staff & research consultant	TA	**X**			
1	Design and conduct a participatory baseline assessment	Consultancy fee for 4 months, project administrative staff	Baseline report,	TA/ RC	**X**			
2	Conduct gender-based and intersectionality analysis on the findings from the baseline	Office utilities, internet, stationery, staff	Gender and Intersectionality analysis report	TA				
3	Gender and intersectionality mainstreaming	Logistics; accommodation, food meeting costs and transport for 20 people	Gender and intersectionality manuals	TA	**X**			
4	Identify, equip, and create segregated services for girls and boys in three rehabilitation centres for emergency service delivery to street children	Medical equipment procurement fee for 3 rehabilitation centers		TA/PC	**X**			
5	Recruit, train and provide continuous mentorship of service providers on survivor centred, gender sensitive and intersectionality-oriented emergency health services to street children	Logistics; accommodation, food meeting costs and transport for 20 people	Service providers trained	TA/PC	**X**			
6	Provide integrated emergency health services to street boys and girls and referral to complimentary legal and psychosocial services	Utilities, internet, logistical cost, and project staff	Health services are delivered	Nurses	**X**	**X**	**X**	**X**

7	Conduct mass awareness campaigns and mobilisation of street children on information related to sexual abuse and available health services	Logistics; transports x4 sessions/per months, media and communication, stationery	Awareness raising	CFs	**X**	**X**	**X**	
8	Conduct Street children peer-led educators training and mentorship to facilitate peer to peer information sharing and influence on attitudes and social behaviours	Logistics, communication costs, project staff	Empowerment of street girls and boys, increased service utilization	FCs		**X**	**X**	**X**
9	Establish street children community support group and facilitate referral, sharing of information	Logistics: orientations materials, referral cards, quarterly meetings	Support groups created	FCs/PCs		**X**	**X**	**X**
10	Mid-evaluation	Logistics: visits at each center, data collectors, transport, meetings costs	Progress analysis, gaps, and mapping strategies	TA		**X**		
11	Evaluation	Consultancy cost for 3 months, project administrative staff	Lessons learned, areas for new targets	TA/RC				**X**
0	Dissemination	Conference costs for 60 people; transport, accommodation, and food x30 project staff and implementing partners	Accountability, resource lobbying platform	TA				**X**

6.4.Project Risk Analysis

The project is the first to target street children in relation to sexual abuse and access to emergency health services in Malawi. While it provides an excellent opportunity to reduce the vulnerability of street children to sexual abuse and the devastating health consequences, it is also likely to encounter several risks before implementation, during and after implementation. The table below highlights these risks, their likelihood of occurrence, impact, and mitigation strategies. Although this is the preliminary risk analysis, we will update the mitigation plan regularly, test and input gaps as we learn to thrive in this relatively new area of focus.

Table 3: Project risk matrix

Risk definition	Risk statement	Likelihood	Impact	Mitigation Plan
Funding	The project`s onset depends on funding by the first quarter of 2022. This is dependent on donor interest	High	High	Submit a proposal to at least five potential donors, pitch presentation to Malawi`s First Lady through street children foundation
Political and policy regulatory environment	The project involves minors, consent in research and services is not guaranteed	Low	High	Preliminary consultation with Ministry of Health, ministry of gender to provide legal consent of children with unknown guardians
Project acceptability	Likelihood of street community backlash	High	Low	Engagement of street community and support groups for services will improve attitudes.
Inadequate medical supplies	Reliance on the Ministry of the health supply chain of medical supplies might be inefficient with logistical delays	High	High	Allocate money for the immediate purchase of medical supplies, agree on a decentralized supply chain system with the district health office.
Staff	Staff may quit because of the challenging nature of dealing with street children	Low	Low	Train staff and offer ongoing mentorship to ensure motivation
Mobile nature of population group	Follow up of street children to adherence to PEP might be challenging with the mobile nature of children	High	Low	Proper counselling and offer option to take drugs from the rehabilitation centre when accessing other basic needs
Safety of survivors	Child survivors may not be safe to access services if threatened by perpetrators on the streets	High	High	Our referral services include legal and psychosocial support, which connect children to temporary shelters and secret survivor safety homes.
COVID-19	The ongoing COVID-19 pandemic poses a challenge for mass community	High	Low	Measures of COVID-19 will be observed during gatherings and service delivery

	awareness and service delivery if countries are on lockdown			

6.5.Project Sustainability Plan

The project will be implemented as an entry point to make street children's health problems visible in Malawi. Therefore, the aim is to ensure that we set a model guidance for the sustainability of health services. We expect the established referral systems and structures to continue working after the end of the project by strengthening partnerships with the Ministry of Health and Ministry of Gender. In the process, we will also lobby for the integration of nurses in the government system by the third year of implementation to sustain the services with available staff and medical supplies from the Ministry of Health.

We also aim to provide evidence of value-based care to convince the government to invest in ongoing services for street children. Through our evidence generated from the baseline research and the evaluation, we will highlight the unmet needs and dimensions for services delivery beyond the streets to show the interlinked pathways with communities. Thus, creating opportunities for partner organizations to prioritize those gaps and the value of money to the donors can help with more funding. By training street children as peer educators and working collaboratively with community support groups, we will build a solid network for information sharing and influencing at the community level.

7. PROJECT BUDGET

Overall, the project will cost €287.280 to deliver emergency health services for street children over three years and 6 months to evaluate the project to inform future targets. The budget is divided into five sections arranged according to the total cost per year. The estimates have been predicated based on the standard salary scale in Malawi, Malawi Ministry of Health pay scale for service providers and essential medical equipment required stipulated by WHO guidelines on PEP services (World Health Organization, 2003).

In the first year, the project will seek €98.630 to cover human resources, consultation, administration, service delivery and demand creation. A projected €34.300, 35% of the budget, will cover service delivery to procure medical equipment and train service providers. Most equipment will be one-off, such as examination coach, medical fixtures, drugs cabinets, and other essential items directed by WHO guidelines. Consultation for establishing the project and conducting baseline assessment will take 27% (€26.600) of the total budget in the first year, to cover payment of Technical Advisor estimated at €2.000 per month, and research consultant at €2.000 as a lump sum for baseline assessment. The human resource will cover €24.800 for two Project Coordinators estimated at €1.000 per month, six nurses at €400 per month, and six community facilitators at €250 per month. In the first year's project, coordinators will work for seven months while nurses and community facilitators await fully equipped rehabilitation centres for three months. Demand creation through awareness and training of peer groups are projected to cost €6.000 (6%) in the first and administration will cost €6.930, which is 2% of the budget.

The second-year cost will reduce to €93.170 due to the cut off procurement of medical equipment. A more significant part will cover Human Resource €67.200, as all staff will now work for 12 months. It is imperative to note that health systems building for effective emergency health service delivery is mainly dependent on health workforce investment and proved to improve value-based care, reducing subsequent trauma to the victims (Olson et al., 2020). Service delivery cost will be reduced to € 4.00 for refresher training of nurses. As the Ministry of Health will supply most supplies, however, an allocated € 2.000 per year will be available to purchase supplies in cases of delayed supply chain systems. Awareness and peer-led activities for demand creation will increase to €8.000 as we try to reach out to more street children.

The third-year cost will reduce to €66.470, mainly due to the integration of nurses into the government system as a measure for the sustainability of services. However, the most operational cost will remain the same, with a notable reduction of human resources to €42.000. Lastly, the six months of evaluation will cost €29.010, covering consultation at €8.000, Project Coordinator salaries for six months at €12.00, dissemination of findings and maintenance of operation cost for rehabilitation centres and peer groups a project phase-out strategy. Table 4 below provides a summary budget and refer to appendix 3 for a detailed budget.

Table 4: Summary of project budget

Budget Summary								
Item	**Year 1**	**%**	**Year 2**	**%**	**Year 3**	**%**	**Year 4**	**%**
Human Resource	€ 24.800	25%	€ 67.200	72%	€ 42.000	63%	€ 12.000	41%
Consultants (Technical Advisor and research)	€ 26.600	27%	€ 6.000	6%	€ 6.000	9%	€ 8.000	28%
Administration operations	€ 6.930	2%	€ 7.970	9%	€ 7.970	12%	€ 4.010	14%
Service deliverly (equipment and capacity building)	€ 34.300	35%	€ 4.000	4%	€ 2.500	4%	€ 2.000	7%
Demand creation (Awareness, peer led initiatives, and community support groups)	€ 6.000	6%	€ 8.000	9%	€ 8.000	12%	€ 3.000	10%
Total :	€ 98.630		€ 93.170		€ 66.470		€ 29.010	
Project Total Cost	€ 287.280							

8. PARTICIPATORY MONITORING AND EVALUATION

The project will use a gender-sensitive results-based monitoring system, which applies a gender lens at all stages of the project cycle (Vahlhaus, M. & Prey, 2014). During the baseline assessment, a gender analysis will be performed to analyze gendered relations on the target group, including identifying gender-specific and intersectional needs for street girls and boys. The gender and intersectional data variables will be integrated into the service delivery tools, and activity indicators will be monitored for progress. Refer to Appendix 1 for a detailed log framework covering preliminary gender-sensitive outcomes, outputs, activities, and indicators.

At the start of the project, we will conduct a baseline survey on street children`s KAP and experiences around sexual abuse and access to health services. Then, following a need-based implementation of the benefits for a year, we will conduct the same survey (baseline) at the end of the period from October 2023 to December 2023. During this period, we will measure if we have attained the 95% increase in KAP among street children and explore their experiences to establish what street children would want to change in service delivery to increase access and utilization. Based on the finds, we will tailor the intervention for the year 2024.

At the end of the project, we will conduct an adequacy evaluation to compare if the project has met set targets over time during the three years of implementation. This will involve completing the same KAP survey (baseline) and exploring street children's perceived experiences. The results will be compared with the baseline assessment and midline to determine association factors for accessibility of health services. Additionally, data from rehabilitation centers will be analyzed to determine if the project has met the goal of 95% improved access to emergency health services, stratification of gender, age, livelihood means (socioeconomic status), and geographical locations to account for gender and intersectionality differences.

The results will be disseminated through a national conference presentation and reports to the donors, government ministries and partner organizations. In addition, we will share lessons and the immediate areas of interventions. Throughout the project, we will provide quarterly reports and yearly narrative reports to the donors for accountability.

9. CONCLUSION

Under the precarious environment of street life in Malawi, the young, neglected, impoverished and vulnerable street children battle to escape the health consequences of sexual abuse. Worse as a society, we stopped recognizing this horror on the streets, and rather we conform to the common narrative that sexual abuse is inevitable. Sexual abuse begets more sexual abuse, thus resulting in more adverse health consequences.

Public health services to reduce the risk of HIV infection and pregnancy following exposure to sexual abuse are mandated to be provided within 72 hours in public health facilities in Malawi. However, these services have failed to meet the needs of the street children, as they are positioned at multiple points and require legal notification from police. Moreover, the street children are further compounded by intersectional and gendered barriers, which exacerbates their vulnerability to sexual abuse, health-seeking behaviors, and agency to navigate through the pathways of accessing public health services. Street girls are a particular concern group, and their limited access to emergency health services bear multiple gendered health problems and reproduce the circle of vulnerability to sexual abuse.

Given the urgency of health services following sexual abuse, this project proposes integrating health services in street-based rehabilitation centers and bottom-up learning from street children to tailor the services to their specific gendered and intersectional needs. Additionally, the project builds and strengthens the health delivery system through multisectoral collaboration, capacity building of service providers, and integration in the government systems that serve as a vital sustainability plan. As a result, the collective care delivery value chain will improve access to equitable, inclusive, and quality emergency health services among Malawian street girls and boys.

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APPENDICES

Appendix 1: Project Log Framework

Project Log Framework			
Objectives	**Indicators**	**Means of Verification**	**Assumptions**
Goal			
Reduced vulnerability to sexual abuse and its associated health problems of HIV infection and unplanned adolescent pregnancy among street children (7 to 17 years) in Lilongwe, Blantyre and Zomba	**1.1.**Percentage decrease of sexual abuse cases among children below 18 years **1.2.** Percentage decrease in HIV incidence among young people below 18 years **1.3.** Percentage increase of adolescent pregnancies among girls aged 10 to 19 years	Malawi demographic health surveys, AIDs indicator surveys, district health offices and prison data	Our interventions partly contribute to risk reduction of sexual abuse, new HIV infections and pregnancy among young people in Malawi
Outcomes			
Improved access to equitable, inclusive, and quality emergency health services by 95% among street children (7-17 years) in Lilongwe, Blantyre, and Zomba by October 2025	**2.1.**95% of street girls and boys use appropriate and prioritized emergency health services and combined preventive services at the rehabilitation centres from November 2022 to October 2025 **2.2.**95% of street girls and boys have good knowledge, attitudes and practices around	Baseline data and end-line data, rehabilitation centre registers, KAP surveys, qualitative end line findings	Street children and communities support the project without backlash

	sexual abuse and health services by October 2025 **2.3.**Street children`s perspectives of experiences in accessing emergency health services at the end of the project		
Gender and intersectionality sensitive data	**2.4.** 100% reporting of gender and intersectionality disaggregated data on each level of the project	Evaluation report of all outcome measures	
Outputs			
Output 1: Mainstreamed gender and intersectionality in the project activities based on findings from baseline assessment	**3.1.**6 Gender-sensitive and intersectionality manuals for project service delivery, organizational and partnership conduct	Project manuals	Project technical Advisor has the capacity to guide mainstreaming process, Street children have the will, and legal consent is provided for minors
Activity 1: Design and conduct a participatory baseline assessment on street children KA P and experiences around sexual abuse and emergency health services	**3.2.**At least 20 % of street girls and boys aged 7 to 17 years complete baseline assessment **3.3.** One fully-fledged baseline data report	Baseline assessment report, project reports	
Activity 2: Conduct gender-based and intersectionality analysis on the findings from the baseline	**3.4.**One gender analysis report with specific needs for street girls and boys	Gender analysis report	
Activity 3: Conduct training on gender and intersectionality mainstreaming for key implementing organizations, project technical staff, and key project delivery stakeholders	**3.5.**20 technical staff, stakeholders and key implementing organisation representatives trained on gender mainstreaming **3.6.**95% of participants completed training,	Training report, pre- and post-training survey results	

	3.7. 80% increase knowledge on gender mainstreaming and intersectionality after training		
Output 2: Established survivors centred and gender-sensitive space to provide integrated emergency health services and complimentary referral services to legal and psychosocial care to street girls and boys in Lilongwe, Blantyre, and Zomba by September 2022	**4.1.** Proportion of survivor centred and gender-sensitive integrated emergency health services provided in each rehabilitation centre from November 2022 to October 2025	quarterly project progress reports, annual narrative reports, and rehabilitation centre monitoring visits reports	Trained service providers remain working in the rehabilitation centres regularly for the period of the project'.
Activity 4: Identity, equip, and create segregated services for girls and boys in three rehabilitation centres for emergency service delivery to street children	**4.2.** 3 rehabilitation centres that are fully equipped with a basic standard of medical supplies for emergency health service provision **4.3.** One girls-only space within each rehabilitation centre to offer girls services **4.4.** Three supply chain system protocols for medical supplies for each rehabilitation center, directed from each district`s health offices	Rehabilitation centre registers, project reports, procurement receipts, MoU with Ministry of Health and district health offices, rehabilitation centre stock registers	There is no interrupting supply of medical supplies from the Ministry of Health through district health offices
Activity 5: Recruit, train, and provide continuous mentorship of service providers on survivor centred gender-sensitive and	**4.5.** Six nurses and six community facilitators were recruited (12)	Training report, rehabilitation monitoring report, staff retention surveys	Service providers retain the knowledge and skills to provide quality and inclusive

intersectionality-oriented health service delivery	**4.6.** 100% of service providers complete training **4.7.** 90% improved knowledge, attitudes, and practices around service delivery for street children at the end of the training **4.8.** 90% staff retention at the end of each year		services throughout the project
Activity 6: Provide integrated emergency health services to street boys and girls and referral to complementary legal and psychosocial services	**4.9.** At least 1900 or more street girls' and boys' access one or more emergency health services; HIV and pregnancy testing, HIV PEP and ECPs, STIs screening and prophylaxis and condoms sexual abuse in each rehabilitation every year **4.10.** 95% of street girls and boys who avail of emergency health services know their HIV and STI status **4.11.** 95% of street girls and boys who have been initiated on HIV PEP and STI prophylaxis complete the required dose **4.12.** 95% of street children who tested positive for HIV are referred to complementary HIV and AIDs services from a partner organization	Rehabilitation registers, monthly and quarterly reports, stock registers, service referral registers, partners reports	Street children can make a health-seeking decision following demand creation activity

	4.13. 95% of adolescent girls aged 10 to 17 who have been initiated on ECPs complete the required dose **4.14.** At least 95% of children are referred to legal and psychosocial services based on preference		
Activity 7: Establish and strengthen strategic partnerships for referral and complementary legal, psychosocial, and other services	**4.15.** 3 street children support groups formulated and oriented in each city that have 10 street community and urban slum members **4.16.** At least 20 street girls and boys were referred to rehabilitation centres by a member of the street children advisory group in a month **4.17.** Number of MoUs signed **4.18.** Six joint quarterly review meetings with partner organizations and with street children support group **4.19.** Three joint advocacy and project promotion activities with partners in a year	Meetings minutes, Street children advisory group registers, project stakeholder matrix Meetings minutes, advocacy campaign reports	Stakeholders remain with high interest and power to support the delivery of the project
Output 3; Increased participation of street girls by 95% in health service awareness	**5.1.**Proportion of street girls and boys participating in community awareness campaigns	Monthly awareness campaign reports	Women and girls in urban slums and market areas are receptive to awareness

campaigns, peer-led education, and mentorship activities by December 2024			campaigns through strengthened mobilization Covid -19 cases remain manageable to gather at least 50 to 100 people per in awareness campaigns with strict regulations
Activity 8: Conduct mass awareness campaigns and mobilisation of street children on information related to sexual abuse and available health services	**5.2.** Proportion of community members participating in community awareness campaigns		
Activity 9: Conduct Street children peer-led educators training and mentorship to facilitate peer to peer information sharing and influence on attitudes and social behaviours	**5.3.**30 street children trained as peer educators and mentors per year **5.4.**50% of peer educators are girls, and 50% are boys **5.5.**At least 50% more street girls participating in the peer education sessions	Peer educators training report and registers	

Appendix 2: Implementation Plan

	Implementation Plan													
	Activities	**Time Frame**												**Responsibility**
		Year 1 (2022)												
		Q 1			**Q 2**			**Q 3**			**Q 4**			
		M1	**M 2**	**M 3**	**M 4**	**M 5**	**M 6**	**M 7**	**M 8**	**M 9**	**M1 0**	**M1 1**	**M12**	
1	**Project Inception Phase**													
1.1	Recruitment of Project Technical Advisor (TA)													Funding NGO
1.2	Develop ToRs for key implementing organizations and research consultant													TA
1.3	Conduct preliminary stakeholder consultation with two key implementing organizations, MGCDSW, MOH and Malawi Police													TA
1.4	Develop job descriptions, advertise and recruit project administrative staff: Project Coordinators (PCs), Nurses, Community Facilitators (CF)													TA
1.5	Orientation meeting of key project administration staff and research consultant on the overall project delivery													TA
1.6	Facilitate adoption project framework and development of partner project delivery strategies based on expertise													TA

1.7	Conduct district project inception presentation through City Executive Committee (CEC)														TA, PCs
1.8	Advertise and recruit lead baseline research consultant														TA
	Phase 1: Baseline														
2	**Objective 1:Explore the Knowledge, Attitudes, and Behaviours (KAB) and experiences around sexual abuse and emergency health services among street boys and girls aged 7 to 17 years in Lilongwe, Blantyre, and Zomba cities in Malawi by June 2022**														
	Output 1:Available baseline assessment data on the level of street children`s knowledge, attitudes and practices; and the intersectional and gendered specific needs of girls and boys														
2.1	Design and conduct participatory baseline assessment protocol on street children KAB, intersectional and gendered experiences around sexual abuse and access to emergency health services														Research Consultant
2.2	Conduct gender analysis of baseline findings, emergency health service delivery manuals, organizations policy guidelines on street children engagement														TA
2.3	Produce full baseline research report														Research Consultant
2.4	Conduct three days of training for gender and intersectionality mainstreaming in project delivery with key implementing organizations, project administrative staff and key multisectoral partners														TA

2.5	Produce gender-sensitive and intersectionality oriented project delivery manuals: rehabilitation centre manual, awareness campaign and peer-led mentorship, multisectoral collaboration, organizational manuals														TA
2.6	Conduct weekly virtual update meetings with project implementation staff														TA, Research consultant, PCs
	Phase 2: Service Delivery and Demand Creation														
3	**Objective 2:** Establish three gender-sensitive and survivor-centred spaces for integrated emergency health service delivery for street girls and boys in Lilongwe, Blantyre and Zomba cities by September 2022 and ongoing														
	Output 2: Established three survivors centred and gender-sensitive spaces to provide integrated emergency health services and complimentary referral services to legal and psychosocial care to street girls and boys in Lilongwe, Blantyre and Zomba														
3.1	Identify three rehabilitation centres for emergency service delivery to street children														TA, PCs
3.2	Create girls-only spaces within the three rehabilitation centres														TA, PCs
3.3	Procure and equip rehabilitation centres with essential standard clinical equipment														PCs
3.4	Create and agree on an efficient supply chain system for medical supplies: HIV PEP and ECPs, testing kits, STI														TA

	prophylaxis and condoms drugs with the Ministry of Health and District Health Office														
3.5	Inspection and approval of rehabilitation centres														TA, PCs
3.6	Conduct five days of training of service providers on evidence-based gender and intersectionality service delivery														TA
3.7	Distribute gender-sensitive and intersectionality manuals/guidelines for integrated emergency health service delivery for street children														TA
3.8	Deploy service providers in assigned rehabilitation centres Lilongwe, Blantyre and Zomba														PCs
3.9	Launch of service delivery in each city														PCs
3.10	Provide integrated emergency health services to street boys and girls and referral to complementary legal and psychosocial services														Nurses
3.11	Conduct monthly rehabilitation centre monitoring and support visits														PCs
3.12	Establish and strengthen strategic partnerships with government institutions and gender focussed organizations for complimentary referral services to legal, psychosocial, HIV; AIDS, SRHR														TA

4	**Objective 3: Empower at least 95% of street girls and boys with knowledge and skills to influence attitudes, health-seeking behaviours and decisions concerning their health by June 2025**														
4.1	Output 3: Increased participation of at least 95% of street girls and boys aged 7 to 17 years in health service awareness campaigns, peer-led education and mentorship activities by June 2025														
4.2	Conduct monthly awareness campaigns and mobilisation sessions of street children on information related to sexual abuse and available health services														CFs
4.3	Conduct Street children peer-led educators training and mentorship to facilitate peer to peer information sharing and influence on attitudes and social behaviours														CFs
4.4	Weekly peer-led information sharing sessions														CFs

	Activities	**Time Frame**												
		Year 2 (2023)												Responsibilities
		Q 1			**Q 2**			**Q 3**			**Q 4**			
		M1	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**	
5	**Objective 2:** Establish three gender-sensitive and survivor-centred spaces for integrated emergency health service delivery for street girls and boys in Lilongwe, Blantyre and Zomba cities by September 2022 and ongoing													

	Output 2: Established three survivors centred and gender-sensitive spaces to provide integrated emergency health services and complimentary referral services to legal and psychosocial care to street girls and boys in Lilongwe, Blantyre and Zomba													
5.1	Provide integrated emergency health services to street boys and girls and referral to complementary legal and psychosocial services													Nurses
5.2	Conduct monthly rehabilitation centre monitoring and support visits													PCs
5.3	Conduct refresher training of service providers													TA
5.4	Conduct quarterly review meetings with partners													PCs
6	**Objective 3: Empower at least 95% of street girls and boys with knowledge and skills to influence attitudes, health-seeking behaviours and decisions concerning their health by June 2025**													
	Output 3: Increased participation of at least 95% of street girls and boys aged 7 to 17 years in health service awareness campaigns, peer-led education and mentorship activities by June 2025													
6.1	Conduct monthly awareness campaigns and mobilisation sessions of street children on information related to sexual abuse and available health services													CFs
6.2	Conduct the second cohort of street children peer-led training and mentorship													CFs
6.3	Weekly peer-led information sharing sessions													CFs

6.4	Establish street children community support groups with influential people within the streets and urban slums (businessmen, security guards, women, ward council leaders)													CFs
6.5	Conduct orientation of street children -community support groups													CFs, PCs
6.7	Distribute IEC materials and referral cards to street community support group members to refer children to health services													CFs
6.8	Conduct joint quarterly review meetings with street support groups and with peer0led educators													CFs, PCs
6.9	Collaborate with partners on advocacy, influencing and knowledge dissemination commemorations													PCs
6.10	**Midline Evaluation**													TA, PCS

	Activities	**Year 3 (2024)**												**Responsibilities**
		Q 1			**Q 2**			**Q 3**			**Q 4**			
		M1	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**	

7	**Objective 2:** Establish three gender-sensitive and survivor-centred spaces for integrated emergency health service delivery for street girls and boys in Lilongwe, Blantyre and Zomba cities by September 2022 and ongoing													
	Output 2: Established three survivors centred and gender-sensitive spaces to provide integrated emergency health services and complimentary referral services to legal and psychosocial care to street girls and boys in Lilongwe, Blantyre and Zomba													
7.1	Conduct three days meeting to revise project delivery activities, manuals, indicators based on mid evaluation findings													TA
7.2	Provide integrated emergency health services to street boys and girls and referral to complementary legal and psychosocial services													Nurses
7.3	Conduct monthly rehabilitation centre monitoring and support visits													PCs
7.4	Conduct quarterly review meetings with partners													PCs
8	**Objective 3: Empower at least 95% of street girls and boys with knowledge and skills to influence attitudes, health-seeking behaviours and decisions concerning their health by June 2025**													
	Output 3: Increased participation of at least 95% of street girls and boys aged 7 to 17 years in health service awareness campaigns, peer-led education and mentorship activities by June 2025													
8.1	Conduct monthly awareness campaigns and mobilisation sessions of street children on information related to sexual abuse and available health services													CFs

8.2	Conduct third and fourth cohort of street children peer-led educators training and mentorship													CFs
8.3	Weekly peer-led information sharing sessions													CFs
8.4	Conduct joint quarterly review meetings with street support groups and with peer-led educators													CFs, PCs
8.5	Collaborate with partners on advocacy, influencing and knowledge dissemination commemorations													PCs

	Activities	**Year 4 (2025)**												**Responsibilities**
	Phase 3: Project Evaluation													
		Q 1			**Q 2**			**Q 3**			**Q 4**			
		M1	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**	
9	**Objective 2:** Establish three gender-sensitive and survivor-centred spaces for integrated emergency health service delivery for street girls and boys in Lilongwe, Blantyre and Zomba cities by September 2022 and ongoing													
	Output 2: Established three survivors centred and gender-sensitive spaces to provide integrated emergency health services and complimentary referral services to legal and psychosocial care to street girls and boys in Lilongwe, Blantyre and Zomba													

9.1	Provide integrated emergency health services to street boys and girls and referral to complementary legal and psychosocial services													Nurses
10	**Objective 3: Empower at least 95% of street girls and boys with knowledge and skills to influence attitudes, health-seeking behaviours and decisions concerning their health by June 2025**													
	Output 3: Increased participation of at least 95% of street girls and boys aged 7 to 17 years in health service awareness campaigns, peer-led education and mentorship activities by June 2025													
10.1	Weekly peer-led information sharing sessions													CFs
10.2	Conduct joint quarterly review meetings with street support groups and with peer-led educators													CFs
11	**Project endline evaluation**													
11.1	Final evaluation report													
11.2	Dissemination of findings													
11.3	Mapping targtes to sustainability													

Appendix 3. Project Budget

Project Budget											
		Year 1				Year 2		Year 3		Year 4	
	Description	Unit	Cost (€)	Quatinty	Total (€)	Quntity	Total (€)	Quantity	Total (€)	Quantity	Total (€)
Human Resource											
Project Coordinators	2 full time for three years, and 6 month of evaluation year; first year will work for 7 moths. Salary estimates based on 30% Tax deductions	2	€ 1.000	7	€ 14.000	12	€ 24.000	12	€ 24.000	6	€ 12.000
Nurses	6 in total; 2 per each center. Fist year will work for 4 months, starting in September. By Third year, all nurses will be intergrated in the governement system Salary estimates based on 30% Tax deductions	6	€ 350	3	€ 6.300	12	€ 25.200	0	€ 0	0	€ 0
Community Facillittors	6 in total; 2 per each city. First year will work for 4 months starting Sepetember. And 6 months of evaluation Salary estimates based on 30% Tax deductions	6	€ 250	3	€ 4.500	12	€ 18.000	12	€ 18.000	0	€ 0
Sub-total		**€ 24.800**				**€ 67.200**		**€ 42.000**		**€ 12.000**	
Technical Advisor (local consultant)	1 full time for the first year, then 3 months per year	1	€ 2.000	12	€ 24.000	3	€ 6.000	3	€ 6.000	3	€ 6.000
Research consultant	Include one consultant , estimate lump sum consultancy fee @ 2000, for each phase	1	€ 2.000	1	€ 2.000	0	€ 0	0	€ 0	1	€ 2.000
Sub-total		**€ 26.000**				**€ 6.000**		**€ 6.000**		**€ 8.000**	
Administration Operations											
Stationary	Estimated to cover resources for examination records. Labels for specimen, consent forms, pathology referral forms, information brochures and use for the staff. Estimated @100 per month for each center*1st year's services start in September	1	€ 100	4	€ 400	12	€ 1.200	12	€ 1.200	6	€ 600
Internet and Communication	Incule data bundle for communitication for each project staff; estimated a@20 per person	1	€ 200	4	€ 800	12	€ 2.400	12	€ 2.400	6	€ 1.200

Insurance of spaces	Safety measures, estimated @ 20 per month for each center	1	€ 60	4	€ 240	12	€ 720	12	€ 720	6	€ 360
Utilities	include water for wash facilities and electricity estimated @ 20 per center, per month. *1st years services start in September	1	€ 60	4	€ 240	12		12		6	
Logistics (transport)	Logistics*	1	€ 300	4	€ 1.200	12	€ 3.600	12	€ 3.600	6	€ 1.800
Printers	One printer per each center (once off cost)	1	€ 300	3	€ 900	0	€ 0	0	€ 0	0	€ 0
Laptops	2 laptops for project coordinators (one off cost	1	€ 500	2	€ 1.000	0	€ 0	0	€ 0	0	€ 0
Desktop compunters	3 desk tops , one for each rehabilitation centers (one off cost)	1	€ 350	6	€ 2.100	0	€ 0	0	€ 0	0	€ 0
Maintanance	Estimated mainance per year	1	€ 50	1	€ 50	1	€ 50	1	€ 50	1	€ 50
Sub-total		**€6.930**				**€7.970**		**€ 7.970**		**€ 4.010**	
Service Delivery: Rehabilitation centre and capacity building of service providers											
Basic medical fixtures (assorted)	Once off examination coach. Dest, shairs. Filling cabiten. Refligirator for specimen)	1	€ 20.000	1	€ 20.000	0	€ 0	0	€ 0	0	€ 0
Essential medical equipment and supplies	Once off medical equipment; sterilizing equipment and speculums. Others; syringes, blood tubes, needles, swabs will be ordered through the Ministry of Health supply chain. With 2000 contingency for out of stock supplies per year	1	€ 5.000	1	€ 5.000	1	€ 2.000	1	€ 2.000	0	€ 2.000
Wash and sanitary facilities	Once off cost for linen, clothing, towels, sheets and sanitary pads. Subsequent supply through fundraising and community donations. Only 500 contingent for out of stock	1	€ 3.000	1	€ 3.000	1	€ 500	1	€ 500	0	€ 0
Gender mainstreaming	Traning of key implementing organization, key partners from ministry of helath, gender and Malawi Police= x20 people for 3 days. DSA 35 per person , conference @500, Transport @32 per person=320, projects total=3.00	1	€ 3.000	1	€ 3.000	0	€ 0	0	€ 0	0	€ 0

Project inception	Distrct and city CSO presentation; x60 partcipants , rereshments @100, in all three cities	1	€ 100	3	€ 300	0	€ 0	0	€ 0	0	€ 0
First training of service providers	Target 20 participants (6 nurses, 6 facilitators, 3 child protection workers, 3 police, 2 technical staff)	1	€ 3.000	1	€ 3.000	0	€ 0	0	€ 0	0	€ 0
Reflesher training	Target only 6 nurses and 6 facilitators	1	€ 1.500	0	€ 0	1	€ 1.500	0	€ 0	0	€ 0
Sub-total		**€ 34.300**				**€ 4.000**		€ 2.500		€ 2.000	
Output 3: Awareness raising and empowerment of street children											
6.1.Awareness campaigns	Lump sum estimation per year, for communication, IEC matirials and media	1	€ 4.000	1	€ 4.000	1	€ 4.000	1	€ 4.000	0	€ 0
6.2.Peer educators training program	Training, mentoring and sustaining weekly meetings	1	€ 2.000	1	€ 2.000	1	€ 2.000	1	€ 2.000	1	€ 2.000
6.3.Street children community support	Orientations, and sustaining quarterly meetings * to start in the second year	1	€ 1.000	0	€ 0	1	€ 1.000	1	€ 1.000	1	€ 1.000
6.4 Multisectral advocacy collaboration	Quarterly meetings, joint advocacy and monitoring visists * to start in the second year	1	€ 1.000	0	€ 0	1	€ 1.000	1	€ 1.000	0	€ 0
8. Dissemination	National level dissemination of findings* year 3	1	€ 2.500	0	€ 0	0	€ 0	0	€ 0	1	€ 2.500
Sub-total		**€ 6.000**				**€ 8.000**		**€ 8.000**		**€ 3.000**	
Total cost each year		Year 1:	**€ 98.030**			Year 2	**€ 93.170**	Year 3	**€ 66.470**	Year 4	**€ 29.010**
Grandtotal		€ 287.280									

Appendix 4: Stakeholder Analysis

Stakeholders Analysis							
Stakeholders Analysis	Impact	Influence	Stakeholder interest	How can they contribute	How can stakeholders block the project	Strategies for engaging	Priority
Donors (Icelandic Embassy, USAID, UNFPA)	High	High	Strengthening community resilience to sexual abuse, reducing HIV infection among young people and ensuring access to treatment	Funding	not funding delayed funding	Reporting, Joint monitoring and support visits and visibility	High
Ministry of Gender, Children, Disabilities and Social Welfare	High	High	Priority focus areas on street children; protection, reintegration and support	Provide policy support for delivery of services	Implement restrictive policies	Engagement at all levels; and reporting	High
Ministry of Health	High	High	Priority focus on eradication of new HIV infection among young	Provide police support, medical	Restrict policies and non-compliant	Engagement at all levels; and reporting, developing MoUs	High

			people and access to preventive services	supplies and equipment	with medical supplies		
Ministry of Justice	Medium	High	Focus on child protection and access to just of child survivors of sexual abuse	Provide legal support to services	Implement restrictive policies	Reporting and information sharing	Medium
Malawi Police	High	High	Offer legal services for survivors of sexual abuse	Compliment project services	If they start abusing children	Training, build a partnership, safeguard referral pathways	High
City and District Councils			oversee child protection areas at city and district levels	Act as state legal guardians for children, to easily engage with minors	Poor response based on benefits	Training, build a partnership	Medium
Youth Net and Counselling	High	High	Offers sexual reproductive health, operates a drop-in centre in Lilongwe and Zomba and create demand for service delivery	Can be one of the critical implementing organizations	Refuse to work as a consortium	engagement and partnership building	High

Chisomo Children`s Club	High	low	operates a rehabilitation centre in Blantyre for street children	can support in providing a place to integrate services	Refuse to offer space	Engagement and partnership building	Low
Member Health and Social Trust	High	low	Operates rehabilitation and reintegration services for street children, including assessing basic needs	Can be one of the vital implementing organizations	Refuse to work as a consortium	Engagement and partnership building	High
Shaping our Future foundation:	High	High	Malawi`s First Lady initiative to support vulnerable children and street children	Can support funding and offer psychosocial services	Political orientation can affect the outcome of a project	engagement for referral services	High
Businessmen	Low	High	They are parents, sexual partners or guardians to influence children easily	can impact positively for children to access services	May negatively influence	Engagement as support groups during project implementation	Medium

Businesswomen	Low	High	They are parents, sexual partners or guardians to influence children easily	can impact positively for children to access services	May negatively influence	Engagement as support groups during project implementation	Medium
Urban slums communities	Low	High	They are parents, sexual partners or guardians to influence children easily	can impact positively for children to access services	May negatively influence	Engagement as support groups during project implementation	Medium