90181

SUPPORT TO AIDS AND FAMILY HEALTH

(STAFH)

612-0238

PROJECT PAPER

VOLUME I

SEPTEMBER 1992

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: — DOCUMENT CODE: 3

2. COUNTRY/ENTITY: MALAWI

3. PROJECT NUMBER: 612-0238

4. BUREAU/OFFICE: AFR / 06

5. PROJECT TITLE (maximum 40 characters): SUPPORT TO AIDS AND FAMILY HEALTH

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 09 DD 30 YY 98

7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4): A. Initial FY 92 B. Quarter 3 C. Final FY 98

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY 92 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total						
Grant: DFA	5,650	350	6,000	42,861	2,139	45,000
Loan:						
Other U.S. 1.						
Other U.S. 2.						
Host Country		3,935	3,935		45,668	45,668 1/
Other Donors:						
TOTALS	5,650	4,285	9,935	42,861	47,807	90,668

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) DFA						6,000		45,000	
(2)									
(3)									
(4)									
TOTALS						6,000		45,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each):

11. SECONDARY PURPOSE CODE:

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code						
B. Amount						

13. PROJECT PURPOSE (maximum 480 characters)

The project purpose is to increase the contraceptive prevalence rate and to promote behavioral change to reduce the prevalence of HIV/AIDS/STDs.

14. SCHEDULED EVALUATIONS: Interim MM 09 YY 95 — Final MM 09 YY 98

15. SOURCE/ORIGIN OF GOODS AND SERVICES: ☐ 000 ☐ 941 ☐ Local ☒ Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of 4 pages)

1/ Proportional amount of anticipated host country contributions to the project.

Controller Clearance: CONT: RBAmin:

17. APPROVED BY — Signature: Carol A. Peasley — Carol A. Peasley

Title: Mission Director

Date Signed: MM 09 DD 30 YY 92

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM 10 DD 02 YY 92

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TABLE OF CONTENTS

SECTIONS X AND XI DOCUMENTS NOT DISTRIBUTED

X. REFERENCES

Analyses, background papers, and tables prepared in connection with the STAFH Project design, not distributed with the Project Paper

A. An Update on Population, Family Planning, and AIDS Policy Issues in Malawi (Johnston; April 1992)

B. AIDS and the Workplace

C. Overview of Current and Potential Supply of Services

D. Analysis of Social Marketing Project Status and Prospects (SOMARC: Brown/Mvundula)

E. Analysis of Long-Term Contraception (AVSC: Lynam/Githiari; April 1992)

F. Analysis of IEC Approaches Targeted at Youth (AIDSCOM: Mackie)

G. Analysis of IEC Approaches Utilizing Churches and Religious Groups (HOPE: Asiedu)

H. Logistics Systems and Contraceptive Supply Status Review - Malawi Child Spacing and AIDS Control Programs; (JSI/FPLM Project, Brice Atkinson; 9 January - 9 February 1992)

I. Malawi "FamPlan" Model: draft hard copy of "Costs and Benefits of the Child Spacing Programme in Malawi; January 1992" and "Malawi FamPlan Model Application; 6 February 1992"

J. A Note on the Calculation of Contraceptive Prevalence Rates for Condoms in Malawi; Alan G. Johnston; 5 February 1992

K. An Assessment of Socio-Cultural Influences on Reproductive and Sexual Behavior in Malawi from the Male Perspective; Samu Samu; April 1992

L. An assessment of Socio-Cultural Influences on Reproductive and Sexual Behavior in Malawi from the Female Perspective; Nkaliainga; April 1992

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XI. OTHER KEY DOCUMENTS USED IN THE PROJECT DESIGN

(Available at USAID/Malawi HPN Office, not distributed with Project Paper)

A. MOH Child Spacing Programme 1992-1996

B. 1992-1993 Two Year Reprogramming Document, Malawi National AIDS Control Programme

C. MOH, A Five Year Medium Term Plan for the Prevention and Control of AIDS in Malawi (1989-1993)

D. IDA PHN Sector Credit and 2and Family Health Project, Mission Aide-Memoire, December 1991 and Staff Appraisal Report (Report No. 9036-MAI) and Program Manual

E. The Statement of Development Policies 1987-1996 (DevPol)

F. The National Health Plan of Malawi 1986-1995

G. Recommendations from the Population Review and Strategy Development Workshop for Principal Secretaries (7-8 October 1991)

H. Letter of Health Development Policy (dated January 25, 1991 from Malawi Minister of Finance to World Bank Vice President for Africa)

ACTION MEMORANDUM FOR THE DIRECTOR, USAID/MALAWI

Date: September 30, 1992

From: Stephanie Funk, PID S. Funk.

Subject: Support to AIDS and Family Health (STAFH) Project (Project No. 612-0238)

I. PROBLEM: You are requested to approve and authorize the Support to AIDS and Family Health Project (612-0238) with a six year life of project and a funding level of $45,000,000. The Project will be incrementally funded, with an initial fiscal year (FY) 1992 obligation of $6,000,000.

II. DISCUSSION:

A. Background:

Malawi presently faces two insidious health related challenges: the AIDS epidemic and a rapidly growing population. By the end of this Project in 1998, the loss of potential income due to the projected 400,000 cumulative AIDS deaths may be 14%-21% of Malawi's GDP. Even with the increase in AIDS mortality, population growth rates are expected to persist at a level high enough to make it difficult for the economy to provide adequate jobs, education, food and health for all by 1998.

Malawi is confronting these challenges and has made considerable progress. Policies and programs necessary to gain control over the AIDS epidemic and the rapidly growing population are coming into place. As a result, there are glimmers of hope: knowledge of AIDS and child spacing has increased dramatically, and condom and contraceptive use rates appear to be rising.

However, major constraints to further progress remain. Annual per capita health investments amount to only $3.00. The number of health workers per capita is one of the lowest in Africa. Health workers have little time available to provide preventive health services given an overwhelming demand for curative care fueled by malaria, AIDS and TB epidemics among a rapidly growing population. Ministry of Health (MOH) capacity to implement programs to improve and increase health services, while getting stronger, remains weak, due mainly to a paucity of personnel. Only 136 of the nation's 788 health facilities are able to offer child spacing services, and fewer are able to provide critical AIDS prevention services such as HIV prevention counseling and STD treatment. There are virtually no outreach programs to bring child spacing services closer to clients.

On a more promising note, a number of private and public organizations have begun efforts to address the AIDS epidemic. These non-governmental organizations, though still in the formative stages, have expressed interest in education and training programs that merit government and donor support. On the child spacing

front, Malawi has built a national child spacing program which has made steady progress since 1983. One of the results has been a substantial increase (from 3,000 to 55,000) in the number of users of modern contraceptive methods from 1984 to 1990.

In response to Malawi's urgent health related needs and in line with USAID/Malawi's approved program strategy, the STAFH project will support Malawian efforts to accelerate progress in the fight against AIDS and the national effort to align population and economic growth.

B. Summary of Program Description:

The project's goal is to reduce total fertility and HIV/AIDS/STDs transmission. The project's purpose is to increase the contraceptive prevalence rate and to promote behavioral change to reduce the prevalence of HIV/AIDS/STDs.

Key elements of the project strategy are to: increase the supply of services by increasing the number of fixed facilities staffed and equipped to provide child spacing (CS) and AIDS services and to extend services to communities through community-based distribution programs; improve knowledge of how to prevent AIDS, how to plan families and where to get AIDS and CS information and services; increase contraceptive use by broadening the choice of contraceptive options and making services more convenient; and strengthen two national leadership organizations, the AIDS Secretariat and the National Family Welfare Council (NFWC), to lead the policy dialogue on the approaches outlined above, coordinate service delivery and improve the quality and effectiveness of care given by Malawian service providers.

The project design will maximize impact on the AIDS epidemic and population growth by: emphasizing delivery of services through the private sector; expanding MOH services incrementally; adding CS and AIDS activities onto existing programs rather then creating new ones; focussing resources on groups at highest risk; integrating CS and AIDS activities whenever possible; maximizing leverage over health sector policy by consolidating USAID support in a single project; and utilizing a flexible project design to pursue lessons learned and exploit opportunities to expand successful strategies.

The project will be managed by the USAID/Malawi Mission. Overall supervision of project implementation will be the responsibility of the Chief of the Health, Population, and Nutrition (HPN) Office. That Officer will be assisted by the Population Officer and by a Personal Services Contract (PSC) Project Manager funded by the STAFH Project. Project strategies will be implemented by the GOM, the FHI/AIDSCAP project, and a project-funded institutional contractor. Additional specialized technical assistance will be obtained from centrally-funded USAID projects such as DHS and RAPID. A Project Steering Committee will be formed to periodically address project progress and policy issues likely to affect implementation. The Committee will include: the Principal Secretary for Economic Planning and Development; Principal Secretary of Ministry of Health; Deputy Secretary of Ministry of Finance; Principal Secretary of Ministry of Women and Children Affairs and Community Services; Executive Secretary of National Family Welfare Council; Program Manager of Malawi AIDS Secretariat; Health, Population and Nutrition Officer of USAID; Chief of Party, AIDSCAP; and Chief of Party, Institutional Contractor. Representatives from the MOH Planning Section and Project Implementation Unit (PIU) and the MOH Maternal Child Health/Child

Spacing Unit will also be members of this committee. The Committee will meet initially to elect a chairperson and will then meet every three months or more often whenever deemed necessary. Additionally, USAID/Malawi will establish an internal STAFH Project Committee. This committee is being formed in recognition of the fact that STAFH will require a variety of resources from the Mission for its successful implementation. The committee will be comprised of representatives from relevant mission offices and will meet on a monthly basis to address internal Mission management concerns.

An illustrative summary of the project costs by major category appears below:

ILLUSTRATIVE SUMMARY OF PROJECT COSTS BY MAJOR CATEGORY

($000)

		LOP Funding	FY 92 Obligation	Future Fund to be Obligated
Technical Assistance		25,241	4,600	20,641
Activities	(9,289)			
Personnel	(7,382)			
Oper. Costs/G & A	(4,572)			
Commodities/Med. Supplies	(3,515)			
Misc./Travel	(483)			
Commodities		11,426	350	11,076
Inflation Contingency		1,724	150	1,574
Local Costs		2,139	350	1,789
Training		1,100	50	1,050
Audits and Evaluations		350	-	350
Other USAID Direct		3,020	500	2,520
Total		45,000	6,000	39,000

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A comprehensive monitoring and evaluation plan is included in the PP. The AIDSCAP project and the Institutional Contractor will be responsible for designing and implementing a monitoring, evaluation, and reporting system for their respective project components. In addition, two project evaluations will be conducted during the life of the project. A mid-term evaluation is scheduled for 1995 and a final evaluation for the fourth quarter of 1998. Demographic and Health Surveys, presently scheduled for 1994/95 and 1997/98 will provide essential data for the final evaluation.

The project procurement plan was developed by the REDSO RCMO. A detailed procurement and implementation plan for the first two years is included in the PP.

Finally, as part of the design process, the following analyses were conducted: social soundness and gender analysis, institutional analysis, economic and financial analysis. Summaries of each are included in the PP, and full versions are available as annexes.

III. Revisions from PID/PAIP to PP:

A summary of the STAFH project was presented to AID/Washington in June 1991 as part of the 1993 Annual Budget Submission (ABS). In August 1991, State 261380 granted delegation of authority to the Mission Director, USAID/Malawi for PID approval of the proposed $22,000,000 project with a recommendation that the life of project funding be increased. Assessments conducted in August, September, and October of 1991 highlighted the fact that the private sector was ready to participate in the implementation of family planning and AIDS activities and that STD control was fundamental to reducing HIV incidence. These assessments and simultaneous policy developments influenced the mission to rethink the scope, content and budget of the project. In essence, the PID budget was increased to $45,000,000 and a Non-Project Assistance (NPA) component was added. In December, 1991 the Mission Director and the Health Population Officer were scheduled to be in AID/Washington and requested an informal review of the draft PID. AFR/SA, AFR/DP, AFR/ARTS, AFR/CCWA, RD/POP, and RD/H attended the meeting. In February, 1992, State 53507 reported the results of that meeting and authorized ad hoc delegation of authority to the Mission Director, USAID/Malawi to implement a $45,000,000 combined project/program. The major issue at the review was the appropriate use and level of Non-Project Assistance (NPA). AID/Washington noted that the PP/PAAD must: a) include a sufficient sector analysis which includes all the requirements for sector NPA and identifies and rank orders the most important sector constraints; b) identify reforms which address the most important sector policy/institutional constraints, not just those constraints which are useful to achieving the project purpose; and c) distinguish between policy and institutional reforms that are appropriate for NPA and construction that should more properly be project financed. These concerns combined with USAID/Malawi's growing reluctance to commit additional NPA funds to Malawi prompted the mission to initiate STAFH as a project, as opposed to a project/program hybrid. In late February, 1992 USAID/Malawi held a formal PID review and on February 28, 1992 the Mission Director approved the $45,000,000 PID. This laid the foundation for the attached $45,000,000 Project Paper (PP).

IV. Other Requirements:

A. Documentation:

1. Statutory checklist: The statutory checklist is included as an annex. The checklist has been cleared by phone with AID/Washington.

2. Source/Origin: The authorized A.I.D. Geographic Code for procurement of goods and services, with the exception of ocean shipping, air travel and transportation services, is Code 935 and Malawi. Shipping and air travel/transportation regulations are specified in the Project Grant Agreement. Generally, all reasonable efforts are to be made to maximize procurement of goods and services from the U.S.

3. Initial Environmental Examination (IEE): A Categorical Exclusion was granted on June 18, 1992 based upon 22 CFR Part 216.2 (c) (2) (i) for all training components, and upon 22 CRF 216.2 (c) (2) (viii) for all remaining components of the health care family planning services of this project. The IEE is included as Annex N.

4. Technical reviews: Relevant sections of the PP have been reviewed by the RLA, Regional Commodity Management Office (RCMO), and the Mission Controller (CONT). All clearances have been noted on the PP clearance sheet.

B. Twenty-five Percent Host Country Contribution: The GOM is firmly committed to providing counterpart support to the STAFH project. National programs combatting AIDS and promoting child spacing have been ongoing since the mid and early 1980's, respectively. The GOM will invest an estimated 182.6 million Kwacha or $45.668 million over the life of project in counterpart support to the project's objectives. This amount amply exceeds the required 25% host country contribution of $15 million equivalent.

V. Mission Review:

The Mission Project Paper review was held on Friday, August 7, 1992. In attendance were representatives of all relevant Mission divisions. The following issues arose:

1. Goal/Purpose: The proposed project goal and purpose statements were discussed and it was agreed that the goal/purpose statements would be revised to reflect better the Mission's strategic objectives for fertility and AIDS. This has been accomplished.

2. Project Sustainability: Project sustainability was discussed at length. The discussion focused on the project's potential for organizational capacity building of NFWC, AIDS SEC, and local NGOs. It was noted that the GOM has agreed to absorb into the revenue budget the project-related recurrent local costs of the child spacing services provided in the Grantee's facilities and through MOH employees (e.g., Health Surveillance Assistants) by the end of project. A plan demonstrating the method by which these cost will be absorbed will be completed by the GOM in 1994. It was also noted that this project is designed to sustain new behaviors among individuals and respond to Malawi's urgent need to reduce the transmission of AIDS and increase CS practices.

Through the subgrant program, local NGOs will work towards sustaining these new behaviors and at the same time they will build their organizational capacity.

3. Institutional Capability: It was suggested that an organizational outline of AIDS SEC be added to the PP along with a description of the Secretariat's roles and responsibilities. This has been completed.

4. Management Issues: STAFH is a complex project and will require assistance from various offices within the Mission. To respond to these complexities, the HPN Office has agreed to establish an internal committee, the STAFH Project Committee, comprised of representatives from relevant USAID offices. The Committee will monitor progress of STAFH's implementation and address internal Mission management concerns. A description of this committee has been included in the PP.

5. Technical Issue: Concern over Central Medical Services (CMS) capability to deliver contraceptives to health facilities in a timely and efficient manner was discussed. The HPN office is in close dialogue with the MOH which has expressed similar concerns and is contemplating corrective remedies.

6. PSC: USAID/Malawi was originally going to award a personal services contract (PSC) for a period of three years, renewable for up to three additional years. To comply with statutory regulations, however, this has been revised to an initial contract of two years, renewable up to three additional years.

7. Commodities: It has been decided that USAID/Malawi will not procure residential or office furniture for the institutional contractor or AIDSCAP. The budgets have been adjusted accordingly.

8. Timing: The implementation plan and schedule has been reworked and currently reflects accurate dates.

9. Local Hire Positions: Efforts will be made to ensure that the local hire salaries for AIDSCAP and the Institutional Contractor are on scale with USAID/Malawi's local compensation plan.

10. Budget: The budget has been reconfigured to facilitate project tracking.

11. Host Country Contribution: The HPN Office noted that it is working closely with the MOH to determine the Host Country Contribution which will be at least 25% of the total project costs.

12. FHI/AIDSCAP Cooperative Agreement: The AIDSCAP Cooperative Agreement expires in 1996, and the STAFH project's PACD is 1998. This could present certain problems relating to the continuity of project activities. The HPN office, however, is aware of the timing and is planning for contingencies.

13. Cost Sharing: The difficulties inherent in cost sharing arrangements between AIDSCAP and the Institutional Contractor have been taken into consideration. Despite the potential audit, legal, accounting, and managerial complications, the HPN Office believes that cost sharing arrangements and close collaboration are essential for project success. The situation will be monitored closely.

14. NFWC: It has been decided that NFWC will not allocate subgrants during the initial years of project assistance. The PP reflects this decision.

VI. Delegation of Authority:

As noted earlier, an ad hoc delegation of authority to the field was granted in February, 1992 in State 53507.

VII. Recommendations:

That you sign the attached Project Data Sheet and the Project Authorization for the Support to AIDS and Family Health Project, thereby approving a life of project amount of $45,000,000 and an initial FY 1992 obligation of$6,000,000.

Attachments:

1. Project Data Sheet
2. Project Authorization

Drafted by: SFunk, PID
Clearances: DMcCloud, PID
CMcDermott, HPN
RMahoney, PAE
RBAmin, FMO

PROJECT AUTHORIZATION

Name of Country: Malawi

Name of Project: Support to AIDS and Family Health Project (STAFH)

Number of Project: 612-0238

1. Pursuant to Title II of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1989 (Sub-Saharan Africa, Development Assistance), I hereby authorize the Support to AIDS and Family Health Project (the "Project") for Malawi (the "Cooperating Country") involving planned obligations not to exceed $45,000,000 in grant funds over a six year period from date of authorization, subject to the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the Project. The planned life of the Project is six years from the date of initial obligation.

2. The Project consists of assistance to the Cooperating Country to decrease sexually transmitted HIV/STD and to lower the fertility rate through educational and communication programs aimed at behavioral change, such as reducing high risk behavior in target groups, promoting the use of condoms, improvements in STD treatment and counselling services, and popularizing modern methods of contraception.

3. The Project Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.

4. A. Source and Origin of Commodities, Nationality of Services

Commodities financed by A.I.D. under the Project shall have their source and origin in the United States, in the Cooperating Country, or in countries included in Geographic Code 935, except as A.I.D. may otherwise agree in writing.

Except for ocean shipping, the suppliers of commodities or services shall have the United States, the Cooperating Country, or other countries included in Geographic Code 935 as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the Project

shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels of the United States or Code 935 countries. Air travel and transportation shall be financed only on U.S. flag air carriers to the extent they are available. Procurement of commodities and services of U.S. source, origin and nationality shall be maximized to the extent practicable.

B. Conditions Precedent

1. General Conditions Precedent

Except for the hiring of the Personal Services Contractor and except as A.I.D. may otherwise agree in writing, prior to any disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the Grantee shall furnish to A.I.D, in form and substance satisfactory to A.I.D.:

(a) an opinion of counsel acceptable to A.I.D. that this Agreement has been duly authorized and/or ratified by and executed on behalf of, the Grantee, and that it constitutes a valid and legally binding obligation of the Grantee in accordance with all its terms.

(b) a written statement setting forth the names and titles of persons holding or acting in the Office of the Grantee and of any additional representatives, and representing that the named person or persons have the authority to act as the representative or representatives of the Grantee, together with a specimen signature of each such person certified as to its authenticity.

(c) written evidence that a Ministry of Health full-time Project Coordinator and a full-time Accountant have been appointed and assurance that they will commence work within 60 days of their appointment.

(d) written evidence that the Grantee has held the initial Project Steering Committee meeting. This Committee will meet, every three months, or whenever deemed necesary to address Project progress and policy issues likely to affect implementation of the Project and attainment of its objectives. Committee members will include: Principal Secretary for Economic Planning and Development; Principal Secretary of Ministry of Health; Deputy Secretary of Ministry of Finance; Principal Secretary of Ministry of Women and Children Affairs and Community Services; Executive Secretary of National Family Welfare Council; Program Manager of Malawi AIDS Secretariat; USAID Health, Population and Nutrition Officer;

Chief of Party of AIDSCAP; and Chief of Party of the Institutional Contractor. Representatives from the Ministry of Health Planning Section and Project Implementation Unit (PIU) and the Ministry of Health Maternal Child Health/Child Spacing Unit will also be members of this committee. The Steering Committee should meet as soon as possible to elect a chairperson and discuss conditionality affecting the project.

2. Conditions Precedent to Contracting with an Institutional Contractor for Assisting with Child Spacing Services

Except as A.I.D. may otherwise agree in writing, prior to A.I.D. entering into a contract with an Institutional Contractor to assist the Grantee in providing child spacing services, the Grantee shall furnish to A.I.D., in form and substance satisfactory to A.I.D., written evidence that:

(a) The Grantee has revised and approved child spacing/family health service guidelines which ensure that all those who seek child spacing information and services, will have unhindered access to them and the Grantee has disseminated the guidelines to all service providers;

(b) The Grantee has agreed to modify the pre-service curricula at Ministry of Health and private health training schools to ensure that every enrolled and registered nurse, medical assistant and clinical officer successfully completing training after September 30, 1992 will be designated by the Grantee as a qualified provider of child spacing (except IUD) services in Malawi; and

(c) A revised in-service family health training program qualifying health providers to deliver child spacing services has been developed and implemented that excludes IUD training.

C. Special Covenants

1. The Grantee agrees to undertake or cause to be undertaken the following:

(a) Local Cost Contributions. The Grantee agrees that the contributions of local communities to support the extended delivery of family health services may be managed and distributed by those communities as they so choose.

(b) Sexually Transmitted Disease Drugs and Medical Supplies. The Grantee agrees that the drugs and medical supplies purchased under the Project expressly for STD research and treatment will be separately labelled and targeted to STD

patients, and that records will be maintained to monitor and control such distribution. The Grantee further agrees, in collaboration with project technical assistance to institute and implement a reordering and restocking system capable of meeting the project's needs.

(c) Expedited Review and Approval Procedures. The Grantee agrees to implement new procedures to expedite the review and approval of scientific research, and educational and promotional material funded by this Project for AIDS/HIV/STDs and child spacing.

(d) Recurrent Costs. The Grantee agrees to absorb into the revenue budget the Project-related recurrent local costs of the child spacing services provided in the Grantee's facilities and through Ministry of Health employees (e.g., Health Surveillance Assistants) by the end of Project. By September 30, 1994 the Grantee will submit a plan satisfactory to A.I.D. demonstrating the method by which these costs will be absorbed.

(e) Annual Workplans. The Grantee agrees to submit to A.I.D. annual workplans describing GOM activities under this Project which address objectives for the year, estimated financial expenditures, the party or office responsible for each action in the workplan and such details as are required to ensure monitoring and coordination.

(f) Annual Reports. The Grantee agrees to submit with each annual workplan (starting in year two of the Project) an annual report on the preceding year's progress, problems and achievements as they relate to the Grantee's activities.

(g) Use of Project Goods. The Grantee agrees to ensure that all commodities procured for the Project will be used exclusively for Project purposes, that usage will be carefully monitored and controlled, and that an inventory status report will be provided to A.I.D. by 30 September of each year.

(h) Long-Term Trainees. The Grantee will ensure that all trainees financed by A.I.D. under this Project and employed by the Government will, upon completion of their training, serve the Government (for a period not less than the duration of their training) in a position commensurate with the training received.

(i) Population Policy Statement. The Grantee will develop and disseminate a national population policy statement which is distributed to the Grantee's personnel and incorporated into all relevant training programs.

(j) Norplant. The Grantee will approve and, assuming satisfactory review of the pilot project, register Norplant by December 31, 1992.

(k) Community-Based Distribution. The Grantee will issue, assuming satisfactory review of the pilot project, a directive allowing trained community/field workers to initially supply and resupply oral contraceptives.

(l) Project Evaluation. The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include during the implementation of the Project:

i. evaluation of progress towards attainment of the objectives of the Project;

ii. identification and evaluation of problem areas or constraints which may inhibit such attainment;

iii. assessment of how such information may be used to help overcome such problems; and,

iv. evaluation, to the degree feasible, of the overall development impact of the Project.

Carol A. Peasley

Carol A. Peasley
Mission Director
USAID/Malawi

30 September 1992

Date

Drafter: PDO:SFunk:jo: _____ Date: 9/30/92

Clearances: HPN:CMcDermott: _____ Date: _____
PAE:Rmahoney: _____ Date: 9/30/92
PID:DMcCloud: _____ Date: 9/30/92
CONT:RBAmin: _____ Date: 9/29/92
REDSO/RLA:TFillinger: (BY FAX) Date: 9/21/92

VS DOC: 1843D

LIST OF ACRONYMS AND ABBREVIATIONS

A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AIDS SEC	AIDS Secretariat (MOH)
AIDSCAP	AIDS Control and Prevention (USAID Project)
AIDSCOM	AIDS Communication
AIDSTECH	AIDS Technical Services
API	Assessment of Program Impact
AVSC	Association for Voluntary Surgical Contraception
CBD	Community-Based Distribution (of Contraceptives)
CCAM	Chitukuko Cha Amai m'Malawi (National Women's Group)
CDSS	Country Development Strategy Statement
CHAM	Christian Health Association of Malawi
CHSU	Community Health Services Unit (MOH)
CONGOMA	Council of Non-Governmental Organizations of Malawi
CPR	Contraceptive Prevalence Rate
CS	Child Spacing
CSM	Contraceptive Social Marketing
CYP	Couple Years of Protection
DDC	District Development Committee
DEVPOL	Statement of Development Policies 1987-1996 (GOM)
DHI	District Health Inspector (MOH)
DHO	District Health Officer (MOH)
DHS	Demographic and Health Survey
EC	European Community
ENM	Enrolled Nurse Midwife
EP&D	Economic Planning and Development
EU	Epidemiology Unit
FFS	Family Formation Survey
FHI	Family Health International
FY	Fiscal Year
GABLE	Girls Attainment in Basic Literacy and Education (USAID Project)
GOM	Government of Malawi
GPA	Global Programme on AIDS (WHO)
HA	Health Assistant
HEU	Health Education Unit
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPN	USAID Health, Population and Nutrition Office
HRID	Human Resource and Institutional Development
HSA	Health Surveillance Assistant (MOH)
HSMP	Health Social Marketing Project
IC	Institutional Contractor
IDA	International Development Agency/World Bank
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IUCD (IUD)	Intra-Uterine Contraceptive Device
K(MK)	Malawi Kwacha
KAP	Knowledge, Attitude and Practice
KCN	Kamuzu College of Nursing

LOP	Life of Project
LSHS	Lilongwe School for Health Sciences
M&E	Monitoring and Evaluation
MBC	Malawi Broadcasting Corporation
MCH	Maternal and Child Health
MDU	Manpower Development Unit (MOH)
MIS	Management Information System
ML/LA	Minilaparotomy under Local Anesthesia
MOA	Ministry of Agriculture
MOEC (MOE)	Ministry of Education and Culture
MOF	Ministry of Finance
MOH	Ministry of Health
MOLG	Ministry of Local Government
MOWCCS	Ministry of Women, Children Affairs and Community Services
MTP	Medium Term Plan
MWRA	Married Women of Reproductive Age
NACP	National AIDS Control Programme
NFWC	National Family Welfare Council
NGO	Non-Governmental Organization
OVI	Objectively Verifiable Indicator
PD	Per Diem
PHC	Primary Health Care
PHICS	Promoting Health Interventions for Child Survival (USAID Project)
PHN	Public Health Nurse
PHRDU	Population, Human Resources Development Unit (EP&D)
PID	Project Identification Document
PIL	Project/Program Implementation Letter
PIR	Project Implementation Report
PSIP	Public Service Investment Program
PVO	Private Voluntary Organization
RAPID	Resources for Awareness of Population Impact on Development (USAID Project)
SEATS	Service Expansion and Technical Support (USAID Project)
SHARED	Services for Health, Agriculture and Rural Enterprise Development (USAID Project)
SOMARC	Contraceptive Social Marketing (USAID Project)
STAFH	Support to AIDS and Family Health
STD	Sexually Transmitted Disease
TA	Technical Assistance
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TOT	Training of Trainers
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

EXECUTIVE SUMMARY

Since independence in 1964, the population of Malawi has more than doubled, from 4 to 9 million. Should present growth rates in the range of 3.2% persist, the population is projected to double again by 2010. At the same time, AIDS has become a major disease facing the nation. An HIV seroprevalence of 9-10% among adults in 1991 means there are approximately 400,000 adults now infected with HIV. The infection's spread through Malawi's population has been rapid. Unchecked, population growth and the AIDS epidemic will erode economic growth and cripple national development.

The constraints to improving this situation are almost overwhelming. Annual per capita health investments by government amount to less than $3.00 and the number of health workers per capita is one of the lowest in Africa. Additionally, only 230 of the nation's 788 health facilities are able to offer child spacing services, and fewer are able to provide critical AIDS prevention services such as HIV prevention counseling and STD treatment. Also, there are few outreach programs to bring child spacing services closer to clients.

Despite these formidable obstacles, glimmers of hope exist. Malawi has instituted national policies and programs necessary to gain control over the AIDS epidemic and the high population growth rate. As a result, knowledge of AIDS and child spacing has increased dramatically, and condom and contraceptive use rates appear to be rising. In addition, a number of nongovernmental organizations have begun efforts to address the AIDS epidemic, but require the support of both the government and donors. The Support to AIDS and Family Health (STAFH) Project, therefore, is being launched in an environment of support from both the top and bottom.

The STAFH Project has as its overall goal reduced total fertility and reduced HIV/AIDS/STD transmission. Its purpose is to increase the contraceptive prevalence rate, and to promote behavioral change to reduce the prevalence of HIV/AIDS/STDs. Its total budget is $45 million, and the life of project is six years (1992 - 1998).

STAFH's strategy to attain its goal and purpose includes:

(1) increasing the supply of services by increasing the number of fixed facilities staffed and equipped to provide

child spacing and AIDS services and extending services to communities through community-based distribution programs;

(2) emphasizing delivery of services through the private sector;

(3) improving knowledge of how to prevent AIDS, how to plan families and where to get AIDS and child spacing information and services;

(4) increasing contraceptive use by broadening the choice of contraceptive options and making services more convenient; and

(5) strengthening two national leadership organizations, the AIDS Secretariat and the National Family Welfare Council (NFWC), to lead the policy dialogue on the approaches outlined above, coordinate service delivery and improve the quality and effectiveness of care given by service providers.

By the end of the project in 1998, STAFH will help reduce both HIV incidence and the total fertility rate. Key indicators of the success and impact of STAFH's investment by 1998 include a reduction from 25% to 15% in HIV prevalence among women attending the antenatal clinic at Queen Elizabeth Central Hospital (QECH) and a reduction in the total fertility rate from 7.6 to 6.8.

This strategy will be carried out by a number of actors. The USAID/Malawi Mission will manage the project in collaboration with the Ministry of Health (MOH), the Ministry of Women and Children Affairs and Community Services (MOWCCS) and a Project Steering Committee. The project will be implemented by the National Family Welfare Council (NFWC), MOH and an institutional contractor (IC) for the child spacing component, and, for the AIDS component, by the AIDS Secretariat (AIDS SEC) and contractors provided under the AID/Washington centrally managed AIDS Control and Prevention (AIDSCAP) Project.

Of the total $45 million project budget, $25.3 million will be channelled through the competitively selected institutional contractor and AIDSCAP for technical assistance, commodities, medical supplies, training, workshops, mass media campaigns, material development, research, social marketing, information/education/communication (IE&C) activities, and management information systems (MIS). One important element of this component is a subgrant program to NGOs/PVOs totalling $4.7 million, with the IC responsible for implementing a $4.1 million program for child spacing activities, and AIDSCAP a $600,000 program for AIDS activities. The subgrant program will be the principal means of providing financial assistance to private sector providers, including NGOs/PVOs, to improve and expand child spacing and AIDS services.

NFWC and the IC will work in tandem, as will the MOH's AIDS Secretariat and AIDSCAP, in awarding subgrants in their respective areas. Grants that support both AIDS and child spacing will be encouraged wherever possible.

The project also will finance $2.1 million in direct support to the Government of Malawi (GOM) to upgrade sites, improve core child spacing services, training and IE&C activities. In addition to this direct GOM support, USAID/Malawi will procure $11.4 million for contraceptives and other commodities through an Operating Year Budget (OYB) transfer to AID/W. A total of $3.4 million has been allocated for additional specialized technical assistance (obtained from centrally-funded USAID projects such as DHS and RAPID), pilot/operation research grants, and long and short term training. Other project management requirements, plus an allowance for inflation and contingency, amounts to $2.8 million.

An important aspect of the project strategy is to combine, within one project, AIDS prevention and child spacing activities. In many ways, these two activities will be implemented separately, but it is the intention of the Mission to integrate them in every way possible. There is little precedent for this approach in terms of major project design elsewhere, but it is an approach which displays specific advantages and which is gaining acceptance. To a large extent the target groups of the two activities are the same. Also, they both rely on significant participation by the Ministry of Health, require the allocation of substantial MOH resources, and utilize similar MOH services and facilities. This can make them competitors for scarce health resources, but if they are regarded in every way possible as complementary, then the resulting efficiencies should further enhance achievement of individual objectives. Finally, from the perspective of Mission management of health sector programs, combining these two activities allows the Mission to consolidate what tend to be management-intensive activities, and, with major responsibility for implementation on institutional contractors, to more effectively concentrate Mission resources on strategic thinking.

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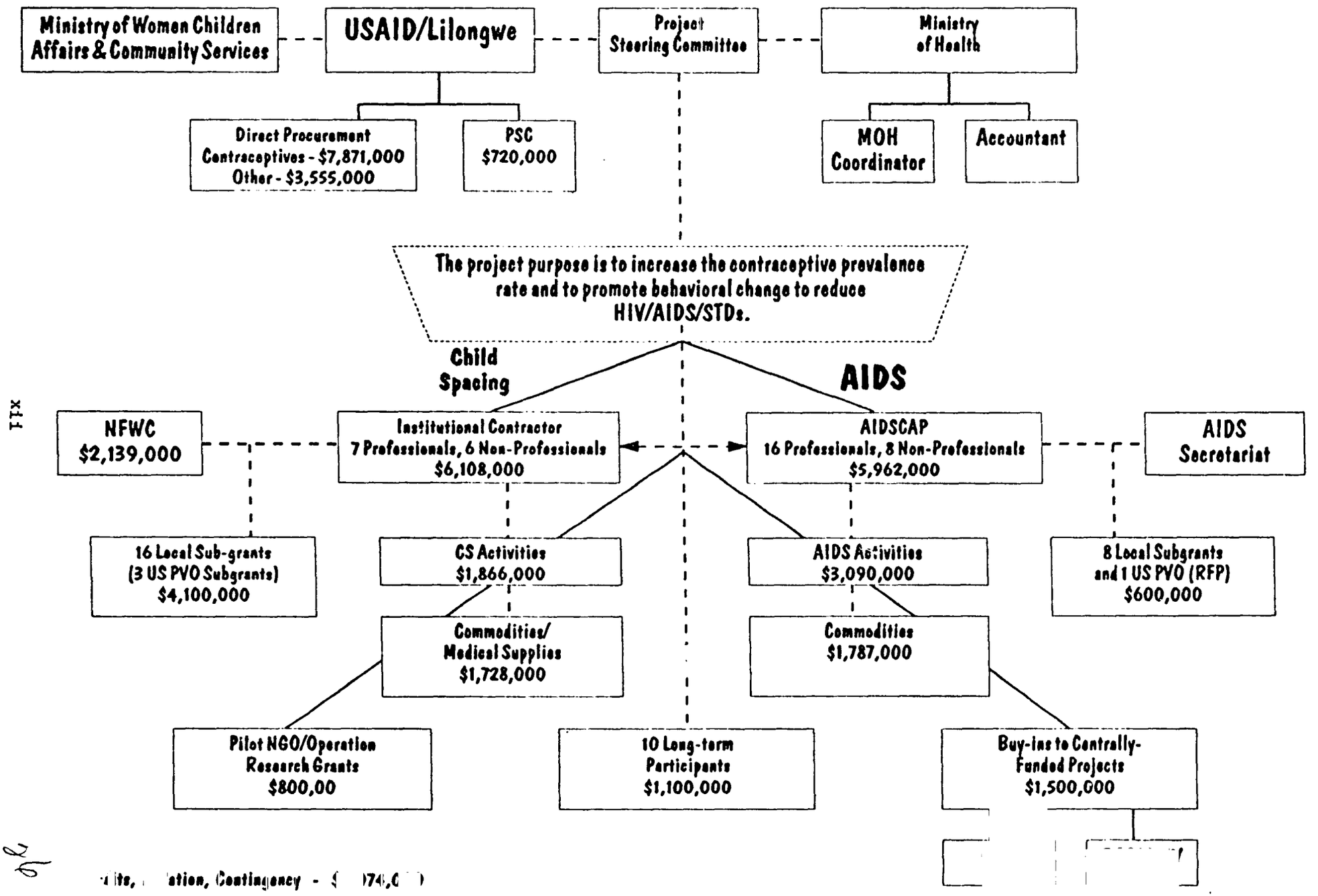

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I. BACKGROUND

A. Development Problems

1. The AIDS Epidemic

AIDS/HIV arrived in Malawi sometime in the early 1980's and is now widespread in the population. Seroprevalence among one sample of reproductive age urban women rose from 2% in 1985 to 25% in late 1991. The infection's spread through Malawi's population shows no sign of abating. An estimated HIV seroprevalence of 9.6% among adults in 1991 suggests that up to 400,000 are now infected. Actual AIDS cases are thought to be in the range of 20,000. In 1997, under the "best" case scenario, AIDS is projected to kill 40,000 adults. Between 350,000 and 450,000 cumulative AIDS deaths (of all ages) are expected by 1998. Conservative estimates indicate the number of tuberculosis cases, closely related to AIDS, increasing from 5,000 cases in 1985 to 20,000-25,000 annually by 1998.

Implications of the AIDS epidemic are grave. Malawi will experience unprecedented numbers of deaths among adults in their productive years. Key cadres in government, industry and academia will be depleted. Hard-won gains in infant and child health will be lost. With AIDS, it is feared that there will be no improvement in child mortality and the child mortality rate in 1998 will remain unchanged at 240 deaths per 1000 births, as opposed to an expected drop to 179/1000 in the absence of AIDS. Hospitals and health care workers will be overwhelmed by the needs of AIDS and TB patients. Three hundred thousand children may be orphaned by AIDS by 1998.

Although the AIDS epidemic will lessen population growth, it will do so largely by increasing death rates among productive adults, thereby increasing the dependency ratio. Projections suggest that, without additional interventions, the epidemic will reduce the annual population growth rate from the current level of 3.2% to a range of 2.0%-2.3% by 1998. However, assuming STAFH project targets for AIDS prevention and control can be achieved, population growth may be reduced only to the 2.5%-2.8% range by 1998. At this level, population growth will remain excessively high and remain a key impediment to national development. By adding the planned child spacing interventions, the growth rate, should be reduced to below 2% by 1998.

Projections of the epidemic's economic impact suggest that by 1998 the direct costs of managing AIDS cases could consume one-third of the Ministry of Health (MOH) recurrent curative care budget. AIDS' impact on the labor force will erode productivity. The loss of potential income due to AIDS deaths

may rise from the equivalent of 7% of Malawi's GDP in 1992 to 14%-21% in 1998.

2. Rapid Population Growth

Since independence in 1964, the population of Malawi has more than doubled from four to nine million, exclusive of refugees which now number one million. Forecasts of Malawi's growth rate in the 1990s range from a low of 2.0% (with a continued severe AIDS epidemic) to 3.2% (the present population growth rate). Under either demographic scenario the implications of population growth are distressing. Population pressure will build on the agriculture sector where plot size for many is becoming untenably small and a once verdant countryside will be progressively denuded. The economy -- once robust by African standards -- will not be able to generate sufficient numbers of jobs, and the already daunting task of providing health coverage and educational attainment will become all but impossible.

As high population growth rates cause trouble for the nation at large, a total fertility rate exceeding seven causes difficulties for women of reproductive age and their children. Large numbers of children become more difficult to feed, clothe and educate as purchasing power and arable land erode. Excessive pregnancies sap women's strength while they and their children become more susceptible to disease and premature death.

B. Progress to Date

1. The AIDS Control Program

Malawi has established the basis for a solid AIDS control program. Policies and programs necessary to begin gaining control over the epidemic are in place. Significant progress has been achieved since 1989 when the first Five Year Medium Term Plan (MTP) for AIDS control began. Strong collaboration exists among WHO/GPA, the GOM and donors on AIDS program planning, financing and evaluation.

Although it is time consuming, AIDS policy is formulated through a nationally representative committee which incorporates a broad spectrum of socio-cultural perspectives. Examples of an increasingly open and enlightened policy and program environment include: (a) the decision to incorporate AIDS education into the nation's schools; (b) the increasingly frequent use of AIDS data and case projections in technical and public briefings; (c) public acknowledgment of the AIDS epidemic by the Life President; (d) a growing concern with AIDS on the part of the nation's political party and its related women's organization; (e) approval for advertising condoms on

national radio; (f) a policy of non-discrimination against persons with HIV and AIDS; (g) approval of the use of persons with AIDS as health educators; and (h) the production of videos portraying Malawi-specific AIDS themes.

Efforts to date have resulted in a dramatic increase in general knowledge of AIDS -- from negligible levels in 1984 to virtually universal knowledge in 1992. Anecdotal and piecemeal evidence suggests that men are beginning to use condoms more frequently, albeit inconsistently, where condom use was virtually nil in 1984.

2. The Population and Child Spacing Program

In 1983 the child spacing program in Malawi was moribund. Over the course of the past eight years, Malawi has achieved slow but steady progress in building a national program. A number of recent GOM actions indicates a warming trend in the policy and program environment:

- **Principal Secretaries' Policy Recommendations** - In October 1991, Principal Secretaries recommended that the country develop its first explicit population policy statement and that a number of progressive program policies be implemented to liberalize the delivery of and access to child spacing services.

- **PHRDU Established** - A Population and Human Resources Development Unit was established in the Office of the President and Cabinet (OPC) to formulate population development policies and plans.

- **NFWC Established** - The nation's first national-level organization devoted exclusively to the promotion of child spacing - the National Family Welfare Council - was approved by the Life President and Parliament;

- **Maternity Leave Instituted** - The GOM instituted a maternity leave policy for government workers which encourages a three-year child spacing interval.

- **GOM Project Approvals** - Within the last 18 months the GOM has approved USAID-supported projects to: (a) increase access to voluntary surgical contraception; (b) test pill resupply at the community level; (c) implement contraceptive social marketing (CSM) nationwide; and, (d) undertake Malawi's first Demographic and Health Survey (DHS).

As a result of these and other actions, users of modern contraceptive methods for family planning increased from 3000 in 1984 to 55,000 in 1990. Findings from a 1991 survey and a February 1992 program assessment suggest that the prevalence

rate for modern contraceptive methods is moving upward -- from 1% in 1984 to 3% in 1991. With continued Government commitment and increased donor support this upward trend can accelerate.

C. Constraints to Further Progress

Some constraints affect AIDS prevention primarily, some affect child spacing primarily, and some affect both. Each of these categories is discussed separately below.

1. Constraints to both AIDS Prevention and Child Spacing

a. Insufficient Funding of Primary Health Care

Although 7-8% of the national revenue budget is devoted to health, annual per capita health investments amount to the equivalent of less than $3.00. Preventive health programs like AIDS prevention and child spacing get little priority in the revenue budget. Within tight MOH budgets, curative care is emphasized over prevention programs, and within the preventive health budget, there are many competing public health priorities vying for scant resources. Government health facilities account for over 60% of total patient contacts with the formal health care system. These services, including provision of drugs, are offered free of charge, thereby limiting the funds available to pay for health care. Consequently, revenue resources for child spacing and AIDS prevention are slight.

b. Not Enough MOH Staff

The number of MOH health workers available to provide child spacing and AIDS prevention services is severely limited by a number of constraints. In addition to the GOM budget limitations and policies noted above, several key constraints include: low capacity at health training institutions and exclusion of comprehensive CS training in pre-service curriculums; high attrition rates from training programs; the current 12-week in-service training requirement to qualify CS providers; and government delays in filling administrative posts from outside the health ministry. The limited number of personnel are not well distributed, serving mainly in urban areas due to the staffing needs of central and district hospitals and the tendency of married nurses to follow their husbands' urban-based careers.

c. Not Enough MOH Staff Time

The amount of time MOH staff are able to devote to child spacing and AIDS prevention is severely limited by: health policies which allocate the majority of staff time to curative

care; an increasing level of demand for curative care caused by rising malaria, AIDS and TB epidemics among a rapidly growing population; and staff absences due to participation in training programs, particularly among mid- and senior-level staff.

d. Limited MOH Implementation Capacity

MOH implementation of donor-funded projects is slow due to the health manpower constraints outlined above; complicated and uncoordinated donor policies, procedures and requirements; an oversupply of donor-funded (medical/clinical) technical assistance relative to assistance for management, administration and implementation; insufficient MOH decentralization; an overly heavy project management load for available staff; and the difficulty of coordinating planning, implementation, and reporting for the many donor-funded inputs.

Capacity is also limited by the slowness of the government's manpower system, requiring as long as 18 months to establish and fill posts, and the complexity of arranging transfers and promotions.

e. Limited Supply of AIDS Control and Child Spacing Services

Survey results suggest significant unmet demand for child spacing. A 1984 survey indicated 16% married women of reproductive age (MWRA) wanted no more children and 43% of non-pregnant women wanted to delay the next birth. A 1991 survey found 20% of MWRA wanting no more children. Anecdotal reports of significant unmet demand are consistent and lend credence to survey findings. Child spacing services are not adequate to meet current demand. Only 230 of the nation's 788 public and private sector health facilities provide child spacing services, and there are few outreach programs for extending child spacing services beyond clinics. Far fewer facilities provide critical AIDS prevention services, such as STD diagnosis, treatment and prevention counseling.

2. <u>Child Spacing Specific Constraints</u>

In addition to the above general constraints, the following also hinder progress specifically with respect to child spacing.

a. Providers' Perception of Child Spacing Policies Outdated

Current child spacing policies are based on the prevailing political-cultural climate of 1982. In response to changes of the past several years, the GOM is updating guidelines to align them with the current political and cultural climate. However, until updated guidelines are disseminated, trainers and service providers continue to operate under outmoded perceptions of

official population policy which constrain provision of services. A clear sense of direction and strong advocacy of a population policy - coming from the highest level of government - in support of slower population growth and giving high priority to child spacing would contribute greatly to overcoming the apparent reluctance of many mid-level GOM officials to move ahead forcefully with child spacing.

b. Incomplete Knowledge of Contraceptive Options and the Perceived Value of More, Rather Than Fewer, Children

While on the increase, knowledge of contraceptive options and the benefits of child-spacing is far from universal. Rumors and misconceptions remain. More information on methods and sources of services is required to convert the growing interest in child spacing to effective use. High levels of infant and child mortality, the strong need for domestic labor within the smallholder farming system, women's low literacy and economic status, and the general assumption that larger families contribute to long-term socio-economic security, are all strong countervailing forces to lowering fertility.

3. <u>AIDS Prevention Specific Constraints</u>

In addition to the above general constraints, the following also hinder progress specifically with respect to AIDS prevention.

a. AIDS Policies Enlightened But Slow to be Formed

It has taken longer to obtain National AIDS Committee approval for recent AIDS IEC materials and research protocols than it did to develop them. While this problem is not unique to Malawi, the relative paucity of information on AIDS and the compelling need to increase the reach of the control program makes it particularly important to expedite activities.

b. Incomplete Knowledge of AIDS

Surveys reveal important gaps in detailed practical knowledge of how AIDS is transmitted and prevented. Studies of Malawian sexual behavior are few. High risk behaviors (such as having multiple sexual partners) remain prevalent, and those engaged in such behaviors often do not perceive themselves at risk. Condom use has increased but is still at a very low level and consistent use is feared lower.

c. Impact of AIDS Control Strategies Uncertain

Ample evidence exists to show that IEC programs have led to increases in AIDS knowledge among Malawian adults, and some evidence exists to suggest that knowledge has changed behavior,

i.e., an increase in condom use. What is missing in Malawi and elsewhere is more solid evidence to link particular interventions with declines in HIV incidence.

D. Conformity with USAID Policies and Plans

In December, 1989, AID/Washington approved the USAID/Malawi Mission Country Development Strategy Statement. The goal of the Program Strategy is to enhance the economic well being of the average Malawian household. Associated sub-goals are to raise per capita income and improve food security, health status and work-force productivity. Achievement of these goals and sub-goals rests on five strategic objectives:

(1) increase foodcrop production and productivity,
(2) increase off-farm employment,
(3) reduce fertility,
(4) decrease infant and child morbidity and mortality, and
(5) control the spread of AIDS.

STAFH is designed to be the Mission's principal vehicle for addressing the third and fifth strategic objectives: reducing fertility and controlling AIDS. In addition, the project is expected to have a significant, although secondary, impact on decreasing child morbidity and mortality as birth intervals increase and fewer children are born to AIDS-infected women. Similarly, controlling the spread of AIDS will have direct ramifications for agricultural productivity. Finally, the Mission's basic education activity, GABLE, should assist in improving the effectiveness of the STAFH educational activities by allowing messages to be delivered to a more literate population.

Lessons learned from the portfolio applicable to this design include: (a) the Project HOPE AIDS and Child Survival projects demonstrated a significant level of private sector interest in which companies are willing to assume recurrent costs; (b) the SEATS project demonstrated CBD feasibility in the private sector; (c) SOMARC demonstrated social marketing is feasible; (d) SHARED demonstrated PVO interest and a model for subgrant financing; and, (e) PHICS demonstrated a workable model for a planning, budgeting and financial management system for providing local cost support to MOH, the feasibility and advantages of portfolio consolidation, and that institutional development objectives are achieved slowly in the public sector.

Based on an April 1991 review of the health sector porfolio, the Mission decided to integrate into one project support for AIDS control and for child spacing activities. The STAFH project is the response to that decision. The advantages of

consolidation are expected to include improved conceptualization of the Mission health sector strategy, more effective management and coordination of Mission funded health sector activities, and increased leverage over developments in the sector. The Mission's consolidation strategy is to phase-out all USAID AIDS and CS activities outside the context of the bilateral project, and thereby to minimize the number of implementing agencies and the number of TA sources utilized under the bilateral project.

The Mission also will make use of other components of the USAID portfolio to support its health sector activities as follows:

PHICS: Support for MOH institutional and human resource development; national in-service training including AIDS and CS; and strengthening MOH units which support AIDS and CS (e.g., HIS, HEU, CHSU/EU, MDU and LSHS).

HRID: Complement PHICS by addressing selected institutional and human resource development needs of public and private sector health training institutions (MOH, KCN and CHAM).

SHARED: Complement STAFH by addressing institutional and organizational development needs of Malawian PVOs and NGOs.

STAFH: Support the delivery of AIDS prevention and child spacing services through strengthening national programs and through support to the private sector.

GABLE: Complement STAFH by influencing a key determinant of fertility and sexual activity -- girls' access to education.

II. PROJECT DESCRIPTION

A. Project Goal and Purpose

While distinct, reducing both fertility and HIV/AIDS/STD transmission are linked by a common target group, a focus on the equal importance of education and service delivery and commodities, and the need for behavioral change. The project's goal and purpose are as follows:

goal: to reduce total fertility and HIV/AIDS/STDs transmission.

purpose: to increase the contraceptive prevalence rate and to promote behavioral change to reduce the prevalence of HIV/AIDS/STDs.

By combining these two sets of activities, the Mission expects the resulting management efficiencies and greater potential overall impact to strengthen the achievement of one of its major program objectives, improvement of the health status of average Malawian households.

B. Project Strategy

To achieve the its goal and purpose, the project includes activities designed to accomplish the following:

-- improve and expand knowledge about, and provision of services for, child spacing and AIDS prevention, in particular through private sector activities;

-- broaden the choice and availability of contraceptive options; and

-- strengthen national leadership organizations important to further developing and sustaining viable local initiatives.

Expanded knowledge and services. As described in the above section on "Constraints," insufficient Ministry of Health funding, staff, and staff time, and limited MOH project implementation capacity, all have led to less than adequate provision of services for child spacing and AIDS prevention. In recognition of these constraints, and in recognition that a multifaceted approach is necessary to attack the problem, the project includes components to expand MOH physical facilities and outreach programs, to expand and improve staff skills and qualifications, and to develop and utilize as much as possible private sector and nongovernmental entities. These will

include private sector firms, mass media, schools, women's groups, churches and youth centers, nongovernmental organizations, and traditional channels such as initiation ceremonies and peer groups.

Contraceptive availability. A broad choice and wide availability of contraceptive options are necessary if the project is to reach its target population. Options will be defined not only in a technical sense, but also by client satisfaction. Again as noted in the "Constraints" section, survey results suggest significant unmet demand for child spacing. More information on methods and sources of services is required to convert the growing interest in child spacing to effective use. However, success is possible only through client satisfaction, and this will require improvements to the quality, safety and cultural appropriateness of services, as well as improved access to and convenience of more affordable services. Project activities are included to achieve these improvements.

National leadership organizations. Enhanced national commitment to AIDS prevention and child spacing programs will be promoted through strengthening activities with the AIDS Secretariat and National Family Welfare Council. The focus of these activities will be on developing the organizations' policy making and analysis capabilities, their technical and administrative capabilities, and their provision of support services to their clients.

A major priority of the project is to have as great an impact as early as possible, in particular concerning AIDS prevention. Given the current situation as described in the above "Background" section, rapid action is necessary to alleviate what is becoming a desperate situation. To attain maximum impact quickly, AIDS prevention efforts will be focussed on four primary target groups at greatest risk, i.e., youths in and out of school, employed males, male STD clients, and bargirls/freelancers and bar owners. In addition, a design decision was made to utilize an existing AID/W managed cooperative agreement for the provision of technical assistance for the AIDS prevention activities, thereby allowing the Mission to arrange the arrival of contractors as quickly as possible after project authorization. Finally, both CS and AIDS activities will be added to ongoing private and GON programs, to take advantage of existing structures and service delivery systems. This also will provide a longer term advantage of helping integrate project activities into organizations' ongoing work.

A final but important aspect of the project strategy is to combine, within one project, AIDS prevention and CS activities. In many ways, these two activities will be implemented separately, but it is the intention of the Mission

to integrate them in every way possible. There is little precedent for this approach in terms of major project design elsewhere, but it is an approach which displays specific advantages and which is gaining acceptance. To a large extent the target groups of the two activities are the same. Also, they both rely on significant participation by the Ministry of Health, require the allocation of substantial MOH resources, and utilize similar MOH services and facilities. This can make them competitors for scarce health resources, but if they are regarded in every way possible as complementary, then the resulting efficiencies should further enhance achievement of individual objectives. Finally, from the perspective of Mission management of health sector programs, combining these two activities allows the Mission to consolidate what tend to be management-intensive activities, and, with major responsibility for implementation on institutional contractors, to more effectively concentrate Mission resources on strategic thinking.

It is important to note, however, that substantial commitment by the Mission will be necessary to ensure that project activities are implemented in a complementary fashion, and that in particular the two primary contractors, one for the AIDS prevention activities and one for the CS activities, work closely together in the performance of their respective responsibilities. This essential cooperation will be included in the bid document for the CS institutional contractor and will be evaluated as part of applicants' responses, and will be included in the cooperative agreement negotiated under AIDSCAP for the AIDS activities.

C. Project Components

1. AIDS Prevention and Control Component

A three-pronged strategy will be followed which will utilize sets of activities organized by target groups. This strategy is briefly described below, followed by an outline summarizing the organization of the AIDS component activities. Those activities then are described in detail. Implementation of these activities will be primarily the responsibility of a project-financed unit established through a cooperative agreement under the AID/W AIDSCAP Project, working in conjunction with the MOH's AIDS Secretariat.

a. Strategy

The three elements of the strategy are education for behavioral change, condom promotion and distribution, and reduction of sexually transmitted diseases (STD). The objectives of each

element of the strategy are: behavioral change -- to increase condom demand, acceptability and consistent use; to increase STD-related symptom recognition and treatment-seeking; to delay age at first intercourse; and to decrease the number of sexual partners; condom promotion -- to encourage a policy environment leading to successful and sustainable condom programs; and reducing STDs -- to prevent the spread of AIDS by focussing on high-risk groups.

b. Outline of activities

Activities are organized by four high-risk target groups, plus a fifth grouping which includes secondary target groups. The four high-risk groups are: youths in and out of school, employed males, male STD clients, and bargirls/freelancers and bar owners.

(1) **Target Group: Youth**

Activities:
-- AIDS education in schools to effect behavioral change
-- Educational radio programming and development of audio material
-- Education and counselling in youth centers

(2) **Target Group: Employed Males**

Activities:
-- Education and counselling at worksites
-- Community outreach program through community leaders

(3) **Target Group: Male STD Clients**

Activities:
-- Upgrading STD services
-- Education through community outreach and social mobilization
-- Social marketing of STD services

(4) **Target Group: Bargirls/Freelancers and Bar Owners**

Activities:
-- Peer programs and community outreach
-- Improved District Health Inspector Program for STD management
-- Marketing of condoms in bars
-- Community outreach to freelancers

(5) **Target Group: Others**

Activities:
-- Education and access to services for unmarried women
-- Peer education and counselling, and some research, for female STD clients
-- CSM program and peer education for employed middle-aged men

c. <u>Detailed Activity descriptions</u>

(1) **Target Group: Youth**

(a) Group Profile

Youth 10-19 years old represent 23% of Malawi's population of nine million. Youth are the primary target group since their infection rates are low and sexual attitudes and behaviors are in the formative stage. One study of 18-19 year olds found the HIV prevalence rate to be 2-4% for non-rural males and 8-12% for females. A 1990 study found that knowledge of condoms was relatively high -- 57% among urban students and 39% among rural students. One-third of primary students and 85% of secondary students know that condoms prevent HIV transmission and 60% of school teens believe condoms are an acceptable method of HIV prevention.

(b) Activities

(i) AIDS Education

The project will provide the means to continue and improve the national AIDS education in the schools initiative. TA and support for local costs will be provided to: monitor and evaluate the program; revise curriculum; reproduce and disseminate materials; and provide refresher training to teachers. The project will assist other government ministries to assess and revise AIDS curriculum for use in youth education and training programs.

(ii) Radio Programming and Audio Material

The project will help the Malawi Broadcasting Corporation (MBC) develop radio programming for youth, including radio soap operas, discussion programs with influential persons and youth, and companion print materials. Audio materials will be recorded on cassette tapes to expand their use. Formative research to guide materials development will be conducted by technical assistance collaborating with Chancellor College and possibly other Malawian institutions.

(iii) Youth Centers

In order to reach out-of-school youth, the project will assist the AIDS SEC in developing a model package of youth center materials, including print and audio materials (for playing on hand-wound or solar-powered cassette players) and facilitators' guides. Formative assessments of the behavior, attitudes and practices of these youth will serve as the basis for youth center materials which will deal with both AIDS and STDs. Model packages will be adapted and implemented through public and private sector programs. Participants will learn about low-risk behaviors and obtain counselling and support to maintain sexual and reproductive health. Condoms will be available for distribution at youth centers or referral will be made to community-based condom distributors and local clinics.

(2) Target Group: Employed Males

(a) Group Profile

This target group is composed of men who are employed in the formal sector which includes government; industries such as construction, trucking and transport; and agricultural estates. Employed men are often separated from spouses; have disposable income; and rely on commercial sex. STD incidence rates on estates are 21-23% per year among employed males. Few in this target group report using condoms consistently during high-risk sexual encounters. Though increasingly willing to use a condom if a partner so requests, nearly one-third cite "unavailability" as the reason they did not use a condom during their last sexual encounter.

(b) Activities

(i) Worksite programs

An assessment of two worksite models will be conducted. From the assessment and studies of male attitudes, knowledge and behavior, an AIDS-in-the-workplace program will be developed and supported. Male responsibility for child spacing also will be covered.

The focus of this program will be on preventive education and counselling to change behavior and male social norms. Mass and small media will be developed and used to teach low-risk behaviors (i.e., condom use, partner protection, early identification and treatment of STD), and correct misperceptions about infection, disease and STD. Low literacy materials will include explicit instructions for correct condom use. Discussion groups will be supported to help men identify and overcome barriers to low-risk sexual behaviors, and to

support mutual sexual decision-making, including condom use and child spacing.

Implementing agencies will coordinate with district hospitals to ensure adequate condom supplies. A small initial supply of condoms will be distributed free at first contact at the worksite. Thereafter, the social marketing program will follow up to market condoms in the workplace.

The project will improve STD management in company clinics currently providing health services and initiate STD services in new clinics. Clinic staff will be trained to diagnose and treat STDs, counsel clients and teach men with STDs how to use a condom.

(ii) Community-based program

The AIDS SEC, in conjunction with regional and district health management teams, will develop a community outreach program that involves community leaders in peer education programs for males. Church, local government and private sector leaders will be trained to communicate AIDS messages, information on condom use and STD referral. Communication materials developed for the workplace and for out-of-school youth will be adapted and made available to peer educators.

(3) Target Group: Male STD Clients

(a) Group Profile

Male STD clients are at increased risk of contracting HIV since STD are a co-factor contributing to HIV infection and accelerating disease progression. They are also at increased risk since behaviors contributing to STD transmission also transmit HIV. Studies indicate that urban STD patients in Lilongwe have an HIV infection rate approaching 60%. Male STD clients are a prime target group since male STD symptomatology is more obvious and profound than that of females, and more often results in seeking early treatment. Through treatment and counseling of males presenting with STDs, efforts will be made to reach female partners and contacts as well. Condom use among STD patients is abysmally low -- in one study, only 28% of male STD patients reported ever using a condom and only 10% could correctly demonstrate use. Only 62% have ever seen a condom and a mere 8% think condoms can prevent HIV infection. Approximately 40% of those who have used a condom report problems with condom breakage. If asked by a partner to use a condom, one-quarter will refuse to use one or withdraw their intention for sex.

(b) Activities

(i) Upgrading STD Services

Project funds will support procurement and testing of STD drugs and promote their broader dissemination throughout the health care system. Based on STD management guidelines and protocols developed by AIDS SEC, regional health office teams will be trained as trainers to improve STD services at central and district hospitals. Clinic staff will be trained to deliver three or four critical health messages to STD patients and convey basic knowledge on condom use (how and when to use and dispose of them). Ample supplies of condoms will be available at STD clinics.

(ii) Community outreach and social mobilization

Various methods of informing communities and STD clients on service availability will be tested by district training teams. Motivated volunteers will be sought to identify, educate and refer male counterparts for treatment and work with them to: (a) reduce the number of unprotected sexual acts; (b) overcome barriers to condom use during every sexual encounter; (c) improve knowledge of contraceptive options; and (d) share condom supplies with friends. Peer educators will distribute condoms supplied by the district training team. A secure condom supply will be provided by the CSM project at places men congregate, such as bars, resthouses, etc. Activities will be complemented by mass communication programs (e.g., videotapes, radio programs) at the national and community level.

(iii) Social marketing of STD services

The project will conduct a feasibility study of the potential for privatizing STD services through the social marketing of family health services. This envisions an NGO providing services such as STD therapy, child spacing and AIDS/HIV prevention counseling with some form of cost recovery. STD drugs would be provided to the NGO without charge initially and prices charged to clients would be subsidized. Condoms will be provided through the CSM program and resupply would come through combined donor and GOM-subsidized channels.

(4) Target Group: Bargirls/Freelancers and Bar Owners

(a) Group Profile

The risk of transmitting HIV is particularly acute among women who have multiple sexual partners to whom they sell sex. Estimated HIV seroprevalence among bargirls is 75-85%. Other

STD rates are also high - gonorrhea 29%, trichomonas 27%, positive syphilis serology 21% and genital ulceration 6% among bargirls in Blantyre. Registered bargirls are legally required to submit to regular medical assessments by health inspectors in government hospitals. Infected patients often change work locations making treatment follow-up difficult. One study reported that although perception of risk among bargirls was quite high, only 10% thought they were personally at risk.

(b) Activities

(i) Peer education programs for bargirls

Formative research will assess: (1) bargirls' work, medical, relationship and divorce history; (2) the level of discrimination experienced from health care providers, community members, bar owners, etc.; (3) issues of "self-worth"; and (4) resources available to provide assistance (women's organizations, advocacy groups) Based on this research, a peer educators training program will be developed. A U.S. PVO competitively-awarded grant and NGOs will be supported to carry out these activities. Using specific criteria (e.g., status/seniority, profit drive, communication skills, desire to lead), bargirl peer leaders will be identified and trained. Using small groups to facilitate role playing and skill-building, peer education will address self-care and self-protection issues as well as protection of others. Free condoms will be made available to bargirls initially, and distribution of social marketing condoms will be encouraged for long-term sustainability. Access to information about contraceptive methods (e.g., orals and sterilization) will also be provided.

(ii) Improving the District Health Inspector program for STD management

Based on AIDS SEC guidelines to improve STD case management, training teams led by Regional Health Inspectors and AIDS coordinators will collaborate with District Health Inspectors to improve "food handlers" clinics for bargirls. Training will include: (1) introducing presumptive treatment at initial visits; (2) emphasizing STD case management over diagnostics; (3) improving counseling; and (4) emphasizing condom promotion, consistent correct use and distribution. Operations research will determine the effectiveness and impact of regular spermicide use and periodic mass drug therapy on genital ulcer disease.

(iii) Marketing of condoms in bars

Bar owners will be approached to consider ways in which they can assist in AIDS prevention efforts, including condom marketing and promotion. Close monitoring of this approach in

terms of customer preferences, compliance and profit margins will inform program expansion to other areas. Bar owners and bargirls will be encouraged to serve as vendors of social marketing condoms.

(iv) Community outreach to freelancers

Outreach to unregistered bargirls and freelancers will be provided through expanded peer education activities and will focus on strengthening condom negotiation skills and identification of income-generating options such as becoming condom vendors. Women will be referred to district food handler clinics for STD diagnosis and condoms, and child spacing clinics for information on child spacing.

(5) Target Group: Secondary Target Groups

(a) Unmarried Women

Unmarried sexually active women are at significant risk of HIV infection, particularly because their ability to negotiate relationships is compromised. Since there is great social and economic pressure on women to marry, a significant number of women may have been married and divorced one or more times, thereby moving in and out of low and high risk status. The project will support activities providing HIV prevention education which also looks at: influences to engage in risk-associated sexual behavior; catalyzing women's networks within the community to support normative change for women's roles as sexual partners; and increasing access to condoms, STD case management services and contraceptives.

(b) Female STD Clients

There are many barriers to STD management among female clients. STDs are frequently asymptomatic in women and testing is generally limited to syphilis screening for antenatal women, and then only when reagents are available. Women currently recorded as STD clients represent the "tip of the iceberg" of STD infections and are an important group for targeting of comprehensive HIV/STD prevention programs. The project will support activities that provide STD/HIV prevention education and counseling to enable female STD clients to more quickly recognize symptoms, seek treatment and change behavior to reduce risk of STD/HIV infection. Operations research will determine the effectiveness of spermicides and periodic mass drug therapy in controlling STDs - subject to protocol approval by the GOM. Condoms and condom education and counseling will also be provided when women present for treatment. They will also be referred to child spacing clinics for contraceptive services.

(c) Employed Middle-Aged Men

This group shares characteristics with the employed male target group but there are distinctions. The project will support and extend ongoing national AIDS control programs through activities to: increase individual perception of risk, reduce age differences between sexual partners, and expand access to condoms and increase correct usage. Given their lack of condom knowledge, skills and confidence, the project will ensure access through the private sector to information on correct use and to dispel misperceptions. The main condom distribution point for these men will be the social marketing program. STD management will be improved in employee health clinics and in the private sector.

2. Child Spacing Component

The project will strengthen and expand child spacing services throughout three levels comprising the national health service delivery system, and will support contraceptive social marketing. The three levels, and CS methods to be provided at each, are:

Level One: Comprehensive child spacing services - Core services plus minilaparotomy/local anesthesia (ML/LA); Norplant and, in some cases, vasectomy.

Level Two: Core child spacing services - CBD services plus injectables.

Level Three: Community-based service delivery ("CBD") - vaginal barrier methods; condoms; initial and re-supply of oral contraceptives; and referrals for other methods.

Implementation of activities will be the responsibility primarily of a project-financed institutional contractor, which will work in conjunction with the NFWC and the MOH. Project activities also will be implemented directly by the GOM and by NGOs/PVOs, the latter under grants issued through the IC.

a. Strategy

The strategy for implementing the CS component is multifaceted, with particular emphasis on assisting the GOM to implement its new population and CS policies, increasing client satisfaction by improving services and choice and by utilizing socio-cultural research, and expanding the roles of the private sector and influential national organizations, in particular the NFWC. The target audience will be expanded by the use of community-based agents as the primary providers of barrier methods and orals, and by explicitly targeting men for CS IE&C activities. Finally, project activities will promote the integration of child spacing, AIDS, and maternal and child health planning, service delivery and information networks.

b. Outline of activities

The following is an outline of planned project activities:

(1) Comprehensive Child Spacing
  (a) Improved services at MOH and CHAM hospitals

(2) Core Child Spacing
  (a) Improved services at GOM, CHAM, NGO and private facilities
  (b) Training

(3) Community-Based Distribution (CBD)
  (a) Expanded MOH service provision
  (b) Training in CS of other GOM extension agents
  (c) Training of CHAM staff
  (d) Subgrants to NGOs and private sector entities (e.g., agricultural estates)

(4) Contraceptive Social Marketing
  (a) Continuation of activities now under Malawi Health Social Marketing Project

c. Detailed Activity Description

(1) Comprehensive Child Spacing Services

Ministry of Health (MOH) Hospitals. The project will support the transition from the currently used method of tubal ligation -- abdominal surgery under general anesthesia -- to a less invasive, less expensive and safer method, minilaparotomy using local anesthesia (ML/LA). ML/LA services will be added to 22 MOH District hospitals, four per year starting in 1993, for a total of 25 MOH hospitals providing VSC services by 1998 (three hospitals will come on-line in 1992 with USAID/AVSC support). Pending necessary GOM approvals, Norplant services will be initiated at all 25 MOH hospitals, phased-in after ML/LA services are institutionalized. Five MOH hospitals will be selected as sites for vasectomy service.

Comprehensive child spacing services capability will be instituted first at those hospitals where demand is highest (e.g., requests, population density, staff skills/availability, etc.).

Christian Health Association of Malawi (CHAM) Hospitals. Eight CHAM hospitals will be able to provide ML/LA services by the end of 1992 through separate USAID/AVSC support. The project will fund the establishment of ML/LA services in the

remaining two non-Catholic CHAM hospitals, support the addition of Norplant services at these ten CHAM hospitals, and introduce vasectomy services in three to four CHAM hospitals. Approximately 95 surgeons (doctors and clinical officers) and 425 other service providers (including counsellors and IEC workers) will be trained to provide ML/LA, Norplant and vasectomy services. For service personnel, training also will include child spacing services, counseling and referrals.

In-country capability to provide training will be developed within the CHAM and MOH hospitals over the project period, starting with counseling and surgical skills related to ML/LA. Third-country training will be required for the first surgical and counseling teams for Norplant and vasectomy; these teams will then, with technical assistance, begin training teams in-country.

Finally, the Association for Voluntary Surgical Contraception (AVSC) has helped to establish long-term contraceptive services at several private and public facilities in Malawi, and it is expected that this kind of activity will be continued in some form through the life of this project.

(2) Core Child Spacing

Ministry of Health. The project will expand and improve core service capability at all 272 level-two MOH facilities (rural hospitals, clinics, health centers, dispensaries and maternities) by 1998. At present, some 154 of these facilities provide core CS services of varying quality. A detailed expansion plan will be prepared by the end of year one with priority given to facilities not yet providing CS services but where demand is high, population dense and referrals for comprehensive services feasible. A total of 148 additional MOH and MOLG facilities will have core CS service delivery capacity by the end of the project. Operations research will show how to expand access and improve efficiency by re-organizing clinic schedules and improving client flow, record keeping and contraceptive re-supply.

Ministry of Local Government (MOLG). Twenty of the 94 MOLG health facilities currently provide some child spacing services. The project will support upgrading core services at these twenty sites. This will consist of training appropriate staff, technical assistance and minor renovations if appropriate. Since current staff at these facilities are not eligible to take the MOH's qualifying training course for child spacing providers (having not had the basic training background required by MOH), additional qualified staff will have to be recruited at these facilities. The project will then arrange CBD training for the current personnel. MOLG facilities will also support the CBD program. During year two the project will support a detailed analysis of the needs and potential of the

remaining 74 MOLG facilities to provide core services. Should the assessment so indicate, the project will assist up to 30 MOLG facilities to add core service delivery capability.

Other Ministries, Parastatals, and NGOs. Only seven of the 98 facilities managed by parastatals, NGOs and ministries other than the MOH and MOLG currently provide core child spacing services. During the first year the project will support an analysis of the potential of these facilities to provide core child spacing services. If so indicated, the project will assist up to 50 of these sites (50%) to add core CS capability.

CHAM Clinics. Eighteen (11%) of 157 CHAM fixed clinical facilities presently provide core child spacing services. The project will support the incorporation or upgrading of core service capability at an additional 80 facilities where religious tenets do not prohibit modern contraceptive methods.

Private commercial sector. Seven (7%) of the 102 health facilities operated by estates (63) and companies (39) in the private sector presently provide core child spacing services. Private sector interest in expanding CS services is high. The project will support the incorporation or upgrading of core service capability at an additional 35 private sector facilities.

Private Practitioners. It was found that twenty-four of the 65 private practitioners provide core CS services. The project will support the integration of core CS service capability into as many as 10 additional facilities.

Training. An estimated 360 MOH staff and 570 service providers from other sectors will need to be trained in core child spacing services (i.e., take the MOH qualifying CS program). At this time, the existing 12-week course is under review and, it is hoped, will be condensed to no more than four weeks. Combined with inclusion of qualifying CS course work in the pre-service training of ENMs and other cadre, this shortened course will rapidly increase the personnel qualified to provide core CS services. Subsequent to their initial CS training, service providers will receive a 1-week refresher course about (on average) every third year.

Summary of Core CS Service Delivery Assistance. The following table summarizes project support to expand core child spacing services at level two fixed facilities. Of the 788 stationary sites, the project will support institutionalization of core services at 319 new sites (an increase of 300%). Overall, 549 sites will be able to deliver core CS services by 1998.

Summary of Core Child Spacing Delivery

Institution	Existing MOH Health Facilities	Number Providing CS in 1992	STAFH Objective	Additional Sites Required
MOH	272*	154	272	118
MOLG	94	20	50	30
OTHER GOM/NGO	98	7	53	46
CHAM	157*	18	98	80
COM/EST	102	7	42	35
PRIVATE	65	24	34	10
TOTAL	788	230	549	319

* Excludes mobile units

(3) Community-Based Distribution (CBD) Services

Ministry of Health. Expansion of community-based services by the MOH will involve several cadres of CBD agents: Health Surveillance Assistants (HSAs), primarily as male motivators; Village Health Workers (volunteers); and Traditional Birth Attendants (TBAs), primarily as distribution agents. Some TBAs, HSAs and volunteers who are identified by their communities will be trained to distribute appropriate contraceptives and refer persons with unmet needs to CS providers. Pilot activities and CBD agent network expansion will also involve the National Family Welfare Council which, working with technical assistance from the Institutional Contractor and from the PHICS project will train, equip and supervise these motivators and agents.

- HSAs - The project will support in-service training or retraining of up to 1,860 village volunteers at the regional or district level. Approximately 1,000 of the male HSAs will be given special training to become male motivators and they will work with communities in selection and monitoring of CBD agents active in the community. They will also assist in re-supply as well as monthly reporting. Interested female HSAs will receive training in CS methods and distribution. HIV/STD information and prevention strategies will be integrated into HSA CS training and re-training.

- o TBAs - TBAs have been trained under UNICEF and UNFPA projects and have received, in some cases, training as child spacing promoters. The Project will support training of volunteers (including TBAs) in CS services as well as training in safe motherhood. Preliminary indications are that up to 90 TBAs/volunteers per year could be trained by MOH from years two through five of the project, for a total of 360. Other TBAs/volunteers will be trained by participating NGOs (via subgrants) and in close collaboration with UNICEF and UNFPA. They will be supervised and receive logistical support from the nearest participating health facility.

Other Ministry and Parastatal CBD. Several Ministries and some parastatal organizations have cadres of agents working in local communities. Many of these agents have already received orientation and training in CS and CS IEC. Some have expressed interest in becoming more involved in community-based child spacing services. The project will support appropriate ministries, organizations and district development committees to determine how best to utilize these non-MOH extension agents. Project managers will develop a plan to assess and expand the role of non-MOH extension agents in child spacing and, if feasible, up to 300 CBD agents will be trained.

CHAM. CHAM clinics and hospitals have also trained TBAs, HSAs and primary and community health workers who could be utilized for community child spacing services if given additional training, materials and contraceptive supplies. CBD agents and supervisors will be trained with STAFH support; the number will depend on CHAM grant submissions.

NGOs and Private Sector. For interested organizations, including agricultural estates and local and international NGOs, the project will provide funding through subgrants to support CBD expansion. During year one, project managers will actively campaign to generate NGO and estate interest in CBD. It is anticipated that approximately 20 grants averaging $125,000 would be provided over the LOP for training and support for NGO CBD agents. The number of CBD agents trained will depend on NGO grant submissions.

Summary of Training and Retraining Requirements

Institution	No. Trained in CBD under Project
MOH/HSAs	1,200*
MOH Volunteers	360
Other Ministries	300
Total	1,860

* An additional 3,000 HSAs will be trained under the PHICS project, which will include a CS CBD component.

3. Contraceptive Social Marketing (CSM)

Malawi launched its first nationwide social marketing program in August 1991, implemented by Lever Brothers with support from the USAID-funded Malawi Health Social Marketing Project (MHSMP). The condom was the first health product marketed due to its important dual role in child spacing and STD prevention.

To date, Protector brand condom sales have been lower than projected. Close coordination between MHSMP/Lever Brothers and the MOH AIDS SEC to find the optimum balance between free and subsidized condom strategies, and new MHSMP initiatives utilizing major brewers to distribute Protector condoms in bars, restaurants and entertainment establishments, should increase sales.

Once the condom program is running smoothly, the MHSMP plans to introduce its second product sometime in 1993, an oral contraceptive (OC) pill. When SOMARC ends in 1993, the Mission and the GOM will need to evaluate the program and effect a transfer of responsibilities to the Institutional Contractor. The project will support the MHSMP and private sector companies to continue and expand CSM services. Close collaboration with project-funded CBD programs will be encouraged. The NFWC will be supported to resolve important policy and program issues related to CSM expansion, such as over-the-counter purchase of OCs and regulations regarding OC prescription, restrictions on contraceptive advertising and product registration. Funding will be provided to support NFWC's initiatives in training, IEC and quality assurance. By project end, annual sales of condoms are expected to total 4.0 million units with oral contraceptives at 1.4 million cycles.

D. Capacity-building Component: The MOH AIDS Secretariat (AIDS SEC) and the National Family Welfare Council (NFWC)

The AIDS SEC and NFWC are at the center of national efforts to control AIDS and extend access to child spacing services. Their mandate is to support providers directly with TA, training, guidelines and data, and indirectly by improving the policy and regulatory climate in which providers operate. Primarily through activities funded under the two project-funded contracts (AIDSCAP and the IC), the project will strengthen AIDS SEC and NFWC capacity to perform the following critical national leadership and service delivery support functions:

-- To promote Advocacy, consensus-building, and policy dialogue to increase the level of GOM and public commitment to

control AIDS and extend access to CS, and to use computer models for policy analysis and dialogue;

-- To coordinate setting national AIDS and CS program priorities and goals, develop multi-sectoral AIDS and CS plans and strategies, and monitor and facilitate implementation plans;

-- To increase the level and effectiveness of GOM support to AIDS and family planning to include strengthening of the Government of Malawi's capacity to monitor and evaluate family health programs (in conjunction with PHICS);

-- To expedite the review, approval and dissemination of new AIDS and CS policies, guidelines, research protocol and findings and IEC materials and approaches; to expedite review, approval and registration of new contraceptive methods and STD drugs; and to expedite duty-free status for key program commodities;

-- To provide, or arrange to be provided, TA, training and materials to providers to improve technical, management and administrative capacity to design, conduct, monitor and evaluate AIDS control and CS programs;

-- To coordinate setting service standards, development of treatment protocols and assist with quality assurance;

-- To institutionalize and manage a system for the routine collection, dissemination and use of epidemic surveillance data, child spacing service statistics, and demographic health survey results;

-- To develop a national AIDS and CS research agenda, conduct research (or arrange for it be conducted), utilize findings for policy and program formulation and evaluate program effectiveness and impact, and coordinate GOM clearance for research such as Demographic and Health Surveys.

The project will also support assessments of the AIDS SEC and NFWC to ensure: accordance between their organizational design and evolving functions; selected AIDS SEC functions are decentralized and others integrated into MOH units; optimum allocation of CS responsibilities is made between the NFWC and the MOH child spacing unit; and future organizational and staffing requirements are met.

E. Expected Accomplishments

The STAFH project has been designed to fundamentally improve the quality of life for the average Malawian. By reducing fertility, and thereby slowing population growth, the project

will enable the gains in GDP growth achieved by the economy to translate into real increases in per capita income. By reducing HIV/AIDS transmission, and ultimately deaths due to AIDS, national productivity levels will be maintained and the forecasted increases in the dependency ratio will be reduced. Beyond reducing the anguish associated with the deaths of nearly half a million adults and children, this will serve to sustain the nation's productive capacity. In specific terms, the project is expected to reduce fertility by increasing the contraceptive prevalence rate and increasing child spacing services and demand for them. Transmission of HIV/AIDS/STDs will be reduced through education and information messages that aim at profound behavioral and attitudinal change.

Below is a brief summary of people and systems level impact. In Section III.E., Monitoring and Evaluation Plan, below, there is a more detailed discussion about specific indicators which provide information about achievement of project objectives.

1. People Level Impact

Beyond the specific indicators for achieving project goals and purpose by 1998, a smaller population than would have existed without this project intervention will realize the following longer term impact: increased per capita GDP; increased per capita health and education expenditures, and eventually reduced infant and child morbidity and mortality; and, reduced death and productivity losses associated with HIV/AIDS and STDs.

2. Systems Level Impact

By working through existing NGO and Government facilities and institutions, the longer term effectiveness and viability of these institutions will increase. These improvements should pertain to areas of the quantity and quality of service delivery, as well as to improved consumer satisfaction with the services. Moreover, by further developing the community based distribution system for contraceptive and AIDS prevention commodities, the distribution of such commodities is expected to increase both in quantity and variety as well as in geographic distribution.

F. Government and Other Donor Programs

1. Conformity with Government of Malawi Policies and Plans

The project was designed in close collaboration with the MOH, and proposed activities fit within an increasingly progressive and well-defined population and AIDS policy and planning framework.

At present, GOM population policies are implicit in various documents, including "The Statement of Development Policies 1987-1996 (DEVPOL)" and "The National Health Plan of Malawi 1986-1995". In October 1991, senior GOM officials recommended a "comprehensive population and human resources development policy statement" be formulated as a Supplement to DEVPOL. The statement, Malawi's first explicit population policy, is now being drafted and finalization is expected by the end of 1993.

MOH child spacing program plans are articulated in a September 1991 document entitled, "Ministry of Health Child Spacing Program 1992-1996" in which the MOH expresses its determination to "... expand child spacing services to the whole country so that many more people can benefit..." Other key policy documents include the statement of "Recommendations from the Population Review and Strategy Development Workshop for Principal Secretaries (7-8 October 1991)," and the "Letter of Health Development Policy" (dated 25 January 1991 from Malawi's Minister of Finance to the World Bank).

The newly-formed National Family Welfare Council (NFWC) will coordinate the development of a comprehensive child spacing service delivery strategy for both public and private sectors.

GOM AIDS prevention policies have been formulated mainly by the National AIDS Committee which represents the main elements of Malawian political, civic and religious life. GOM AIDS prevention program strategies and plans have been detailed in a series of documents, the most recent of which is the "The Malawi National AIDS Control Program - Reprogramming Document (1992-1993)."

Malawi's first comprehensive health manpower and training plan is currently being developed by the MOH and is expected to be issued in 1993.

2. <u>Coordination with Other Donors</u>

An active health sector donors group has led to comparatively good coordination among donors in Malawi. For AIDS prevention and control activities there has been a reasonably clear demarcation of donors' funding responsibilities. The process of sharing funding responsibility among donors for different program components and costs has become institutionalized and centers upon collaborative GOM and donor reviews of program plans and participation in the evaluations on which future plans are based. For population and child spacing activities there has been a less structured coordination of donor support. The national population program lacks a planning and evaluation process in which key donors participate. When the new NFWC assumes its coordination role, this problem may be solved. In

the meantime, the Mission coordinated closely with other donors in the design of the project's child spacing component, particularly with UNFPA and ODA which are also planning population/child spacing projects.

As an integral step in the design, the Mission undertook a detailed inventory of donor assistance for AIDS prevention and child spacing to ensure project support is well coordinated and duplication is avoided. Results of this inventory are in **Annex C.**

III. PROJECT MANAGEMENT AND IMPLEMENTATION

A. Management Roles and Responsibilities

1. Summary. The MOH AIDS SEC and the NFWC are the two GOM organizational focal points for Malawi's AIDS control and child spacing project activities. Both of these organizations will play important roles in project planning and management. MOH will assign a full-time coordinator who will be responsible within MOH for the coordination of MOH activities. USAID also will be actively involved in project management since AIDS control and child spacing are central to its development assistance strategy in Malawi. Implementation of project activities will be the responsibility primarily of project-funded technical assistance. USAID will engage technical assistance through two mechanisms, a U.S. institutional contractor (IC) and the Cooperative Agreement with AIDSCAP. The contractor and AIDSCAP will work with the AIDS SEC, the NFWC and the Mission to augment available staff and existing service delivery systems. These entities will help expedite service implementation while also strengthening the capacity of AIDS SEC and NFWC to plan and coordinate an expanding program. In addition, a Project Steering Committee will meet regularly to address project progress and policy issues.

2. Ministry of Health

a. The Planning Section and Project Implementation Unit (PIU) will appoint an MOH staff person to assume full-time primary responsibility for implementing project-funded MOH activities whose duties include: (1) coordinating with EP&D and Ministry of Finance regarding sectoral budget preparation, local costs inclusion in PSIP and development budgets, and phasing-in support for recurrent project costs under the revenue budget; (2) ensuring project activities are well coordinated with those of other donors; (3) nominating and reviewing candidates for training and arranging

trainers for scheduled training and workshops; and (4) participating in the Project Steering Committee.

b. The MOH AIDS Control Program Secretariat will assume the lead role on key project management and coordination committees for AIDS-related issues. For example, AIDS SEC will: (1) identify and work to resolve key AIDS policy and program constraints to project implementation; (2) develop annual AIDS workplans and budgets with AIDSCAP, the IC and Mission; (2) provide TA and training for selected project-funded activities; (4) coordinate and expedite GOM review and approval process for project-funded AIDS research; (5) serve on MHSMP advisory group to ensure condom strategy coordination and help increase use and sale of Protector Brand condoms; and (f) collaborate with mission in annual performance evaluations of AIDSCAP and the IC.

c. MOH HQ MCH/Child Spacing Unit will: (1) develop annual MOH CS workplans and budgets; (2) develop programmatic and budgetary guidance for district-level CS plans; disseminate guidance to regions; receive, review, consolidate and submit district workplans and budgets to IC/Mission; (3) implement and periodically update the USAID-funded (PHICS) family health in-service training program; (4) manage the national contraceptive logistics program; and (5) participate in the Project Steering Committee.

d. MOH regions and districts will use programmatic and budgetary guidance provided by MOH HQ to develop annual CS and AIDS workplans and budgets for presentation, review and finalization at annual regional family health review meetings, after which they will be consolidated and sent to MOH HQ. The regions and districts will implement or coordinate implementation of AIDS and CS activities under their jurisdiction.

e. MOH HQ Accounts Section will appoint MOH staff person to assume full-time responsibility for financial management, control and accounting for project-funded MOH component. The Accounts Section will be responsible for funding activities approved in the annual workplan and budget and accounting of budget funds earmarked to MOH under the project.

3. The National Family Welfare Council (NFWC)

The NFWC, a parastatal under MOWCCS, will assume the lead role on project management and coordination committees for CS-related issues. This includes: (a) working to remove key policy constraints to project implementation; (b) developing annual child spacing workplans and budgets with the IC, MOH (i.e., CS unit, health districts and regions) and Mission; (c) providing TA and training for selected project-funded

activities; (d) coordinating and encouraging non-government organizations' involvement in child spacing advocacy and services; and (e) collaborating with the Mission in annual performance evaluations of the IC.

4. USAID/Malawi

USAID/Malawi will be responsible for project direction, oversight, management and impact through:

- o regular dialogue with senior GOM officials (e.g., MOH, MOWCCS, MOF and EP&D);
- o reviewing and approving key implementation documents such as annual work plans and budgets, subgrant proposals, research protocols, key personnel appointments, job descriptions and scopes of work;
- o reviewing and complying with Project Implementation Report (PIR) requirements and required reports from contractors;
- o supervising the IC's and AIDSCAP's chiefs of party; and
- o ensuring project coordination and collaboration with other donors.

Within USAID/Malawi, the STAFH Project will be managed by the Health, Population and Nutrition Office. Overall supervision of project implementation will be the responsibility of the Chief of the Health, Population and Nutrition (HPN) Office. That officer will be assisted by the Population Officer and by a Personal Services Contract (PSC) Project Manager funded by the STAFH Project.

A STAFH Project Committee within USAID will also be established to assist the HPN Office. This committee will have as members representatives from the Program Analysis and Evaluation (PAE) Office, the Project Implementation and Development (PID) Office, and the Controller and Executive Offices. The Chief of the HPN Office will be the chairperson of the STAFH Project Committee. The function of the Project Committee is to monitor progress of project implementation and to address, in particular, internal Mission management and implementation issues. STAFH is a complex project, and will require a variety of resources from the Mission for its successful implementation. Initially, committee meetings will be held monthly.

USAID/Malawi also will undertake direct commodity procurement of various items (see Annex P), approve specifications, monitor commodity end-use and disposition, and take responsibility for

monitoring inventory reports and arranging audits (in collaboration with the Inspector General's Office) as required. The Mission also will be responsible for final selection of TA contractors and resolving contractual or management issues arising in the course of project implementation.

5. Project Steering Committee

A Project Steering Committee will be formed to periodically address Project progress and policy issues likely to affect implementation of the Project and attainment of its objectives. Committee members will include: Principal Secretary for Economic Planning and Development; Principal Secretary of Ministry of Health; Deputy Secretary of Ministry of Finance; Principal Secretary of Ministry of Women Children Affairs and Community Services; Executive Secretary of National Family Welfare Council; Program Manager of Malawi AIDS Secretariat; Health, Population and Nutrition Officer of USAID; Chief of Party, AIDSCAP; and Chief of Party, Institutional Contractor. Representatives from the MOH Planning Section and Project Implementation Unit (PIU) and the MOH Maternal Child Health/Child Spacing Unit will also be members of this committee. The Steering Committee should meet as soon as possible to elect a chair person and discuss conditionality affecting the project.

The Committee will meet every three months, or more often whenever deemed necessary, on a regularly scheduled basis to be determined after project implementation begins. This Committee will consider and act on policy issues crucial to Project implementation and objectives.

6. USAID Contractors: Institutional Contractor (IC) and FHI/AIDSCAP

a. IC and AIDSCAP as Co-implementors

AIDSCAP will be operating under a Cooperative Agreement while the IC will be operating under a competitively-awarded contract. There are inherent complexities and difficulties involved in having two major providers of TA. Since it is the Mission's intention that STAFH integrate CS and AIDS/HIV/STD activities wherever possible, it would have been ideal to contract for TA under a single contract. However, there are important and deciding advantages to utilizing the AIDSCAP mechanism, and this approach in effect precludes combining the AIDS and CS activities under one contractor as part of the design. CS activities are not part of the AIDSCAP Cooperative Agreement, so could not be included in the Malawi buy-in. The FHI/AIDSCAP team offers specialized expertise that is available for quickly starting project activities in Malawi. Given the severity of

AIDS and the velocity of HIV transmission, this is an important advantage. AIDSCAP's technical personnel have worldwide expertise which is exceptional by international standards, they have already performed assessments of the situation in Malawi, and the organization is already operating projects in other, including African, countries. Finally, since the AIDS epidemic is relatively new, little is known about the most effective methods for combatting it. That is, although some interventions appear to work in some countries, it is almost impossible to know what specific intervention will work in a specific country. Thus, AIDS-related activities are appropriate for a Cooperative Agreement since many of the needed activities are pilot projects rather than specific actions appropriate for specifications to a potential contractor.

USAID/Malawi recognizes that the AIDSCAP Cooperative Agreement expires in 1996, some two years prior to the completion of this project. A detailed assessment and evaluation will be conducted in 1995 prior to the end date of the Cooperative Agreement to determine future technical assistance needs and contracting methods for the remainder of the project.

For child spacing activities, the needed interventions are quite well defined, both in Malawi and other countries. This makes it appropriate to define activities for an IC. In addition, there are many potential contractors with the needed expertise in family planning and there are many firms fully capable of developing a relatively weak and immature national CS program. Also, by allowing the IC to focus on the single objective of improving CS services, better results are expected.

For all of the above reasons, USAID decided on two principal TA instruments and accepts responsibility for ensuring coordination of TA and resolution of any eventual conflicts or disagreements arising among the TA providers.

b. Summary of Respective Roles and Responsibilities

The IC and AIDSCAP will perform similar functions in many respects, although AIDSCAP will focus exclusively on AIDS-related activities and the IC will focus primarily on child spacing activities while integrating some AIDS activities into its programs as appropriate.

The IC will coordinate CS project implementation in the private sector and assist the public sector according to the purposes, goals and strategies outlined in the USAID/Malawi STAFH Project Paper. In the public sector the IC will meet the needs for TA, training, commodities, and management support in liaison with the NFWC. AIDSCAP will implement AIDS prevention activities in collaboration with AIDS SEC, NGOs, other ministries and

participating institutions. Both entities will work closely together so maximum integration of CS and AIDS services can be achieved.

All activities undertaken by AIDSCAP and the IC must have prior concurrence of the NFWC or AIDS SEC, as appropriate. NFWC and AIDS SEC will also be consulted regularly by AIDSCAP and the IC to ensure that plans are developed collaboratively with GOM personnel and that all activities undertaken by the project conform with GOM strategic plans. These plans are found in the documents described in Section I.E.

The following sections outline the responsibilities of IC and AIDSCAP, initially describing activities that each entity will perform and then identifying activities specific to each.

c. Coordination

Day-to-day responsibility for coordinating AIDS and CS technical assistance will fall largely to the two main providers of TA, the IC and AIDSCAP. Since CS and AIDS activities will be integrated wherever possible, and since many of these activities are cross-sectoral, coordination will be a major preoccupation of the two contractors, the concerned ministries and USAID. Success will depend upon frequent and effective communication.

While fully cognizant of the legal requirement for separate accounting of funds, USAID nonetheless expects AIDSCAP and the IC to execute cost-sharing arrangements (on equipment use, leases, etc.) wherever appropriate.

d. Planning and Programming

Project implementation will be based on annual integrated workplans and budgets for project-funded AIDS and CS activities developed jointly with the AIDS SEC and the NFWC. These workplans should be based on the project outputs (e.g., logframe) and specify annual plans for training, procurement and travel. Workplans will be based on key documents such as the STAFH Project grant agreement and project paper, MOH AIDS Control Program MTP and reprogramming documents, the NFWC national child spacing service delivery strategy, and annual plans (to be developed). The workplans will be developed using currently established planning systems, such as the annual regional Family Health Reviews and the biannual AIDS reprogramming exercise, and will be reviewed and approved by USAID prior to implementation.

Specific to the IC and AIDSCAP, the IC will develop and monitor CS workplan implementation in collaboration with the NFWC, NGOs, AIDSCAP and MOH. AIDSCAP will develop and monitor AIDS workplan implementation in collaboration with AIDS SEC, the IC

and participating ministries. In collaboration with each other, the IC and AIDSCAP will coordinate the integration of CS and AIDS activities into the overall workplans. USAID will review and approve IC and AIDSCAP workplans and monitor contractor/grantee performance.

e. Technical Assistance (TA)

Technical assistance offered under this project will use certain principles and strategies: work will be performed in tandem with local counterparts to transfer technical skills; the TA needs of both the AIDS and CS components will be integrated whenever possible; TA needs will be prioritized and included in annual workplans; proposed short term TA activities with scopes of work, CVs of consultants proposed, and provisional dates will be provided on a quarterly basis for USAID review and approval.

Advisors will be used, in the following order of priority, whenever possible: local expertise, regional expertise, resident AIDSCAP technical advisors from other priority countries in the region or the AIDSCAP regional office, and external advisors previously used in the project (to avoid unnecessary time spent familiarizing the advisor with the local situation).

With regard to operations research, TA will be provided for: developing a research agenda and incorporating it in annual workplans; designing the research protocol; complying with Malawian review and approval procedures; monitoring and implementation; and reviewing, disseminating and utilizing findings.

The Institutional Contractor (IC) will provide long-term technical assistance as follows:

-- five person years of a Chief of Party/Family Planning Management Advisor to manage overall CS implementation and assist the NFWC, MOH and other implementing agencies in planning, monitoring and guiding CS programs;

-- five person years of a Community Services Specialist to assist government, parastatal, private, commercial and NGOs develop and implement effective community-based service programs;

-- five person years of a Communications/Social Marketing Advisor to assist in all aspects of IEC for family planning and related HIV/AIDS prevention, and in implementing commercial marketing of condoms, oral contraceptives and other drugs (STD, malarials, ORS) as appropriate; and

-- three person years of a Clinical Services Specialist to assist in planning, training, and quality assurance for expansion of permanent and long-term methods.

The Institutional Contractor will provide up to 20 person/months of short-term technical assistance in:

-- contraceptive procurement and logistics systems; development of a health information system as it relates to CS, including timely and accurate reporting on user demand and contraceptive supply; design, implementation and utilization of operations research; service delivery design, implementation and evaluation; pre- and in-service CS training for health care providers; development and implementation of training for CBD agents, supervisors, managers, logistics specialists and IEC agents; design, testing, production and distribution of IEC materials (small and mass media); integration of CS with HIV/AIDS/STD services and programs; and CS policies and guidelines;

-- assisting service providers to enhance their capacity to deliver and evaluate family planning child spacing and population related programs and services;

-- assisting potential subgrant recipients to design child spacing activities consistent with the annual workplan, develop detailed implementation plans and budgets and establish requisite financial management and reporting systems;

-- subgrants management, preparation of reporting systems consistent with MOH and other public sector entities; budgeting and proposal preparation and a financial reporting system; and

-- assisting NFWC in strategy development; preparing national child spacing strategies; developing the annual workplan; monitoring quality standards; and assisting with dissemination of IEC and training materials and programs. This TA will continue and build upon the current USAID/SEATS program of support, ending mid-1994, and expedite its implementation of critical child spacing leadership and support functions. It will also include an assessment of the advisability and probable timing of transferring and institutionalizing the subgrant making function to the NFWC and/or another Malawian organization.

AIDSCAP will provide technical assistance as follows:

-- five person years of a Chief of Party with overall management and technical responsibility for the AIDSCAP

team and assist the AIDS SEC and other implementing agencies in planning, monitoring and guiding HIV/AIDS/STD prevention programs;

-- two person years (with an additional year possible if funding is available) of an STD/HIV Specialist to initiate the STD prevention and control program; and

-- five person years of an AIDS Unit Manager with management and technical responsibility for the Blantyre satellite office and responsible for identifying and assisting community-based organizations interested in CS and AIDS prevention activities.

AIDSCAP will provide short-term technical assistance as follows:

-- AIDS/STD policy formulation; program implementation planning; subgrant design, monitoring and evaluation; design, implementation and utilization of operations research; training program design, execution and evaluation; integration with child spacing services; and modeling, forecasting, surveillance and monitoring;

-- assist providers to strengthen their capacity to plan, implement, monitor and evaluate AIDS/STD prevention programs and services;

-- assist potential and actual subgrant recipients in designing AIDS/STD activities consistent with the workplan, developing detailed implementation plans and budgets and establishing requisite financial management and reporting systems; and

-- assist MOH AIDS SEC to strengthen institutional capacity to fulfill their mandate as the national AIDS leadership organization. This TA will complement and be closely coordinated with the WHO/GPA program to further improve AIDS SEC effectiveness in providing critical AIDS program leadership and support functions. TA objectives include preparing national AIDS control strategies and developing the annual workplan.

Within a short time following signing the STAFH Grant Agreement, USAID/Malawi and GOM will agree upon a Memorandum of Understanding regarding the work of the AIDSCAP team in Malawi.

f. Subgrants

A subgrant program to provide local cost and other types of support to local organizations will be the principal means of providing financial assistance to private sector providers to improve and expand CS and AIDS services. Techniques,

procedures and materials developed under this program are also expected to serve as useful models.

Subgrants are meant to: improve and increase CS and AIDS services; provide CS and AIDS training; conduct and utilize operations research related to developing AIDS and CS policies and designing appropriate approaches and interventions; strengthen the capacity of Malawian organizations to design, implement, account for, monitor and evaluate AIDS and CS services, training and research activities.

Subgrants will be used to support NGOs which have a significant presence in Malawi with the majority of STAFH funds supporting local costs. The project's subgrant budget will be approximately $4.7 million exclusive of additional core funds from AIDSCAP.

-- There will be approximately eight AIDS prevention subgrants to NGOs which will average $50,000 each. These subgrants will be used to fund NGOs executing activities that compliment and expand National AIDS Control Programs. Some of these subgrants will be used to pilot new approaches and initiatives in particular geographic locations. AIDSCAP and the AIDS Secretariat will assist NGO's in program design, execution and evaluation.

-- AIDSCAP is also expected to develop one U.S. PVO subgrant with core and STAFH funds. This subgrant will be awarded in year two of the Project and a Request for Proposal (RFP) on this contract must be reviewed and approved by USAID/Malawi and the AIDS SEC prior to issuance. The AIDS SEC will be consulted as part of the process of developing the RFP and recommending to what organization, and on what basis, it will be awarded.

-- The IC will award 16 subgrants, averaging $125,000 each, to PVO/NGOs for child spacing (and some AIDS/HIV/STD) activities. Needs addressed by these subgrants will be identified during the implementation phase of this project.

-- The IC will fund also up to three U.S. PVO subgrants averaging $700,000 each.

Wherever possible, subgrants will be for integrated AIDS and CS activities. Depending upon the level of demand for subgrants and the pace of subgrant expenditures, USAID may amend the project in year four to increase the subgrant budget. The IC will design and administer this four-year CS subgrant program, as well as design and implement a system for subgrant contracting, finance/accounting, communications and reporting. AIDSCAP will have these responsibilities for AIDS/STD-only subgrants.

Subgrant selection and eligibility will be based on the following criteria:

(1) Potential recipients will be identified during development of annual workplans according to the recipient's perceived potential to implement this project's specific AIDS prevention and child spacing strategies;

(2) Subgrants will be made to the following categories of organizations: Malawian PVO/NGOs, U.S. PVOs already established in Malawi and, under conditions noted in C below, private commercial companies;

(3) Commercial companies are eligible to receive subgrants only if they assume recurrent local costs such as staff salaries. (Subcontracts, as opposed to subgrants, will be used to purchase from private firms commercial goods and services required under the project.)

See **Annex K.2** for recommendations regarding subgrant program administration and procedures. See **Annex K.3** for a listing of potential recipient organizations during the subgrant program's first phase.

The IC will adapt the SHARED/EIL rapid diagnostic technique to determine an organization's eligibility for the subgrant program. For eligible organizations technical and management assistance will be provided to develop detailed implementation plans and budgets. If an organization is found unprepared to manage a subgrant for relatively minor deficiencies which can be addressed over the short-term, the IC will provide the requisite capacity and systems building support. If institutional development and system strengthening needs are sufficiently acute so as to preclude an NGO's ability to manage a CS project efficiently, then the IC will refer the organization to SHARED/EIL.

Under the subgrant program both contractors (IC for the CS component and AIDSCAP for the AIDS component) will provide TA to: identify potential recipients and assess their technical capabilities; develop implementation plans and budgets; strengthen recipients' technical skills and knowledge; establish or strengthen recipients' information, training, IEC, monitoring and evaluation systems; monitor and assist implementation; and evaluate project success. Project managers will be designated by the applicable contractor and for integrated subgrants the IC will designate the project manager.

f. Procurement

The IC will be responsible for: procurement and logistics arrangements to meet primarily private sector providers' needs

for IEC materials, stationery and office supplies, service delivery forms and record books, vehicles, clinical equipment, expendable supplies, etc.; awarding, executing and monitoring subcontracts with private sector firms in-country and in the region for commodity procurement and production and/or duplication of IEC materials identified in annual workplans; monitoring end-use of commodities; technical assistance with designing and pre/post-testing population/child spacing IEC materials to ensure accuracy and quality of technical content, effective use, and impact; and conducting a feasibility study to determine whether and when the NFWC or other local organization(s) could assume technical oversight, logistics and management functions.

AIDSCAP will be responsible for: procuring goods and services required for direct implementation of AIDS/STD activities (exclusive of contraceptives and GOM contributions); preparing technical specifications for and/or procurement of commodities, such as vehicles, office equipment and supplies, drugs, medical equipment and supplies for the public sector; monitoring end-use of commodities; and designing and pre/post-testing AIDS/HIV/STD IEC materials to ensure accuracy and quality of technical content, effective use, and impact.

AIDSCAP will purchase all commodities through a sub-contracted Procurement Services Agency (PSA); thus, the reduced G & A rate for sub-contracts will apply. A Grey Amendment Firm is recommended for the procurement.

g. Monitoring, Evaluation and Reporting

The IC will be responsible for designing and implementing a system for monitoring, evaluating and reporting on project progress, effectiveness and impact consistent with the project paper's monitoring and evaluation plan and coordinated with the mission's API and PIR systems and schedules. This will include an annual inventory status report, annual procurement plan for the project and annual plan for use of short and long-term technical assistance. AIDSCAP will be responsible for designing and implementing the AIDS/HIV/STD component of the monitoring, evaluation and reporting system and the annual inventory status report, procurement plan and technical assistance plan for the STAFH/AIDSCAP funded component.

h. Mission Review and Approval

Both the IC and AIDSCAP will be responsible for obtaining USAID/Malawi approval for their respective workplans, budgets, staffing plans, appointment and replacement of key expatriate and resident-hire personnel, nominees to meet short-term TA needs and scopes of work, research and assessment protocols, subgrants and subcontracts, out-of-country travel, publications, memoranda of understanding (e.g., regarding

coordination arrangements), and monitoring, evaluation and reporting plans.

i. GOM Review and Approval

USAID will be responsible for obtaining GOM clearance and/or approval as appropriate for their respective key resident personnel; the contractor will be responsible for short-term TA, research protocol and publications. The AIDS SEC and NFWC will play central roles in developing annual workplans (which will include TA, subgrant and subcontract plans) with TA from the IC and AIDSCAP.

j. Project Office

Both contractors will be responsible for establishing and staffing one principal and one (or more) satellite project implementation offices in Malawi and developing a memorandum of understanding in which procedures and agreements for sharing administrative tasks, office space, support services, equipment and office costs are specified. The contractors will renovate existing government office space (where available) in preference to commercial renting.

In light of the severe existing MOH manpower constraints as described in Section I, AIDSCAP and the IC will not employ personnel in their principal or satellite offices who are employed (at the time of possible recruitment) by the MOH.

See **Annex G** for IC and AIDSCAP preliminary position descriptions.

k. Supervision and Evaluation

The Chief of the Mission's Health, Population and Nutrition (HPN) Office will meet regularly with the IC and AIDSCAP chiefs of party to review project performance and carry out an annual written performance evaluation based upon criteria mutually agreed upon at the beginning of the year.

The Mission will be responsible to arrange independent evaluations of the project and of IC and AIDSCAP performance. The MOH and NFWC will be invited to participate in such evaluations.

B. Procurement Plan

1. Technical Assistance

a. Institutional Contractor

The REDSO/ESA Regional Contracting Office will contract a U.S. based firm or institution or a consortium of firms and institutions ("Institutional Contractor") to provide eighteen (18) person years of long term technical assistance and twenty (20) person months of short term consultants to implement the CS component of the project and to integrate CS and AIDS prevention project activities. The Institutional Contractor must have demonstrated a strong track record in managing CS programs, appropriate technical and managerial expertise, procurement capabilities, and provision of personnel with strong technical capabilities. As the Institutional Contractor will be providing technical assistance and commodity procurement services, it will be allowed to charge overhead only on the technical assistance services portion. Procurement of goods will be based on a firm fixed fee which will be proposed as a separate line item.

The requirement will be advertised in the Commerce Business Daily and proposals received will be reviewed by a Mission Technical Review Committee (including GOM representation) and RCO. The RCO will issue the RFP with assistance from the RLA and RHPNO, negotiate and award a contract to the most technically qualified and cost effective offeror.

Since there are not at least three Gray Amendment entities with the required expertise amongst which this requirement could be competed, procurement will follow full and open competitive procedures. Notwithstanding, offerors will be encouraged to use Gray Amendment entities to the maximum extent possible.

When Needed: August, 1993
Procurement Time: nine to twelve months

b. Personal Services Contractor

The USAID/Malawi Executive Office will award a personal services contract with a U.S. citizen for a period of two years, renewable for up to three additional years. The PSC will work under the supervision of the Mission Health and Population Officer and assist in managing and coordinating all project elements. The position will be advertised and SF 171s received will be reviewed by a Mission Contractor Review Committee. The Contracting Officer will negotiate and award the contract to the most appropriately qualified individual.

When Needed: November, 1992
Procurement Time: six to nine months

c. Grants and Buy-Ins

While the Institutional Contractor will provide technical services to meet most public and private sector population/child spacing needs, additional technical support will be procured with project funds (supplemented, if available, by AID/W central funds) through buy-ins to the following specialized centrally-funded projects/contracts:

(i) AIDSCAP: AIDS/HIV/STD technical expertise will be obtained from Family Health International (FHI) by an add-on to the AIDSCAP Cooperative Agreement in AID/W. It is anticipated that three long term technical specialists and 48 person months of short term assistance will be required.

(ii) IRD/MACRO DHS III: Technical services to conduct demographic and health and/or contraceptive prevalence surveys will be obtained through a buy-in to the central contract, in 1994 a second DHS will be negotiated for survey to be done in 1997/98. It is expected that 12 person-months of short term assistance will be needed.

(iii) RAPID IV: Twenty-four person months of technical services and funding for local training and educational activities will be procured through a buy-in to this central project (or its follow-on) to provide the expertise for work in the public and private sector to institutionalize population policy analysis.

USAID will award maternal health and research grants to U.S. universities or PVOs collaborating with Malawian institutions in order to conduct investigations on maternal health and research issues critical to implementing AIDS and child spacing interventions. For example, Johns Hopkins University, working with Malawi's Chancellor College, is conducting formative research on initiation practices as they relate to the onset of sexual activity for youth. USAID/Malawi would consider this type of research appropriate for a grant under this project. Other examples of appropriate research are listed in Section V of Annex I, "Social Soundness and Gender Analysis."

2. Commodities

a. Summary of Procurement

As summarized below, commodity procurement will be the responsibility of USAID/Malawi, REDSO/ESA. AID/W, FHI/AIDSCAP, or the IC, depending on the individual item. A detailed commodities list is included in Annex P

(1) Contraceptives

This project will provide condoms, oral contraceptives, foaming tablets and Norplant. These will be obtained through periodic Mission budget transfers to AID/W RD/POP for all contraceptives procured under this project. However, although specific quantities are stated in this Project Paper and may be modified and projections revised based on contraceptive prevalence surveys. As other contraceptive methods are approved for USAID-financing, e.g., Depo-Provera, female condoms, the project may provide these as well.

(2) Vehicles

With the assistance of the REDSO/ESA Regional Commodity Management Officer, the Mission will issue a PIO/C to purchase ten four-wheel drive utility vehicles and four two-wheel drive station wagons for use by the institutional contractor, AIDSCAP technical assistance and USAID PSC. One 15-seat mini-bus will be ordered for FHI/AIDSCAP and one for the Institutional Contractor. In year four a second PIO/C will be issued for replacement vehicles. It should be noted that at the time of this design there are no available service and maintenance facilities for U.S. manufactured utility vehicles, station wagons or mini-buses and not all types of vehicles are available with right-hand drive. If the Mission finds that this situation has changed during the course of project implementation, appropriate action will be taken.

All other vehicle procurement, including bicycles and motorbikes, will be performed by the Institutional Contractor or FHI/AIDSCAP.

(3) STD Drugs, and STD/AIDS Laboratory, Clinical and Medical Supplies

With the assistance of the REDSO/ESA Regional Commodity Management Officer, the Mission will issue the required PIO/C worksheets with AID/W VA as the authorized agent for all STD drugs, controlled laboratory supplies and clinical equipment/kits. Procurement will either be through U.S. Government agents (such as the VA or GSA) or through UNICEF or a combination of these two sources. All other AIDS-related laboratory and medical supplies shall be procured by FHI either on an open market basis or under GSA Federal Supply Schedules. All other clinical equipment/supplies shall be purchased by the Institutional Contractor.

(4) Other Clinical Equipment and Furnishings

The Institutional Contractor will be responsible for procuring clinical equipment and furnishings for use by the GOM and subgrantees as specified in approved workplans and budgets.

(5) Office Equipment and Office/Residential Furnishings and Supplies

USAID/Malawi, will procure with the assistance of REDSO/ESA RCMO when necessary, office equipment furnishings and supplies for use by the Personal Services Contractor.

FHI and the Institutional Contractor will be responsible for procuring computer equipment, office and residential furnishings and supplies for use by its technical assistance and local personnel as well as for the GOM and subgrantees, if necessary.

(6) Subgrantee or GOM Support

Except for those items listed above, the Mission will have no direct responsibility for procuring commodities for subgrantees, the GOM nor for goods required by the Institutional Contractor or FHI once the technical assistance contract is awarded. Rather, the Institutional Contractor will procure any required equipment, vehicles and/or supplies for the GOM and subgrantees, except those related to AIDS treatment. The latter will be purchased by FHI/AIDSCAP, although USAID will review the equipment/supplies/furniture lists before authorizing either party to proceed. The Institutional Contractor will be required to purchase all goods and services in accordance with the procedures set forth in Federal and A.I.D. Acquisition Regulations, Buy American Guidelines and, in the case of subgrantees and unless otherwise agreed to by A.I.D., according to A.I.D. Handbook 13. FHI will be required to purchase all goods and services in accordance with the requirements set forth in A.I.D. Handbook 13 and the standard provisions contained in its Cooperative Agreement.

b. Relevant A.I.D. Guidelines

(1) Development Fund for Africa

This project will be financed by sources provided under the Development Fund for Africa (DFA). Per Congressional guidelines set forth in the legislation authorizing DFA, all reasonable efforts will be made to procure U.S. source and origin goods to the maximum extent practicable. The Equipment List (Annex P) was reviewed by the REDSO/ESA Regional Commodity Management Officer. Only those items which are currently not made in the U.S., or which because of the very nature of the item(s) cannot be purchased and shipped from the U.S. at a reasonable cost or for which there exists no service and maintenance capabilities in Malawi, have been designated as eligible for purchase from Code 899/935 source/origin. When the Institutional Contractor or FHI procures on behalf of subgrantees, the order of preference will be: (a) U.S. only,

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(b) host country, (c) Code 941 (Selected Free World), and (d) Code 935 (Special Free World).

The authorized procurement source for motor vehicles is A.I.D. Code 935 (Free World). This is justified based on the unavailability of service and spare parts for U.S.-manufactured vehicles in Malawi and that no right hand drive utility vehicles, station wagons or minibuses qualifying as U.S.-made are available at the time of this design. No "Special Circumstances" waiver is required to purchase such items from non-U.S. sources.

Based on the above, the REDSO/ESA RCMO has concluded that USAID/Malawi is following the guidelines of maximizing U.S. procurement whenever practicable. However, to ensure that the Institutional Contractor and FHI comply with these guidelines, they will be required to provide a quarterly report at the end of each quarter to USAID of all commodities purchased during the period covered, the geographic codes and the dollar amount per geographic code. This will enable USAID/Malawi to report this information to A.I.D./W on a quarterly basis as required under both DFA and Buy America.

(2) **Commodity Marking**

Goods purchased by the Project shall be appropriately marked with the A.I.D. emblem in accordance with A.I.D. policy set forth in A.I.D. Handbook 15, Chapter 9, entitled "Requirements for Marking A.I.D. Financed Commodities." It is USAID's responsibility to assure compliance with these requirements. When they have not been met, USAID should initiate corrective action which could simply entail informing the contractor or subgrantee of the noncompliance and request correction, or may necessitate the submission of A.I.D. Form 1450-1, "Reporting of Violation - Marking Requirements", to A.I.D./W.

3. <u>Participant Training</u>

USAID/Malawi will arrange for ten Malawians to be provided with U.S. university training leading to graduate degrees. Four qualified university graduates will be selected for training in AIDS-related disciplines such as epidemiology and communications. Six qualified candidates will be trained out of Malawi in population, with an emphasis on graduate programs stressing service delivery, population policy and management. Five are expected to complete doctoral work and five will receive Master's Degrees.

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C. Methods of Implementation and Financing

Project Element/ Activity	Method of Implementation	Method Of Financing	Contracting Agent	Amount ($000)
1. TECHNICAL ASSISTANCE				
Institutional Contractor	A.I.D. Direct Contract	Direct Payment	RCO	13,802
- Activities				(1,866)
- Oper. Costs				(6,108)
- Subgrants				(4,100)
- Commodities				(1,728)
AIDSCAP	Coop. Agreement (Centrally Funded)	Letter of Credit (Add-on)	FA/OP	11,439
- Activities				(3,090)
- Oper. Costs				(5,962)
- Subgrants				(600)
- Commodities				(1,787)
Safe Motherhood/ Research Grants	A.I.D. Direct	Direct Payment/ Letter of Credit	USAID	800
Other Tech. Support	A.I.D. Contracts/ Grants (Centrally-Funded)	Direct Payment/ Letter of Credit (Add-on/ Buy-in/OYB Transfer)	AID/W	1,500
US PSC Project Coordinator	A.I.D. Direct Contract	Direct Payment	USAID/EXO	720
2. TRAINING				
Long-Term Participant Training (U.S.)	A.I.D. Direct (PIO/P)	Direct Payment	USAID	1,100

Project Element/ Activity	Method of Implementation	Method Of Financing	Contracting Agent	Amount ($000)
3. COMMODITIES				
Contraceptives	A.I.D. Direct Contract (Centrally-Funded)	Direct Payment/OYB Transfer	AID/W	7,871
Vehicles, Computer Equipment, Residential and Office Furn/Equipment	A.I.D. Direct Procurement (Purchase Orders)	Direct Payment	USAID/EXO	386
STD Drugs, Laboratory, Clinical and Medical Supplies	A.I.D. Direct Payment (PIO/C)	Direct Payment	VA/GSA/ UNICEF/FHI	400
Shipping/Handling PSA/RPSO Fees				2,769
4. LOCAL GOM PROJECT ACTIVITIES	A.I.D. Direct (PIL)	HC Reimbursement	GOM	2,139
5. EVALUATION AND AUDIT	A.I.D. Direct Contract	Direct Payment	USAID/RCO	350
6. CONTINGENCY AND INFLATION	-	-	-	1,724
			TOTAL	**$45,000**

A review of alternative implementation and financing methods in light of unconventional project needs and funds accountability led USAID/Malawi to select the A.I.D. direct contracting, Buy-In and/or Institutional Contractor methods using direct payments, OYB transfers, direct reimbursement, letters of credit and bank letters of commitment procedures. These methods are consistent with USAID/Malawi's current policies on project financing and implementation.

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D. Implementation Plan and Schedule

Action	Agent	Completion Date
for 1992:		
Sign Pro-Ag with GOM	USAID - GOM	9-28
PIL No. 1 issued	USAID	10-23
Sign PIO/C for PSC	USAID - GOM	10-25
Sign PIO/Cs for HHE, Equip,	USAID - GOM	11-30
Sign PIO/Cs for Vehicles, ADP	USAID - GOM	11-30
Sign PIO/Ts for IC TA	USAID - GOM	11-30
PSC announcement CVs received	USAID	11-30
RFP for IC Prepared and Cleared (Institutional Contractor)	USAID - REDSO	12-15
Logistics Study Conducted (TDY)	FHI	12-21
PSC Selection made	USAID	12-30
for 1993:		
Sign PIO/T for FHI Coop. Ag.	USAID - GOM	01-15
PSC Sec. cleared & begins	USAID - AID/W	02-15
Add-on signed FHI/AIDSCAP	AID/W - FHI	03-01
STD drug list and PIO/C	FHI - AID/W	03-31
IC RFP responses received	USAID - REDSO	03-31
AIDSCAP advisors arrive	USAID - REDSO	04-15
HHE and ADP equipment arrive	USAID - FHI	04-15
FHI orders STD drugs, supplies	FHI	05-01
Work begins on AIDSCAP workplan		05-01
FHI: local staff recruited	FHI	05-28
RFP selection of IC	MOH - USAID	06-15
Orientation trips & mtings end	FHI	06-15
Sub-grant announcements	FHI- USAID	06-15
FHI Workplan approved	FHI - USAID	06-30
PVO competition RFP emitted	FHI - USAID MOH	06-30
IC Grant Signed	REDSO	07-05
1st Quarterly report done	FHI - MOH	07-15
STD drugs arrive	FHI - MOH	07-30
Sub-grants awarded	FHI - USAID	08-30
IC Staff Arrives	IC	08-31
STD workshop held	FHI - MOH	09-30
US PVO grant signed	FHI - USAID	09-30
Regional office (s) opened	FHI - MOH	09-30
2and Quarter report done	FHI	10-15
Reg'l staff recruitment	FHI - MOH	10-31
Contraceptive MIS study	FHI - GOM	11-30
Contraceptive stock inventory	FHI - sub-contract	12-31
Request for Contraceptives made	NFWC - MOH	12-31

Action	Agent	Completion Date
for 1994		
Second sub-grants announced	FHI - USAID	01-15
Policy review workshop	FHI - GOM	01-31
Contraceptive orders placed	USAID	02-15
Sub-grants awarded	FHI - USAID	03-15

E. Monitoring and Evaluation Plan

The goal for the USAID/Malawi program, as expressed in the approved Country Development Strategy Statement, is to enhance the economic well-being of the average Malawian household. Three strategic objectives for the health sector were also defined in that document - reduce infant and child morbidity and mortality, reduce fertility, and assist in the control of the spread of AIDS. The STAFH project joins Promoting Health Interventions for Child Survival (PHICS) as the Mission's principal vehicles for achieving health sector strategic objectives.

1. Project Goal

The Project's goal is to reduce total fertility and to reduce HIV/AIDS/STDs transmission. Indicators which will be tracked on a regular basis for assessing achievement of this goal include:

-- total fertility should decline from 7.6 in 1992 to 6.8 in 1998, and

-- HIV prevalence among women attending the antenatal clinic at QECH should fall from 25% to 15% by 1998.

2. Project Purpose

The project's purpose is to increase the contraceptive prevalence rate and to promote behavioral change to reduce the prevalence of HIV/AIDS/STDs. Several indicators will be tracked on a regular basis to ensure that the project is having its intended impact:

-- condom use among males aged 15 to 24 will increase from 5- 10% to 30-40% by 1998;

-- positive syphilis serology among urban and semi-urban pregnant women will decrease from 8-14% to 4-7% by 1998;

-- contraceptive prevalence rate among women in union of reproductive age will increase from 3-5% to 20% by 1998;

-- mean age of women at first birth will increase from 19 years to 21 years by 1998; and,

-- interval between births will increase such that births spaced less than two years apart will decline from 24% of all births to 15% of all births by 1998.

The sources of information for monitoring achievement of these objectives will include all sources listed above for the project goal, but will also include periodic special surveys to monitor condom use and survey data collected by service delivery NGOs assisted under the terms of this project.

3. Project Outputs

The STAFH project has three related to the AIDS control component and one related to the child spacing component. Each component has several associated indicators.

a. AIDS Control Component

The outputs of the AIDS Control Program are: increased access to condoms and condom education services; increased access to high quality STD drugs and correct STD case management services; and, increased access to education, counseling, and AIDS prevention materials among high risk groups (e.g., youths, STD patients, employed males and bargirls) and the general population.

Indicators which will be monitored during the course of project implementation regarding project success in achieving these outputs include:

-- percent of CHAM and MOH hospitals providing comprehensive STD prevention and control services for males and females increases from nil to 50% by 1998;

-- percent of large private sector companies and estates (over 300 employees) with effective AIDS prevention and condom distribution programs increases from 10% to 90% by 1998;

-- percent of schools providing AIDS prevention education increases from nil to 80% by 1998;

-- AIDS prevention education programs established for bargirls, STD patients, out of school youths and other at-risk men and women;

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-- number of condoms sold through social marketing increases from 0.5 million per year to 4.0 million per year by 1998;

-- number of condoms distributed by National AIDS Control Program increases from 3 million per year to 10 million per year by 1998 with up to 6 million to be provided by the project;

-- GOM commitment of human and financial resources for AIDS prevention increases.

Sources of data for assessing progress toward meeting these targets begins with the data sets identified above. In addition, information which is not collected through routine surveys will be collected by special, periodic surveys. Examples of information which will need to be collected in this manner include annual assessments of how many more private hospitals are providing comprehensive STD prevention and control services and the development of STD education packages and use among the nation's primary and secondary schools.

b. Child Spacing Component

The child spacing component consists of one output measure of achievement - increased access to child spacing information and services. To accurately assess progress towards this objective, the project will carefully assess:

-- number of MOH and CHAM hospitals providing comprehensive child spacing services increases from 3 to 25 (e.g., 100%), and from 8 to 10, respectively, by 1998;

-- number of clinics providing core child spacing services increases from 230 to 549 by 1998;

-- number of MOH Health Surveillance Assistants (HSAs), GOM and PVO field agents, TBAs, and volunteers providing child spacing services via community-based distribution (CBD) increases from 200 to 1,860 by 1998;

-- number of cycles of oral contraceptive pills sold annually through social marketing increases from 0 to 1.4 million by 1998;

-- number of users of modern methods of child spacing (orals, condoms, foaming tablets, injectables, voluntary surgical contraception, including Norplant) increased from 68,000 to 437,000 by 1998;

-- NFWC established and functioning as the national leadership and coordinating body for child spacing activities and providing a full-range of support services to providers; and

-- GOM commitment of human and financial resources for child spacing increases.

Sources of data for assessing progress toward meeting these targets begins with the data sets identified above. In addition, information which is not collected through routine surveys will be collected by special, periodic surveys. Examples of information which will need to be collected in this manner includes annual assessments of how many more private hospitals are providing comprehensive STD prevention and control services and the development of STD education packages and use among the nation's primary and secondary schools.

4. Evaluation

Two project evaluations will be conducted during the life of the project. A midterm evaluation is scheduled for 1995 and a final evaluation for the fourth quarter of 1998. A Demographic and Health Survey, presently scheduled for 1996/97 will provide essential data for the final evaluation.

The purpose of the midterm evaluation is to assess program impact and progress toward achievement of the major project outputs and purpose, identify problems likely to affect successful achievement of the project purpose, and recommend mid-course corrections in project strategy and mechanisms and/or project objectives.

The midterm evaluation will require five outside consultants for a minimum of four weeks each. The team should include a family planning clinic specialist, a contraceptive social marketing/non-clinical distribution specialist, an IEC/training specialist, an HIV/STD/AIDS specialist and a management/ logistics/MIS specialist. The USAID HPN Officer, USAID Personal Services Contractor and AIDSCAP, IC and grantee representatives will also participate.

Prior to the arrival of the evaluation team, project staff will compile all pertinent data for their assessment. The team will also have available all reports prepared in developing IEC materials from focus groups and KAP studies, operations research study reports, and other research studies and analyses.

Specific areas to be assessed in the midterm evaluation include:

a. the effectiveness of AIDSCAP and the IC in providing training and technical support; the extent to which trained personnel are able to function on their own; their ability to sustain their operations; and the adequacy of support services being provided to the subgrantees by AIDSCAP and the IC;

b. the effectiveness and efficiency of the AIDSCAP and IC mechanisms in developing and awarding subgrants and monitoring their implementation;

c. the number of service delivery grants awarded and the effectiveness of the subgrantees in expanding high quality family planning services, increasing numbers of modern methods users, and the effectiveness of AIDS prevention efforts;

d. the number of service delivery points added by public and private sector organizations and the effectiveness of these entities in providing services and identifying mechanisms for future, rapid service expansion;

e. the extent to which AIDSCAP and the IC have been effective in expanding availability and use of family planning services and promoting AIDS prevention efforts;

f. the extent to which project or other external resources will be required to maintain levels of service delivery being provided by subgrantees;

g. the potential for addition or expansion of service delivery grants to larger geographical areas and numbers of clients;

h. the appropriateness and utility of the AIDSCAP and IC mechanisms for channeling other donor funds;

i. the extent to which project implementation, i.e., grant award and implementation, can be accelerated; and

j. the costs of grants award and monitoring mechanism and potential for sustainability of subgrantee activities in the medium and long-term.

The evaluation team will identify problems and issues and recommend solutions. The team will also make a preliminary recommendation regarding a follow-on project and its proposed structure. These recommendations will be discussed with the evaluation committee and plans made for implementation of those recommendations agreed to by USAID and Malawian counterparts.

The final evaluation will assess overall project impact, progress towards achievement of project objectives, and sustainability of sub-projects. Specific issues, team composition, and duration will be similar to the mid-term evaluation. However, the team will make recommendations regarding a follow-on project and suggestions for its design.

Planning for the final evaluation will start at least one year in advance of the PACD. DHS survey data should be available for assessing the impact of the IC on contraceptive prevalence and access to modern contraceptives and other data should be available for assessing the impact of AIDS prevention activities. In addition, AIDSCAP and the IC will be responsible for ensuring that the following are completed and made available to USAID: all available data from the MIS compiled; comprehensive, up-to-date status reports prepared and shared with USAID; reports from all operations research and other studies provided; and grant award and monitoring documents for all subgrantees.

5. Audit

Given the number and size of grants under this project, effective financial management, accountability and audit will be a primary concern. The IC will be required to have a well-established track record in administering and managing USAID-financed projects and subgrant monitoring. AIDSCAP and the IC will be expected to ensure that subgrantees possess adequate administration and financial control systems to meet USAIDS's accountability requirements. Audit firms will be engaged to conduct annual financial and compliance examinations of subgrantees. In addition, AIDSCAP and the IC must comply with Standard Provisions for grants to NGOs which include requirements for submission of annual independent CPA-audited financial statements to USAID.

The project has also made provision for two major contract audits in years three and five. These audits will supplement audits of the grantees, and will focus on the financial management of AIDSCAP and the IC. Sufficient funds are budgeted in the project budget for these audits.

USAID/Malawi Financial Management Office, in coordination with the Office of the Regional Inspector General and the Mission Health, Population and Nutrition Office, will be responsible for: a) developing an audit plan for the project covering the life of the project period; b) monitoring annual audits by the contractors, grantees and the GOM; c) arranging for contract audits (formerly non-federal audits) when necessary; and d) assuring timely closure of audit recommendations.

Both U.S. and non-U.S. grantees and contractors, and all foreign recipients (including GOM), will be responsible for an

annual financial audit of project activities by independent auditors acceptable to the A.I.D. Inspector General and in accordance with U.S. Government auditing standards. Furthermore, subgrantees that receive $25,000 or more per year will also be required to have audits performed by an independent auditor acceptable to A.I.D. Inspector General and in accordance with U.S. Government auditing standards. The grantee and not A.I.D., however, will be responsible for ensuring that the subgrantee's audit is adequately performed and that any audit recommendations are fully implemented.

Technical assistance, where necessary, will be provided to the foreign recipients by USAID, Institutional Contractor, AIDSCAP and/or the A.I.D. Inspector General in contracting for and/or implementation of these audits. Sufficient funds are budgeted in the project budget for this purpose.

6. Financial Review

The GOM through the Ministry of Health and NFWC will be responsible for implementing local project activities as described in Section III of this Project Paper. Based on a review of MOH financial, accounting and control systems performed by USAID/Malawi Financial Management Office in November, 1988 and subsequent continuous periodic reviews, and past experience under PHICS project, it is determined that current MOH financial management system and controls are adequate to account for USAID funds provided under this project. Accounting and payment procedures followed by the MOH are found satisfactory and in compliance with GOM Treasury regulations. Controls exercised from initiation of a transaction to payment were properly segregated such that no unauthorized payment could pass unnoticed.

Project funds for all local currency costs will be disbursed through periodic reimbursements. If MOH financial resources are not adequate to cover the project expenses, sufficient funds may be advanced to meet these expenses upon request from MOH and subject to approval by USAID Controller. In such cases, the advances will be deposited into a separate account with the Reserve Bank of Malawi. The MOH will also maintain a separate ledger account and sub-accounts for recording advances received and expenditures incurred against the advances. The MOH will account for advances by submission of reimbursement claims on a periodic basis. In addition, the MOH will recruit a full-time accountant for financial management, control and accounting for project-funded MOH activities. Funds are budgeted for this purpose. Detailed procedures for requesting and accounting for advances will be specified in Project Implementation Letters (PILs).

A review of NFWC's financial accounting, reporting and control systems was also performed by the Financial Management Office

of USAID/Malawi to ascertain the financial management capabilities of NFWC to adequately account for A.I.D. funds provided directly to NFWC under this project. This review indicated that NFWC is still in its start-up phase and not fully staffed. Prior to receiving A.I.D. funding, NFWC capabilities must be more fully developed and several important issues need resolution. The review, however, indicated that NFWC does maintain adequate financial records and control given the small amount of activity currently taking place. As the number of transactions increases, it will be necessary to have additional staff. Implementation of the recommendations suggested in the report of financial review will also be imperative for NFWC to maintain accurate, current and complete accounting records for expenditures and disbursements of USAID grant funds.

For direct grants to local NGOs/PVOs or other granteees, USAID will perform and/or arrange for a pre-award survey and assessment of the grantee's institutional and financial management capabilities prior to awarding the grant.

For subgrants, the IC and AIDSCAP will be responsible for performing necessary assessments, prior to awarding a subgrant, to determine the potential subgrantee's institutional and financial management capabilities.

IV. PROJECT BUDGETS

A. USAID Inputs

Inputs provided under this project will include: technical assistance ($25.2 million); commodities ($11.4 million); local costs and training ($3.2 million); audit and evaluations ($0.3 million); other USAID direct costs ($3.0 million); and allows for an additional sum for inflation and contingencies ($1.7 million). The supply of these inputs will be monitored through routine implementation management of the project, including semi-annual internal project implementation reviews of all activities.

B. Host Country Contribution

The Government of Malawi is firmly committed to providing counterpart support to the STAFH project. National programs combatting AIDS and promoting child spacing have been ongoing since the mid and early 1980's, respectively. Treatment of AIDS and AIDS-related illnesses already account for a

significant share of health expenditures. With the creation of the National Family Welfare Council in 1992, and encouragement from the $75 million PHN sector credit authorized by the World Bank/IDA, GOM spending for child spacing will also be increasing over the life of project.

Both government and private clinics provide diagnostic, palliative and (limited) treatment services for the estimated 20,000 (1992) AIDS cases; there are an estimated 300,000 HIV positive persons. In addition, STD cases represent a significant burden on health care facilities. In a 1991 survey of health care clinics in urban and semi-urban areas, STD cases alone were found to represent ten percent of outpatient visits. Based on information taken from reporting hospitals, complaints and illnesses related to AIDS/HIV and other sexually-transmitted diseases already account for some 20-40 percent of case load. Since the numbers of HIV positive people developing AIDS and AIDS-related illnesses will continue to rise over the next several years, AIDS cases will represent an increasing burden on the health care system.

Calculation of the GOM's contribution to the project was estimated using casemix information from health institutions and government ministries to derive appropriate weights for AIDS/HIV/STD and child spacing. Based on this casemix reporting and expert estimations, weights of 30 percent (AIDS) and 5 percent (child spacing/safe motherhood) were determined. The weights were then applied to appropriate budgetary line items in the GOM budget, including the Ministries of Health and Women and Children Affairs and Community Services as well as subventions to related health institutions such as CHAM and NFWC.

The sum of these values represents the GOM contribution for the full year. The 1992/93 figures are for six months, since STAFH will start-up in the middle of the GOM fiscal year; out-year values were determined assuming a modest 5% annual increase in these GOM budget allocations.

In sum, the GOM will invest an estimated 182.6 million Kwacha (or $45,668 million) in counterpart support of the project's objectives. The Government recognizes the urgency of the AIDS crisis and is committed to reducing transmission of HIV/STDs. Furthermore, recent discussions held by government officials at various levels suggest that Malawians are increasingly aware of the benefits of lower fertility and are moving towards adoption of a population policy, thereby enhancing the likelihood of increasing future contributions to child spacing activities.

C. Budget Tables

The following tables show planned project expenditures by major category (Table 1), by contracting entity (Table 2), and by project component (Table 3). Table 4 presents the expected host country contribution.

TABLE 1

ILLUSTRATIVE SUMMARY OF PROJECT COSTS BY MAJOR CATEGORY

($000)

		LOP Funding	FY 92 Obligation	Future Fund to be Obligated
Technical Assistance		25,241	1,600	20,641
Activities	(9,289)			
Personnel	(7,382)			
Oper. Costs/G & A	(4,572)			
Commodities/Med. Supplies	(3,515)			
Misc./Travel	(483)			
Commodities		11,426	350	11,076
Inflation Contingency		1,724	150	1,574
Local Costs		2,139	350	1,789
Training		1,100	50	1,050
Audits and Evaluations		350	-	350
Other USAID Direct		3,020	500	2,520
Total		**45,000**	**6,000**	**39,000**

TABLE 2

BUDGET SUMMARY BY MAJOR CONTRACTING ENTITY

($ 000)

I. COOPERATIVE AGREEMENT (AIDSCAP)		II. INSTITUTIONAL CONTRACTOR (IC)	
PERSONNEL	3,052		4,330
OPERATING COSTS	494		1,778
TRAINING	1,138		163
MATERIALS	1,204		250
SUBGRANTS	600		4,100
SOCIAL MARKETING	175		725
COMMODITIES	1,787		1,442
MISCELLANEOUS	258		109
G & A OVERHEAD	2,300	QUALITY ASSURANCE	115
RESEARCH/STUDIES	315	UPGRADES/RENOVATION	364
LOCAL TRAVEL/PD	116	MEDICAL SUPPLIES	286
		MANAGEMENT INFORMATION SYSTEMS	140
TOTAL	11,439	TOTAL	13,802

TOTAL TECHNICAL ASSISTANCE:
(I + II = $25,241)

III. OTHER USAID DIRECT COSTS

PIL TO GOM	2,139
COMMODITIES	11,426
PILOT/OPERATION RESEARCH GRANTS	800
DHS	1,000
RAPID	500
TRAINING	1,100
PSC	720
AUDIT	350
INFLATION/CONTINGENCY	1,724
TOTAL	19,759

TOTAL PROJECT BUDGET:
(I + II + III = $45,000)

STAFH PROJECT: DETAILED COMPONENT BUDGETS
LOP, YEAR 1, YEAR 2, YEARS 3-6 ($000)

I. AIDSCAP COMPONENT	LOP	YR 1	YR 2	YRS 3-6	
A. Technical Assistance and Admin.					
1. Lilongwe Office					
Resident Expatriate:					
Chief of Party	1,200	200	200	800	budget thru LOP
STD Specialist	0	0	0	0	2+ yrs resident/core funded at $400,000
Local Staff:					
Communication Specialist	53	8	9	36	(P4 $8,500 S&H/yr)
Research Assistant (2)	60	10	10	40	(PO-$5,000 S&H/yr)
Accountant	36	6	6	24	(P8 $6,000 S&H/yr)
Administrative Assistant	24	4	4	16	(CEO/PO Grade-$4,000 S&H/yr)
Secretary (2)	48	8	8	32	(D1 $4,000 S&H/yr)
Driver (3)	36	6	6	24	(3 pers-$2,000 S&H/yr)
Operating Costs:	178	22	30	126	
2. Blantyre Office					
Resident Expatriate					
AIDS Unit Manager	1,040	200	200	640	budget thru LOP
Local Staff					
Administrative Assistant/Sec.	24	4	4	16	(CEO/PO Grade: $4,000 S&H/yr)
Research Assistant	30	5	5	20	(PO-$5,000 S&H/yr)
Driver	12	2	2	8	($2,000 S&H/yr)
Operating Costs:*	117	17	20	80	
3. Short Term TA					
Condom logistics (6 months LOP)	100	-	-	100	Core-funded @ $25,000/Mo.
Communication (12 months LOP)	100	-	-	100	
4. AIDS Secretariat Office					
Local Staff					
Training Officer	36	6	6	24	
STD Clinical Officer	55	5	10	40	

* Funds to be used preferentially for renovating office space in RHO offices to accommodate AIDSCAP staff; if not feasible, then for separate office rental.

	LOP	YR 1	YR 2	YRS 3-6	
5. MOH Regional & District					
Local Staff					
Regional Communication/Trg Officer (3)	108	18	18	72	
District Community Officer (3)	90	15	15	60	
Operating Costs:	110	15	19	76	
6. Other (travel, recurrent costs, etc.)	89	17	17	55	
Subtotal, TA & Admin.	3,546	568	589	2,389	*
B. TARGET GROUP PROGRAMS					
1. Youth:	548	30	146	372	
National mass media	398	49	115	234	
Youth Centers	647	48	219	380	
Subtotal: Youth	1,593	127	480	986	
2. Employed Males					
worksites	270	30	100	140	
Partner services @ worksites	116	0	48	68	
Community initiatives	370	20	139	211	
Subtotal: Employed Males	756	50	287	419	
3. Male STD Clients					
Upgrading STD services	201	32	85	84	
Community outreach	79		23	56	
Social marketing of STD services	245		135	110	
Subtotal STD Males	525	32	243	250	
4. Bargirls/Bar owners/Freelancers					
Peer education	335	25	95	215	
DHI program upgrading	137	5	63	69	
Bar managers education	58		16	42	
Freelancers	104		48	56	
Subtotal Bargirls/owners	634	30	222	382	
C. COMMODITY PROCUREMENT	1,787	475	350	962	See Annex P

	LOP	YR 1	YR 2	YRS 3-6	
D. CAPACITY BUILDING	190	0	60	130	
E. POLICY DEVELOPMENT	108	8	28	72	
AIDS/HIV/STD Program Subtotal	9,139	1,290	2,259	5,590	
Less subgrants minus mgmt fee*	(722)	(181)	(271)	(271)	$800,000 for eg's less $78,000 mgmt fee
Less commodity procurement (PSA)	(1,787)	(475)	(350)	(962)	
Amount to which G&A is added	6,630	634	1,638	4,357	
G&A (34.7%)	2,300	220	568	1,512	
Total, AIDSCAP Add-on	11,439	1,510	2,827	7,102	

* G&A charged only on the first $25k of subgrants.
NOTE: No inflation factored in; no unallocated funds (contingency).

II. INSTITUTIONAL CONTRACTOR - CHILD SPACING

	LOP	YR 1	YR 2	YRS 3-6	CALCULATION
A. Technical Assistance and Admin.					
Expatriates:					5 person/yrs
Chief of Party	1,000	0	200	800	
Community Services Specialist	900	0	180	720	5 person/yrs
Communications/Social Marketing Advisor	900	0	180	720	5 person/yrs
Clinical Services Specialist	600	0	200	400	3 person/yrs
20 person/months ST TA	360	0	100	260	@ $15,000/mo.
Local Staff					
Financial Manager	250	0	50	200	
Logistics/MIS Specialist	200	0	40	160	
Bookkeeper	30	0	6	24	(P8 $6,000 S&H/yr)
Admin Assistant	20	0	4	16	(CEO/PO Grade - $4,000 S&H/yr)
Secretary (2)	40	0	8	32	(D1 $4,000 S&H/yr)
Driver (3)	30	0	6	24	(3 pers - $2,000 S&H/yr)
Operating Costs	1,778	6	314	1,458	
Subtotal TA and Admin.	6,108	6	1,288	4,814	

	LOP	YR 1	YR 2	YRS 3-6	
B. Mgmt. Info. Sytems:					
Computer supplies/data collection/MIS	140	20	20	100	
C. Subgrants & Subcontracts:					
CS (+AIDS) small Sub-grants (16)	2,000	0	500	1,500	16 CS (AIDS) grants @ $125,000 avg
USPVO lg CS grants (3)	2,100	0	700	1,400	3 sub-grants @ $700,000 ea
IE&C Mtls - Child Spacing	250	0	75	175	
Subtotal Subgrants & Subcontracts	4,350	0	1,275	3,075	
D. Core CS Services Upgrade & Expansion:					
CHAM: expand core CS 80 new sites	154	18	58	78	19 sites/yr @ $2,000 per site
Private Commercial at 35 sites	70	0	14	56	7 per yr @ $2,000 ea
Private offices at 20 sites	60	0	15	45	5 per year @ $3,000 ea
Subtotal Core CS services	284	18	87	179	
E. Comprehensive CS Services:					
(Possible sub-contract from IC for expansion and upgrading of comprehensive CS services at MOH 22 new sites, 3 3 existing; CHAM 2 new sites, 8 existing ('92))					
MOH/CHAM construction and equip.	176	12	43	121	3000/Site * 22 @ 4 per yr
Do 25,000 ML/LAs - med supplies	150	20	30	100	25,000 @ $12 case x .5 (MOH gives . 5)
Norplant 13,550 cases - med supls	136	7	10	119	13,550 @ $10 case - reimbursement
Do 1,100 vasectomies - reimburse	13	1	3	9	1100 cases @ $12/case
Training (MOH & CHAM):					
Surgical/Norplant/Vasect	55	10	15	30	ref AVSC ppl - below thru 96 only
TOT (Basic & in-service)	108	21	29	58	
Quality Assurance and Management	115	10	35	70	Local CHAM costs, vehicle
Subtotal, Comp. CS Services	753	81	165	507	
N.B. Does not include cost of Norplant sets or contingency					
F. Social Marketing PGM	925	0	225	700	
G. Commodities (see Annex P)	1,442	0	430	1,012	
Total, Instit. Contractor - CS	14,002	125	3,490	10,387	

	LOP	YR 1	YR 2	YRS 3-6	
III. SC SERVICE EXPANSION THROUGH/GOM					
A. MOH (PILs) expansion of core CS at 178 sites, 40/yr:	880	0	232	648	
B. MOLG upgrade 40 sites (PIL)	80	0	20	60	10 per year @ $2,000 ea
C. Other Ministries, NFWC, NGOs, (PIL) upgrade core CS at 50 sites	100	0	20	80	10 per yr @ $2,000 ea
D. NFWC (PIL)	500	100	100	300	
Total, GOM Core Upgrades	1,560	100	372	1,088	sub-total core CS
IV. COMMUNITY-BASED DISTRIBUTION					
A. MOH Facilities: CBD Services	486	0	67	419	PIL to NFWC, TA from the IC
B. Other GOM, Parastatals	93	10	16	67	PIL to NFWC, TA from the IC
Total, CBD With GOM	579	10	83	486	subtotal CBD services
V. OTHER USAID CONTRACTS/GRANTS/BUY-INS					
A. Maternal Health & Research Grants	800	100	250	450	USAID grants to local & US researchers
B. DHS Buy-in	800	0	500	300	Repeat DHS in '96/97
C. RAPID IV Buy-in	500	0	150	350	
D. LT trg 10 Grad degrees + ST trg	1,100	60	200	840	4 Doctorates; 6 master's + st trng
Total, Other	3,200	160	1,100	1,940	
VI. COMMODITY PROCUREMENT	11,426	2,000	1,500	7,926	USAID; Detailed list see Annex P
VII. PROJECT MGT., AUDIT & EVAL.	1,070	120	300	650	
VIII. INFLATION & CONTINGENCY	1,724	-	200	1,524	
TOTAL PROJECT BUDGET	45,000	4,025	9,872	31,103	

SUMMARY	LOP	YR 1	YR 2	YRS 3-6
AIDSCAP Component (I)	11,439	1,510	2,827	7,102
Child Spacing Component (II-V) *	19,341	395	5,045	13,901
Commodity Procurement	11,426	2,000	1,500	7,926
Project Mgt., Audit & Eval.	1,070	120	300	650
Inflation and Contingency	1,724	-	200	1,524
Project total	45,000	4,025	9,872	31,103

* Includes other USAID-procured TA.

Illustrative Host Country Contribution Budget
(in millions of Malawi Kwacha)

Item	Actual 92/93 (a)	Weights AIDS	Weights CS	Total Weights	Weighted 92/93 0.5 year	Weighted 93/94 whole year	Weighted 94/95 whole year	Weighted 95/96 whole year	Weighted 96/97 whole year	Weighted 97/98 whole year
Ministry of Health										
Health Administration	12.9	0.30	0.05	0.35	2.26	4.52	4.52	4.52	4.52	4.52
Health Institutions	67.1	0.30	0.05	0.35	11.74	23.49	23.49	23.49	23.49	23.49
Training Institutions	4.3	0.10	0.05	0.15	0.32	0.65	0.65	0.65	0.65	0.65
Ministry of Women's & Children's	Affairs & Comm. Services									
Administration	1.0	0.05	0.10	0.15	0.08	0.15	0.15	0.15	0.15	0.15
Social Welfare	2.1	0.10	0.10	0.20	0.21	0.42	0.42	0.42	0.42	0.42
Adult Literacy	2.7	0.05	0.05	0.10	0.14	0.27	0.27	0.27	0.27	0.27
Women's Affairs	0.3	0.05	0.05	0.10	0.02	0.03	0.03	0.03	0.03	0.03
Children's Affairs	0.4	0.05	0.00	0.05	0.01	0.02	0.02	0.02	0.02	0.02
Nat'l Family Welfare Council	0.6	0.05	0.95	1.00	0.30	0.60	0.60	0.60	0.60	0.60
Christian Hosp. Assoc. of Malawi	5.4	0.20	0.05	0.25	0.68	1.35	1.35	1.35	1.35	1.35
Sub-total					15.74	31.49	31.49	31.49	31.49	31.49
Total with 5% annual nominal increase (b)						33.06	34.71	36.45	38.27	40.18
GRAND TOTAL... (000 Malawi Kwacha)						---	---	---	---	182,673
Grand Total in US thousand dollars equivalent (c)										$45,668

NOTES:

a) Figures are from 92-93 Malawi government revenue budget

b) MOH Budget allocation will increase 5% annually in nominal terms

c) * US$ equivalent @ US$1 = MK is $ 45.6 million

V. SUMMARIES OF ANALYSES

A. Summary of Social Soundness and Gender Analysis

Recent research has shown that although child spacing programs in Malawi were established just ten years ago, and still are not widely-available in rural areas, public awareness and receptivity has increased substantially between 1982 and the present. In 1984 just over one-fourth of female respondents could name a modern child spacing method and just 1% were using a modern method; these proportions had increased to 97% and 3-5% in the most recent survey in 1991. Men are concerned that they do not have the same access to information on child spacing that women do, but the majority have used or have no objection to the use of modern methods.

The extent of adopting sexual behaviors that reduce the risk of HIV/STD transmission is less encouraging than the response to child spacing opportunities, but knowledge of AIDS is almost universal in Malawi and increases in condom use and avoidance of high-risk relationships have been noted. Intensive educational and condom promotion efforts, not yet fully implemented, are expected to have a substantial effect in bringing about behavioral change. Particular care must be taken that rural women and youth are exposed to IEC and possess the information that will permit them to protect themselves.

The proposed activities and strategies for achieving project goals are socially sound and feasible in the Malawian context. The child spacing component of the project will be particularly beneficial to Malawian women, reducing the risk of morbidity and mortality presently associated with pregnancy and childbirth. The sexually-active population of both genders will benefit from activities designed to reduce risks of transmission of HIV and STD, and also provide treatment for STD.

Specific recommendations aimed at enhancing the feasibility and benefits of the project include the following:

-- Efforts must be made to raise male involvement in child spacing. This can be accomplished by increasing the number of male service providers who can interact more easily with male clients, ensuring confidentiality, and employing community outreach programs, print materials and local leaders as advocates and spokesmen for child spacing.

-- Child spacing and HIV/STD service provision and IEC delivery should be integrated into existing maternal and child health programs so that the linkages between child spacing, STD prevention and healthier outcomes for mother and child alike can be emphasized and communicated.

-- Further documentation of sexual behaviors, particularly those which apparently allow for the possibility of multiple sexual partners within legally constituted marriages, should form a focal point for research and interventions.

-- Educational materials providing a full program of integrated family life education for schools (including the Centres for Distance Education), adult literacy programs, youth centers, and NGO training activities should be developed.

-- Training for church leaders as educators on child spacing and HIV/STD for their adherents should be modified to stress factual and accurate communication, target women and youth, and incorporate preventive messages.

-- Radio, newspaper, and magazines are the most important and trusted forms of media for reaching large numbers of people with child spacing and HIV/STD messages, and thus should be fully exploited.

-- Traditional medical and ritual specialists retain influential and trusted positions among people in their local communities. As conservative estimates of the numbers of such specialists are in the 10,000-15,000 range, immediate efforts should be made to assess their suitability as child spacing and HIV/STD communicators, and training programs should be designed for them.

In addition to these and other recommendations for more effective project implementation, an extensive agenda for socio-cultural research is proposed.

B. Summary of Institutional Analysis

The main means of fueling a rapid expansion of AIDS control and CS services in Malawi under this project is through a program of subgrants for the private sector. Several Malawian organizations were assessed in terms of their potential to manage a subgrant program, the three principal ones being the Christian Health Association of Malawi (CHAM), the Council of Non-Governmental Organizations of Malawi (CONGOMA) and the National Family Welfare Council (NFWC).

With relatively weak secretariats, memberships which do not support broad and potentially divisive subgranting authority, and institutional weaknesses, neither CHAM nor CONGOMA were deemed to be in a strong position to administer a subgrant program.

The NFWC, a parastatal, is in its start-up phase, not fully

staffed, and as yet has no track record. However, the NFWC is in a relatively stronger position to manage a subgrant program due to its autonomy; importance to the GOM; ability to serve both public and private sectors; and a broad mandate to promote family health and welfare. Prior to assuming such a function several important issues need resolution: whether donor support must be channelled to the NFWC through its parent ministry (MOWCCS); and whether and to what extent the NFWC Board supports NFWC involvement in AIDS prevention. The analysis concludes that it will be necessary to rely on a project-funded contractor to perform the subgranting function over the medium term until these and other issues are resolved and NFWC capabilities built up.

Simultaneously with the management of a subgrant program, the contractor will work with the NFWC on institutional capacity-building and system strengthening. The contractor will assess the feasibility of shifting the subgrant function to the NFWC as it gains experience and administrative capability.

While focussing on the private sector provision of services, the project will also support an expansion of MOH services within the well-known constraints under which the MOH must operate: not enough money and staff for preventive services; limited management and implementation capacity; an insufficient degree of decentralization; and policies which are progressive but slow to be approved and disseminated.

To ease these constraints and minimize the project's management burden on the MOH, several strategies will be pursued: policy dialogue and donor coordination to expedite implementation of MOH decentralization and health manpower plans; the use of project leverage to fill key MOH AIDS, CS and project management posts; utilizing established MOH planning systems; using established project planning and financial management procedures (PHICS); strengthening the capacities of the NFWC and the MOH AIDS SEC to plan and coordinate national AIDS and CS services (see Annex Q for NFWC and AIDS SEC organizational structures); and clarifying project coordination and implementation roles and responsibilities at the project's outset.

C. Summary of Economic and Financial Analysis

The Support to AIDS and Family Health Project has two central concerns - child spacing and AIDS control. The details of the economic and financial analysis, therefore, concentrate on estimating the benefits and costs which accrue to these two project components. As can be seen from the estimates, the economic benefits of these activities clearly exceed the cost

of the proposed interventions. The main focus of the discussion, therefore, is on the cost effectiveness and sustainability of the proposed interventions.

1. Child Spacing

The majority of project funding is dedicated to child spacing activities with approximately $25 million to be spent on these activities over the life of the project. This expenditure is expected to result in an increased number of modern method child spacing users, from 82,000 to 437,000.

The economic value of increasing the number of users of modern contraceptive users is considerable, and includes reducing the birthrate, increasing the birth interval, and perhaps reducing the child bearing period of women. Value to society accrues as the opportunity cost of bearing and raising children is recognized. Reducing the dependency ratio allows household members to engage in other, more economically productive activities. Income that would have been invested in raising children can also be invested in increasing physical or human capital in the population. This is particularly true in the case of delayed first births, which allows women to engage in other activities besides child care.

The increase in families practicing child spacing from 82,000 to 437,000 is likely to reduce annual births by an additional 40,000 to 50,000, on average, by 1998. If the project is able to effect this increase at a steady rate from 1993 to 1998, it would result in 250,000 to 350,000 births averted. This would represent about a two percent decrease in the projected population of about 12 million in the year 1998, which is likely to shift the dependency ratio by 4 to 5 percent. If this shift then has a similar effect on the GDP per capita, real GDP would rise by about $10 per person. By the year 1998, this would represent an increase in GDP of about $120 million. With increases in per capita income accruing during the years from 1993 to 1998, the total value of delayed births associated with this aspect of the project could reach as much as $500 million. Since costs for this component are currently planned for $25 million, this activity has an enviable benefit/cost ratio (20).

2. AIDS

The value of reducing the number of AIDS patients can be determined from a recent study of the economic impact of AIDS in Malawi by Steven Forsythe. His study uses current projections that indicate by the year 2000 there will be 642,000 to 1,076,000 persons with HIV in Malawi. Each AIDS death is expected to cost Malawi about MK 11,015, or about $2,700. If the activities of this project are successful in meeting its objectives of cutting the HIV prevalence in half,

AIDS deaths would be reduced by 250,000 to 450,000. The economic value of this impact, at $2,700 per life saved, would approach $1 billion. With the AIDS component budgeted at $20 million, the benefit/cost ratio (50) is even more attractive than for the child spacing component.

3. Cost Effectiveness

Issues of cost effectiveness are important in the Malawi health sector, where resources are very constrained. This section first looks at general measures of the cost of project outputs, and then discusses the mode in which these outputs are delivered.

The child spacing portion of the project is projected in the project paper to provide up to 437,000 couple years of protection (CYP) by the year 1998. Beginning from the current rate of CYP of 82,000, and assuming a steady increase to the year 1998, this would imply an additional 1,225,000 CYPs provided as a result of this project. With a budget of $25 million, the cost of a CYP would be about $20.40. This is slightly higher than most estimates of a CYP, which average about $20. However, the project is working in a country with a low contraceptive prevalence rate, and the difficulty of institutionalizing child spacing activities may drive the cost higher.

Within the AIDS component, the project is projected to be responsible, ultimately, for preventing 250,000 to 450,000 AIDS deaths. With a budget of $20 million, this indicates a cost per life saved of $80 to $44. This cost is very competitive with the measures of cost per life saved from other interventions, such as EPI or ARI programs, and lower than many other interventions.

As these calculations indicate, this project appears to be a cost effective means of investment in the health sector. In addition, the project appears to be approaching the accomplishment of these outputs in as efficient a manner as possible. The structure of the project utilizes several approaches that have been shown to be effective in similar projects. These include:

Private/Public blend of services. There are a number of advantages to this approach, including a more comprehensive coverage, and the ability to utilize each part of the health delivery system for its relative strengths. Each part can be used to reinforce the desired outcome.

Benefits from integration of AIDS and child spacing. Much of the administrative, supervisory and training activities of the project can be shared. Projects in

general are now trying to develop more integrated approaches that avoid duplication.

Social Marketing activities. There are important demand and supply reasons for using social marketing activities. They can be important for developing demand for the project services and may have important implications for the sustainability of the project outputs.

4. Sustainability of Project Benefits

Sustainability is an important aspect of all projects, and is vital in health projects. There may be some problems with sustainability of the activities under this project, since it generates little of its own revenue. Moreover, low purchasing power in Malawi means that there is little capacity for project beneficiaries to eventually absorb the costs of the services themselves. Thus, longer term problems of financial sustainability are possible.

However, the social marketing programs may be able to enhance sustainability. Working through estates and formal employers should also help with sustainability since these organizations can be shown that it is to their economic advantage to provide these services to their workers and families. Because the formal sector provides a disproportionate share of the AIDS cases, this will reach a large section of the target population. It is important to note, however, that the formal sector in Malawi represents a small proportion (14%) of the total labor force.

Household expenditure surveys in Malawi have shown that households currently spend about two percent of their income on health care. This would indicate an expenditure for the average household of about $25 per year. Thus, an expenditure of about $20.40 per couple year of protection would be prohibitive for most households. Social marketing of condoms, however, may be able to bring this cost down to an affordable level. It is likely that the average household would be able to afford an annual supply of condoms in the range of $5-6.

Recurrent costs to be absorbed by the GOM at the end of the project include: HSA salaries, operating costs of vehicles and equipment, provision of STD drugs, laboratory materials and supplies. These are expected to equal approximately MK2 million ($500,000 U.S. equivalent) per year by the end of the project. However, given Malawi's status as one of the relatively least developed countries, it is quite likely that donor assistance will continue to shoulder a high proportion of recurrent costs for AIDS and family planning interventions. It is reasonable to conclude, therefore, that the project's

recurrent costs will be provided for by a combination of GOM and donor support after 1998.

In sum, therefore, the project appears feasible, highly beneficial and cost effective. Issues regarding sustainability remain, but the project has been designed in ways which enhance, rather than erode, long term sustainability of project activities.

VI. CONDITIONS PRECEDENT, COVENANTS AND NEGOTIATING STATUS

A. Conditions Precedent

1. General Conditions Precedent

In addition to A.I.D. Standard Conditions Precedent and Covenants, except for the hiring of the Personal Services Contractor and except as A.I.D. may otherwise agree in writing, prior to any disbursement under the Grant, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the Grantee shall furnish to A.I.D., in form and substance satisfactory to A.I.D.:

a. A written statement setting forth the names and titles of persons holding or acting in the Office of the Grantee and of any additional representatives, and representing that the named person or persons have the authority to act as the representative or representatives of the Grantee, together with a specimen signature of each such person certified as to its authenticity;

b. Written evidence that a Ministry of Health full-time Project Coordinator and a full-time Accountant have been appointed and assurance that they will commence work within 60 days of their appointment; and

c. Written evidence that the Grantee has held the initial Project Steering Committee meeting. This Committee will meet every three months, or whenever deemed necessary, to address Project progress and policy issues likely to affect implementation of the Project and attainment of its objectives. Committee members will include: Principal Secretary for Economic Planning and Development; Principal Secretary of Ministry of Health; Deputy Secretary of Ministry of Finance; Principal Secretary of Ministry of Women Children Affairs and Community Services; Executive Secretary of National Family Welfare Council; Program Manager of Malawi AIDS Secretariat; USAID Health, Population and Nutrition Officer; Chief of Party of AIDSCAP; and Chief of Party of the

Institutional Contractor. Representatives from the Ministry of Health Planning Section and Project Implementation Unit (PIU) and the Ministry of Health Maternal Child Health/Child Spacing Unit will also be members of this committee. The Steering Committee should meet as soon as possible to elect a chair person and discuss conditionality affecting the project.

2. Conditions Precedent to Contracting with an Institutional Contractor for Assisting with Child Spacing Services

In addition to A.I.D. Standard Conditions Precedent and Covenants, and except as A.I.D. may otherwise agree in writing, prior to A.I.D. entering into a contract with an Institutional Contractor to assist the Grantee in providing child spacing services, the Grantee shall furnish to A.I.D., in form and substance satisfactory to A.I.D., written evidence that:

a. The Grantee has revised and approved child spacing/family health service guidelines which ensure that all those who seek information and services related to child spacing have unhindered access to them and the Grantee has disseminated the guidelines to all service providers;

b. The Grantee has agreed to modify the pre-service curricula at MOH and private health training schools to ensure that every enrolled and registered nurse, medical assistant and clinical officer successfully completing training after September 30, 1992 will be designated by the Grantee as a qualified provider of child spacing (except IUD) services in Malawi; and

c. A revised in-service family health training program qualifying health providers to deliver child spacing services has been developed and implemented that excludes IUD training.

B. Special Covenants

The Grantee agrees to undertake or cause to be undertaken the following:

1. Local Cost Contributions

The Grantee agrees that the contributions of local communities to support the extended delivery of family health services may be managed and distributed by those communities as they so choose.

2. STD Drugs and Medical Supplies

The Grantee agrees that the drugs and medical supplies purchased under the Project expressly for STD research and treatment will be separately labelled and targeted to STD patients, and that records will be maintained to monitor and control such distribution. The Grantee further agrees, in collaboration with project technical assistance to institute and implement a reordering and restocking system capable of meeting the Project's needs.

3. Expedited Review and Approval Procedures

The Grantee agrees to implement new procedures to expedite the review and approval of scientific research, and educational and promotional material funded by this Project for AIDS/HIV/STDs and child spacing.

4. Recurrent Costs

The Grantee agrees to absorb into the revenue budget the Project-related recurrent local costs of the child spacing services provided in the Grantee's facilities and through MOH employees (e.g., Health Surveillance Assistants) by the end of Project. By September 30, 1994 Grantee will submit a plan satisfactory to A.I.D. demonstrating the method by which these costs will be absorbed.

5. Annual Workplans

The Grantee agrees to submit to A.I.D. annual workplans describing GOM activities under this Project which address objectives for the year, estimated financial expenditures, the party or office responsible for each action in the workplan and such details as are required to ensure monitoring and coordination.

6. Annual Reports

The Grantee agrees to submit with each annual workplan (starting in year two of the Project) a short annual report on the preceding year's progress, problems and achievements as they relate to GOM activities.

7. Use of Project Goods

The Grantee agrees to ensure that all commodities procured for the Project will be used exclusively for Project purposes, that usage will be carefully monitored and controlled, and that an inventory status report will be provided to A.I.D. by 30 September of each year.

8. Long-Term Trainees

The Grantee will ensure that all trainees financed by A.I.D. under this Project and employed by the Government will, upon completion of their training, serve in Malawi (for not less than the duration of their training) in a position commensurate with the training received.

9. Population Policy Statement

Grantee will develop and disseminate a national population policy statement which is distributed to the Grantee's personnel and incorporated into all relevant training programs.

10. Norplant

Grantee will approve and, assuming satisfactory review of the pilot project, register Norplant by December 31, 1992.

11. Community-Based Distribution

The Grantee will issue, assuming satisfactory review of the pilot project, a directive allowing community/field workers to initially supply and resupply oral contraceptives.

12. Project Evaluation

The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include during implementation of the Project:

a. evaluation of progress towards attainment of the objectives of the Project;

b. identification and evaluation of problem areas or constraints which may inhibit such attainment;

c. assessment of how such information may be used to help overcome such problems; and

d. evaluation, to the degree feasible, of the overall development impact of the Project.

C. Status of Negotiations

The Government of Malawi has been notified of the above Conditions Precedent and Covenants and has given its preliminary concurrence. They will therefore be included in the Grant Agreement to be signed by the GOM and USAID in September, 1992.

VS DOC: 1801C

VII. LOGICAL FRAMEWORK

1992-1998

NARRATIVE SUMMARY	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
PROJECT GOAL: The project goal is reduce total fertility and to reduce HIV/AIDS/STD transmission.	A. A reduction in HIV prevalence among women attending QECH ante-natal clinic decreases from 25% in 1992 to 15% in 1998. B. A reduction in the total fertility rate from 7.6 in 1992 to 6.8 in 1998.	A. DHS DATA B. MOH STATISTICS AND CENSUS DATA C. MOH SURVEILLANCE DATA	A. INCREASED CONTRACEPTIVE USE WILL DECREASE FERTILITY. B. DECREASED FERTILITY AND HIV WILL HAVE POSITIVE ECONOMIC IMPACT.
PROJECT PURPOSE: The project purpose is to increase the the contraceptive prevalence rate and to promote behavioral change to reduce the prevalence of HIV/AIDS/STDs.	A. An increase in the percentage of males age 15-24 reporting condom use from 5-10% in 1992 to 30-40% in 1998. B. A decrease in the percentage of urban and semi-urban pregnant women with positive syphilis serology from 8-14% in 1992 to 4-7% in 1998. C. An increase in the contraceptive prevalence rate (CPR) among married women of reproductive age (MWRA) from 3-5% in 1992 to 20% in 1998. D. An increase in the mean age at first birth from 19 to 21 in 1998. E. A decrease in the percent of births spaced less than 2 years apart from 24% all births to 15% in 1998.	A. MOH SURVEILLANCE SYSTEM DATA B. PERIODIC SPECIAL SURVEYS TO MONITOR CONDOM USE C. DHS DATA D. MOH AND OTHER HEALTH STATISTICS E. NON-GOVERNMENTAL ORGANIZATIONS' SURVEYS	A. MALAWIANS WILL CHANGE RELEVANT BEHAVIOR TO REDUCE THE SPREAD OF HIV B. SIGNIFICANT DEMAND EXISTS FOR MODERN METHODS OF CHILD SPACING C. MALAWIAN MEN AND WOMEN RECOGNIZE THE RISK FACTORS FOR PREGNANCY AND CHILD SURVIVAL D. STD TREATMENT AND CONTROL WILL REDUCE THE SPREAD OF HIV E. CONTRACEPTION WILL BE AVAILABLE TO ALL WHO SEEK SERVICES

3M(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to the eligibility of countries to receive the following categories of assistance: (A) both Development Assistance and Economic Support Funds; (B) Development Assistance funds only; or (C) Economic Support Funds only.

A. COUNTRY ELIGIBILITY CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND ASSISTANCE

1. Narcotics

a. Negative certification (FY 1991 Appropriations Act Sec. 559(b)): Has the President certified to the Congress that the government of the recipient country is failing to take adequate measures to prevent narcotic drugs or other controlled substances which are cultivated, produced or processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country, to United States Government personnel or their dependents or from entering the United States unlawfully?

No

b. Positive certification (FAA Sec. 481(h)). (This provision applies to assistance of any kind provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance from the Child Survival Fund or relating to international narcotics education and awareness, or the provision of food or medicine.) If the recipient is a "major illicit drug producing country" (defined as a country producing during a fiscal year at least five metric tons of opium or 500 metric tons of coca or marijuana) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

Malawi is not a "major illicit drug producing country" or a "major drug-transit country".

(1) does the country have in place a bilateral narcotics agreement with the United States, or a multilateral narcotics agreement?

N/A

(2) has the President in the March 1 International Narcotics Control Strategy Report (INSR) determined and certified to the Congress (without Congressional enactment, within 45 days of continous session, of a resolution disapproving such a certification), or has the President determined and certified to the Congress on any other date (with enactment by Congress of a resolution approving such certification), that (a) during the previous year the

N/A

or taken adequate steps on its own to satisfy the goals agreed to in a bilateral narcotics agreement with the United States or in a multilateral agreement, to prevent illicit drugs produced or precessed in or transported through such country from being transported into the United States, to prevent and punish drug profit laundering in the country, and to prevent and punish bribery and other forms of public corruption which facilitate production or shipment of illicit drugs or discourage prosecution of such acts, or that (b) the vital national interests of the United States require the provision of such assistance?

c. Government Policy (1986 Anti-Drug Abuse Act of 1986 Sec. 2013(b). (This section applies to the same categories of assistance subject to the restrictions in FAA Sec 481(h), above.) If recipient country is a "major illicit drug producing country" or "major drug-transit country" (as defined for the purpose of FAA Sec 481(h), has the President submitted a report to Congress listing such country as one: (a) which, as a matter of government policy, encourages or facilitates the production or distribution of illicit drugs; (b) in which any senior official of the government engages in, encourages, or facilitates the production or distribution of illegal drugs; (c) in which any member of a U.S Government agency has suffered or been threatened with violence inflicited by or with the complicity of any government officer; or (d) which fails to provide reasonable cooperation to lawful activities of U.S. drug enforcement agents, unless the president has provided the required certification to Congress pertaining to U.S. national interests and the drug control and criminal prosecution efforts of that country? N/A

2. Indebtedness to U.S. citizens (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

a. No
b. No
c. No

3. Seizure of U.S. Property (FAA Sec. 620(e)(1): If assistance is to a government, has it (including any government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? No

4. Communist countries (FAA Secs. 620(a), 620(a), 620(f), 620D, FY 1991 Appropriations Act Secs. 512, 545): Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided either directly or indirectly to Angola, Cambodia, Cuba, Iraq, Libya, Vietnam, Iran or Syria? Will assistance be provided Afghanistan through the Soviet-controlled government of Afghanistan?	Malawi is not a communist country,
5. Mob Action (FAA Sec. 620(j)): Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property?	No
6. OPIC Investment Guaranty (FAA Sec. 620(1)): Has the country failed to enter into an investment guaranty agreement with OPIC?	No
7. Seizure of U.S. Fishing Vessels (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec 5): (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?	No
8. Loan Default (FAA Sec. 620(q); FY 1991 Appropriations Act Sec 518 (Brooke Amendment) (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the counter under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1990 Appropriations Act appropriates funds?	a. No b. No
9. Military Equipment (FAA Sec. 620(s)): If contemplated assistance is development loan or to come from Economic Support Fund, has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual	N/A

"Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

10. Diplomatic Relations with U.S. (FAA Sec. 620(t)): Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

No

11. U.N. Obligations (FAA Sec. 620(u)): What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget? (Reference may be made to the "Taking Into Consideration" memo.)

As of May 26, 1992 Malawi was not in arrears.

12. International Terrorism

a. Sanctuary and support (FY 1991 Appropriations Act Sec. 556; FAA Sec. 620A): Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of internation terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons?

a. No

b. No

b. Airport Security (ISDCA of 1985 Sec. 552(b). Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures?

No

13. Discrimination (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

No

14. Nuclear Technology (FAA Secs. 669, 670): Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology,

without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan.)	No No No
15. Algiers Meeting (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegation of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 26, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.)	Malawi was not represented at the meeting.
16. Military Coup (FY 1991 Appropriations Act Sec. 513): Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been determinated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance?	No
17. Refugee Cooperation (FY 1991 Appropriations Act Sec. 539): Does the recipient country fully cooperate with the international refugee assistance organizations, the United States, and other governments in facilitating lasting solutions to refugee situations, including resettlement without respect to race, sex, religion, or national origin?	Yes
18. Exploitation of Children (FY 1991 Appropriation Act Sec. 599D, amending FAA Sec. 116): Does the recipient government fail to take appropriate and adequate measures, within its means, to protect children from exploitation, abuse or forced conscription into military or paramilitary services?	No
B. COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")	
1. Human Rights Violations (FAA Sec. 116): Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?	No

2. Abortions (FY 1991 Appropriations Act Sec. 535): Has the President certified that use of DA funds by this country would violate any of the prohibitions against use of funds to pay for the performance of abortions as a method of family planning, to motivate or coerce any person to practice abortions, to pay for the performance of involuntary sterilization as a method of family planning, to coerce or provide any financial incentive to any person to undergo sterilizations, to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?

No

1704C

3M(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds. (Part C is not applicable for this project and has not been included).

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE? Yes

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. Host Country Development Efforts (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

(a), (b): The project may indirectly encourage international trade of contraceptives as their acceptance and use increases. Additionally, the assistance is designed to emphasize delivery of health services through the private sector by initiating and expanding services provided by NGOs/PVOs, private companies, estates, and medical practitioners.
(c), (d), (e), (f) - N/A.

2. U.S. Private Trade and Investment (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

Technical assistance will be contracted from U.S. sources, including private organizations and universities. Furthermore, all contraceptives procured under this project will be procured in America.

3. Congressional Notification

a. General requirement (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)?

CN cleared

b. Notice of new account obligation (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. Cash transfers and nonproject sector assistance (FY 1991 Appropriations Act Sec. 575(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted? — N/A

4. Engineering and Financial Plans (FAA Sec. 611(a)): Prior to an obligation in excess of $500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance? — Yes

5. Legislative Action (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of $500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance? — N/A

6. Water Resources (FAA Sec(b); FY 1991 Appropriation Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.) (See AID Handbook 3 for guidelines.) — N/A

7. Cash Transfer and Sector Assistance (FY 1991 Appropriations Act Sec. 575(b): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds unless such requirements are waived by Congressional notice for nonproject sector assistance)? — N/A

8. Capital Assistance (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? — N/A

9. Multiple Country Objectives (FAA Sec. 601(a): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. — See A.1 above.

10. U.S. Private Trade (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

See A. 2 above.

11. Local Currencies

a. Recipient Contributions (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

No project related foreign currencies are owned by the U.S. in Malawi. The host country will contribute at least 25% to the overall project costs.

b. U.S.-Owned Currency (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No

c. Separate Account (FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

N/A

(1) Has AID (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of AID and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has AID taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

12. Trade Restrictions

a. Surplus Commodities (FY 1991 Appropriations Act Sec. 521(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? — N/A

b. Textiles (Lautenberg Amendment) (FY 1991 Appropriations Act Sec. 521(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel? — N/A

13. Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3)): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas? — N/A

14. PVO Assistance

a. Auditing and registration (FY 1991 Appropriations Act Sec. 537): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of AID, and is the PVO registered with AID? — Possible participating PVOs have not been selected, but this requirement will be met when selection takes place.

b. Funding sources (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? — See 14.a. above.

15. Project Agreement Documentation (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and AID LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appending 6G for agreements covered by this provision). — This action will be taken subsequent to the signing of the agreement.

16. Metric System (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through AID policy): Does the assistance of activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will AID specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?	Yes
17. Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?	Yes
18. Regional and Multilateral Assistance (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.	Assistance being provided is complementary to assistance of the World Bank, the U.N., ODA and other bilateral donors involved in AIDS or child spacing activities. The project is suitable for implementation by A.I.D. due to our presence in the country and our experience with project components. Assistance will encourage sharing of information and experiences within the Region.
19. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):	
a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?	No
b. Will any funds be used to lobby for abortion?	No
20. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?	No
21. U.S.-Owned Foreign Currencies	
a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.	N/A

fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

h. **U.S. air carriers** (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U. S. carriers be used to the extent such service is available? — Yes

i. **Termination for convenience of U.S. Government** (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? — Yes

j. **Consulting services** (FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)? — Yes

k. **Metric conversion** (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through AID policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will AID specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage? — Yes. See 16 above.

1. **Competitive Selection Procedures** (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? — Yes

b. Release of currencies (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	No
22 Procurement	
a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?	The institutional contractor will provide technical assistance and commodity procurement services. Firms/Institutions/or Consortiums bidding through full and open competition for this contract are encouraged to use Grey Amendment entities to the maximum extent possible.
b. U.S. procurement (FAA Sec. 604(a)): Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him?	DFA procurement regulations will be followed.
c. Marine insurance (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?	N/A
d. Non-U.S. agricultural procurement (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)	N/A
e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exceptions for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction of engineering services financed from assistance programs of these countries.)	N/A
f. Cargo preference shipping (FAA Sec. 603)): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, d y cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?	DFA procurement regulations will be followed.
g. Technical assistance (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the	Yes, but FMI/AIDSCAP will operate under a cooperative agreement while the institutional Contractor will operate under a competitively awarded contract.

23. Construction

a. Capital project (FAA Sec. 611(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A

b. Construction contract (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A

c. Large projects, Congressional approval (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? N/A

24. U.S. Audit Rights (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A

25. Communist Assistance (FAA Sec. 620(h)): Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes

26. Narcotics

a. Cash reibursements (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes

b. Assistance to narcotics traffickers (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance? Yes

27. Expropriation and Land Reform (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes

28. Police and Prisons (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes

29. CIA Activities (FAA Sec. 662): Will assistance preclude use of financing for CIA activities?	Yes
30. Motor Vehicles (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?	DFA procurement regulations will be followed.
31. Military Personnel (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel?	Yes
32. Payment of U.N. Assessments (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or due?	Yes
33. Multilateral Organization Lending (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer to FAA funds to multilateral organizations for lending)?	Yes
34. Export of Nuclear Resources (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology?	Yes
35. Repression of Population (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?	Yes
36. Publicity or Propaganda (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before congress, to influence in any way the outcome of a political election in the U.S., or for any publicity or propaganda purposes not authorized by Congress?	No
37. Marine Insurance (FY 1991 Appropriations Act Sec. 563): Will any AID contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate?	Yes
38. Exchange for Prohibited Act (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?	No

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. Agricultural Exports (Bumpers Amendment) FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

N/A

2. Tied Aid Credits (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

No

3. Appropriate Technology (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

N/A

4. Indigenous Needs and Resources (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

Assistance recognizes the needs of Malawians to deal effectively with the AIDS epidemic and the rapidly growing population. Key elements of the project are aimed at improving the capacities of Malawian health service providers. In addition, two national leadership organizations will be strengthened to lead the policy dialogue on AIDS and child spacing.

5. Economic Development (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Malawians in general and women in particular will become healthier and more productive members of society as HIV/AIDS/STD transmission is reduced and fertility rates lowered.

6. Special Development Emphases (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

N/A

7. Recipient Country Contribution (FAA Sec. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	Yes
8. Benefit to Poor Majority (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?	Yes. Increased AIDS and child spacing services will be extended to the poor majority in Malawi.
9. Abortions (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):	
a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions?	No
b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations?	No
c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?	No
d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services?	Yes
e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning?	No
f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning?	No
g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization?	No

10. Contract Awards (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	Yes. See 22.g. above
11. Disadvantaged Enterprises (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic American, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?	Yes. See 22.a. above.
12. Biological Diversity (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?	N/A
13. Tropical Forests (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g):	
a. AID Regulation 16: Does the assistance comply with the environmental procedures set forth in AID Regulation 16?	Yes
b. Conservation: Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded: (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally	N/A

sound practices for timer harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. Forest degradation: Will assistance be used for (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest land, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development? N/A

d. Sustainable forestry: If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry? N/A

e. Environmental impact statements: Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable AID regulations requiring an environmental impact statement for activities significantly affecting the environment?	On June 18, 1992, this project was granted a categorical exclusion from the requirement of an IEE based on the project goal and purpose.
14. Energy (FY 1991 Appropriations Act Sec. 533(c)): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?	N/A
15. Sub-Saharan Africa Assistance (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)): If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) to be provided in a manner that takes into account, during the planning process, the local-level perspectives of the rural and urban poor, including women, through close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (d) to be implemented in a manner that requires local people, including women, to be closely consulted and involved, if the assistance has a local focus; (e) being used primarily to promote reform of critical sectoral economic policies, or to support the critical sector priorities of agricultural production and support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities; and (f) to be provided in a manner that, if policy reforms are to be effected, contains provisions to protect vulnerable groups and the environment from possible negative consequences of the reforms?	(a). Community agents will deliver increased AIDS and child spacing services to the poor majority in Malawi. (b). The assistance is designed to emphasize delivery of health services through the private sector by initiating and expanding services provided by NGOs/PVOs, private companies, estates, and medical practioners. (c)(d). Through the subgrant program, assistance is designed to support grassroots or community level input at the planning, execution, and evaluation stages of project activities. Women's networks and associations will be supported, and it is expected that women will represent 50% (or more) of project participants. (e). Assistance is supporting the critical sector priorities of health and voluntary family planning services. (f). N/A.
16. Debt-for-Nature Exchange (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resources management, (e) local conservation programs, (f) conservation training programs (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.	N/A

17. Deobligation/Reobligation (FY 1991 Appropriations Act Sec. 515): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committee been properly notified?	N/A
18. Loans	
a. Repayment capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.	N/A
b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?	N/A
c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?	N/A
d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?	N/A
19. Development Objectives (FAA Secs. 102(a), 11, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?	(1), (2), (3), - N/A. (4) Women's status will be improved as their access to and utilization of health services increase. (5) Regional cooperation will be encouraged.

20. Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):	
a. Rural poor and small farmers: If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.	N/A
b. Nutrition: Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people	N/A
c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.	N/A
21. Population and Health (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition, and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.	Assistance is aimed at extending child spacing and AIDS related services to communities through community-based distribution programs. In addition, the safe motherhood initiative is concerned with making birthing safer for both mothers and infants.
22. Education and Human Resources Development (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.	(a) N/A (b) Ten Malawians will be provided U.S. university training leading to graduate degrees in population and AIDS related disciplines.

23. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is: N/A

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy source, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

b. concerned with technical cooperation and development especially with U.S. private and voluntary, or regional and international development, organizations;

c. research into, and evaluation of, economic development process and techniques;

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

INITIAL ENVIRONMENTAL EXAMINATION

I. PROJECT DATA

Project Location :Malawi

Project Title :Support To AIDS And Family Health (STAFH) Project, 612-0238

Funding :$US 45 million

Life of Project :8 Years

IEE Prepared By :Robert O. Rose
REDSO/ESA Environmental Officer

Environmental Action:Categorical Exclusion

Concurrence : Carol Peasley
Carol Peasley , Director
USAID/Lilongwe

Date : 6/11/92

Concurred by : John Saydet
John Saydet, AFR Bureau Environmental Officer

Clearance : GC/AFR MAK Date: 6/18/92

Clearances:

Chris McDermott, USAID/Lilongwe/HPN : CM 6/9/92
Thomas Lofgren, USAID/Lilongwe/PDO : 6/8/92
Cliff Brown, USAID/REDSO/RLA Date :
Paul Andrew DeBarros, REDSO/REA Date: May 28, 1992

II. PROJECT GOAL AND PURPOSE

The goal of this project is to decrease sexually transmitted HIV and to lower the fertility rate. The project purpose is to increase the use of condoms, safe sexual practices, STD treatment services and modern methods of contraception.

III. PROJECT PROBLEM

By the year 2000:

- The loss of potential income due to the 400,000 projected cumulative AIDS deaths may amount to 14-21% of Malawi's GDP.
- This could reduce the projected annual growth rate from 2.9% (without AIDS) to 2.0-2.3%.
- An estimated 300,000 children will be orphaned as a result of AIDS.
- The direct costs of managing AIDS cases could consume one-third of the Ministry of Health's recurrent curative budget.

Since independence in 1964, the population of Malawi has more than doubled from 4 to 9 million. Should present growth rates, in the range of 3.2% continue by the year 2000, it will become increasingly difficult for the economy to provide adequate jobs, education, food, and health.

The ecological consequences of the projected population explosion, given that the majority of Malawians are farmers and only 22% of the land is arable, would imply that as farms are subdivided and begin reaching their minimum viable economic size, more and more people will begin moving onto and degrading marginal areas, including but not limited to steeped sloped areas, forest reserves, game reserves and parks.

Malawi has begun to undertake policy reforms and other innovative steps to gain control over both the AIDS epidemic and the population growth rate. However, major constraints to further progress remain:

- Annual per capita health investments amount to the equivalent of only $U.S. 3.00,
- The number of health workers per capita is one of the lowest in Africa,
- Only 230 of the nation's 730 health facilities are able to offer child spacing services.
- Even fewer health facilities are capable of offering AIDS prevention services.

IV. PROJECT OUTLINE AND STRATEGY

The overall project strategy is to decrease sexually-transmitted HIV and to the lower fertility rate by increasing the level of financial, technical and commodity resources available to initiate and expand programs designed to increase the use of condoms, safe sexual practices, STD treatment services and modern methods of contraception.

The two key indicators of goal/strategy attainment are:

- A reduction in HIV prevalence among urban pregnant women 15-24 years of age, from 25% in 1992 to 17% in 2000,

- A reduction in the total fertility rate from 7.6 in 1992 to 6.0 in 2000

Key indicators which will be monitored by the Ministry of Health which will indicate whether the Project Purpose had been attained include:

- An increase in the percentage of males age 15-24 using condoms from 1-2% in 1992 to 15-20 % in 2000,

- A decrease in the percentage of urban and semi-urban pregnant women with positive syphilis serology from 8-14% in 1992 to 4-7% in 2000,

- A decrease in the number of non-regular sexual partners by 50% between 1992 and 2000,

- An increase in the contraceptive prevalence rate among married women of reproductive age from 5% in 1992 to 10-17% in 2000,

- A decrease in the percent of births to women: a) less than 18 years of age from 33% in 1992 to 25% in 2000, b) with more than 6 children, and c) with less than 36 months between births.

The above strategy will be achieved through the following activities/interventions, primarily various educational and training and mass media programs:

Activity 1. Services For Youths

- AIDS Education,

- National Mass Media Program through Malawi Broadcasting Corporation,

- Youth Center programs to reach out-of-school youth.

Activity 2. Employed Males

▸Worksite "Aids In-The-Workplace" Educational and Counselling Programs, and improved STD services in company clinics,

▸Community Based Outreach Programs using community leaders from churches, local government and the private sector.

Activity 3. Male STD Clients

▸Upgrading STD Clinical Services, especially training of trainers in order to provide improved STD services at central and district offices,

▸Community OutReach And Social Mobilization, training STD patients as peer educators,

▸Social Marketing Of STD Services, possibly through a private sector NGO.

Activity 4. Bargirls/Freelancers And Bar Owners

▸Peer Education Program,

▸Improving District Health Inspector Program For STD Management,

▸Support For Condom Use By Bar Managers,

▸Community Outreach Of Freelancers.

Activity 5. Secondary Target Groups

▸HIV Intervention Education To **Unmarried Women 18 Years Of Age And Older,**

▸Provide STD/HIV prevention education and counseling to enable **Female STD Clients** to more quickly recognize symptoms, seek treatment and change behavior to reduce risk of further STD/HIV infection,

▸Support activities reaching out to **Middle-Aged Men.**

Activity 6. Child Spacing

▸Add Minilaparotomy/local anesthesia service (ML/LA) to 25 MOH Hospitals , and add vasectomy services at 3-4 hospitals by the year 2000. Train approximately 100 surgeons/clinical officers and 500 other service personnel in counseling and referral for ML/LA. Norplant training will be provided for 40 surgeons/clinical officers, 80 counselors and 50 IEC workers. Up to 7 surgeons, 14 counsellors and 14 IEC workers will be trained for the delivery of vasectomy services,

▸Ten Christian Hospital Association Of Malawi (CHAM) Hospitals to provide ML/LA services by 1995. Support the addition of Norplant services at all 10 CHAM hospitals. Support the training of 20 surgeons, 40 counsellors, and 34 IEC workers for Norplant and up to 8 surgeons, 14 counsellors and 14 IEC workers for vasectomy services,

▸Support the establishment of core service capabilities at all 272 tier two MOH facilities (rural hospitals, clinics, health centers, dispensaries and maternities) by the year 2000,

▸Upgrade core services at the ten of the Ministry of Local Government (MOLG) health facilities currently providing child spacing services. Consider adding core service delivery capabilities to the other 84 MOLG facilities depending on the outcome of an assessment,

▸Support an analysis of the potential for the 98 facilities managed by parastatals, NGO's and ministries to provide core child spacing programs, assisting up to 50% of the sites to add core child spacing services,

▸Support the incorporation or upgrading of core service capability at 80 CHAM clinics where religious tenets do not prohibit modern contraceptive methods,

▸Support the incorporation of child spacing services to 55 of the 102 private sector health clinics (currently 7 offer such services),

▸Support incorporation of child spacing services into 30 of the 65 private practitioners (currently 4 offer such services),

▸Train 1050 MOH staff and 570 service providers in core child spacing (4-week program).

Activity 7. Community Based Services (CBD)

▸Training of Health Surveillance Assistants (HSA's), and Traditional Birth Attendants (TBA's) in child spacing and integration of child spacing with HIV/STD information and training,

▸Train 600 CHAM agents and 60 supervisors (traditional birth attendants, and primary and community health workers in child spacing.

Activity 8. Contraceptive Social Marketing (CSM)

Support the Malawi Health Social Marketing Project (MHSMP) and private sector companies to expand CSM services. By the year 2000 it is estimated that 2-2.8 million condoms will be sold annually.

Activity 9. Capacity Building, MOH AIDS Secretariat and the National Family Welfare Council.

- Support assessments of the above organizations to ensure congruence between organizational design and evolving functions,
- To assure that selected AIDS Sec functions are decentralized and others integrated into MOH units,
- To assure the optimum allocation of child spacing responsibilities between organizations,
- And to anticipate future organizational and staffing requirements.

V. ENVIRONMENTAL ACTION RECOMMENDED

It is believed that the integration of AIDS and Family Planning will on one hand control the spread of this deadly disease while at the same begin addressing one of the biggest constraints to sustainable agricultural and natural resource management in Africa, its population explosion. If successfully implemented, this project should result in an improved quality of life for Malawi's inhabitants, increase the likelihood of developing a viable economy and help natural resource managers in their efforts to decrease pressures on and to sustainably manage Malawi's wildlands.

Based upon 22 CFR Part 216.2 (c) (2) (i) a **Categorical Exclusion** is recommended for all training components of this project. Based upon 22 CFR 216.2 (c) (2) (viii) a **Categorical Exclusion** is recommended for all remaining components of the health care family planning services in this project.

PLAN FOR THE CONSOLIDATION OF THE HPN PORTFOLIO

A. SEATS: Phase-out upon termination of central support for sub-grants to Malamulo/AHS (7/1/94), Ekwendeni (2/1/94), and NFWC (5/1/94). Phase -in bilateral support for technical assistance and local cost support through institutional contractor sub-grants.

B. Futures Group/SOMARC: Phase-out upon termination of central support in 1993. Phase-in bilateral support for technical assistance, commodities (annual OYB transfer), and local support through institutional contractor sub-grants.

C. JSI/FPLM: Shift centrally-funded periodic technical assistance to institutional contractor.

D. HOPE AIDS: Use bilateral project to provide bridge funding in FY 93 OYB to extend grant to meet current estate sector requests for help with AIDS and child spacing activities, then phase-out HOPE in 1994 and use institutional contractor to support estate sector.

E. AIDSCOM: Terminates in November 1992. Bridge funding for priority pre-implementation assessment and survey work via FY 1992 mission buy-in to AIDSCAP. Technical assistance and IEC needs to be addressed by STAFH/AIDSCAP. STAFH support for recurrent costs of AIDS education in the schools via annual PIL.

F. AIDSTECH: Terminates in September 1992. Bridge funding for priority pre-implementation assessment and survey work via FY 1992 mission buy-in to AIDSCAP. Technical assistance and IEC needs to be addressed by STAFH/AIDSCAP. STAFH support for recurrent costs of MOH AIDS surveillance and monitoring.

Three projects on which mission will continue to rely for technical assistance funded bilaterally through STAFH buy-ins:

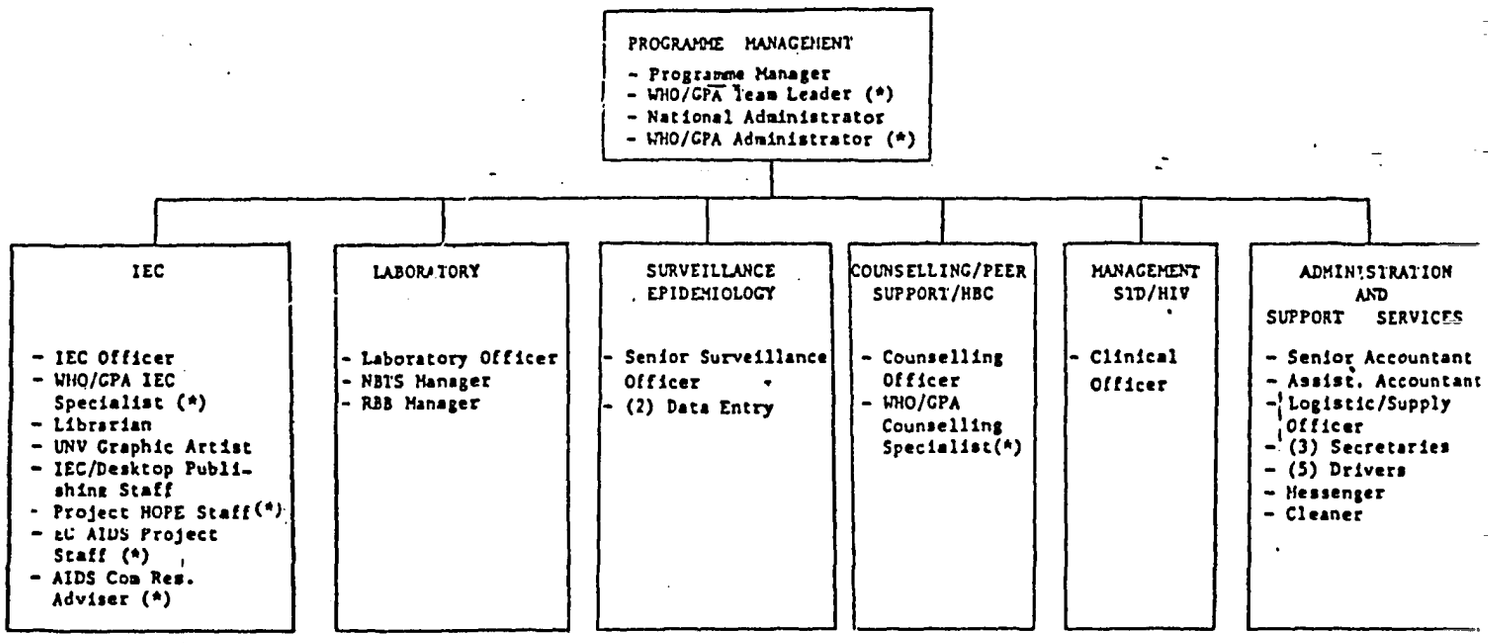
A. AVSC: Continue bilateral buy-ins but shift to STAFH upon termination of current PHICS-funded AVSC MOH project in 1993/94.

B. RAPID: Continue technical assistance but shift from central to bilateral buy-in in 1993.

C. DHS: For a DHS in 1994/95 and 1997/98.

1677D

STRUCTURE OF NATIONAL AIDS CONTROL PROGRAMME



(*) - International Staff

NATIONAL FAMILY WELFARE COUNCIL OF MALAWI

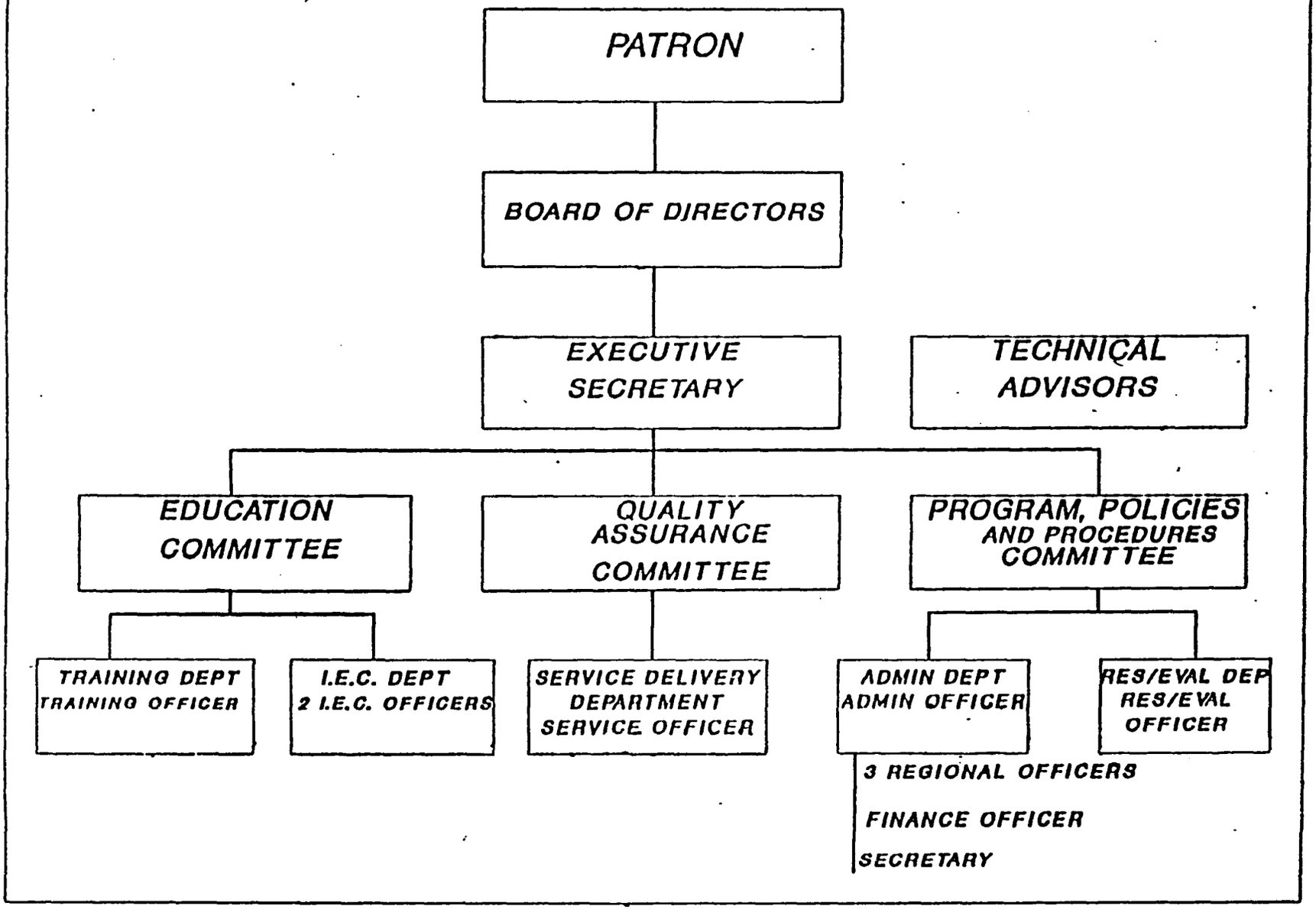


TABLE 4

STAFH PROJECT - PROGRAM BUDGET
YEAR 1, YEAR 2, YEARS 3-6 ($000)

AIDS PREVENTION BUDGET

	LOP	YR 1	YR 2	YR 3-YR 6	
PERSONNEL (Technical Assistance)					
LILONGWE OFFICE					
Resident Expatriate					
Chief of Party	1,200	200	200	800	budget thru LOP
STD Specialist	0	0	0	0	2+ yrs resident/core funded at $400,000
National Staff					
Communication Specialist	53	8	9	36	(P4 $8,500 S&H/yr)
Research Assistant (2)	60	10	10	40	(PO-$5,000 S&H/yr)
Accountant	36	6	6	24	(P8 $6,000 S&H/yr)
Administrative Assistant	24	4	4	16	(CEO/PO Grade-$4,000 S&H/yr)
Secretary (2)	48	8	8	32	(D1 $4,000 S&H/yr)
Driver (3)	36	6	6	24	(3 pers-$2,000 S&H/yr)
AIDS SEC OFFICE					
National Staff					
Training Officer	36	6	6	24	(P8-$5,500 S&H/yr)
STD Clinical Officer	55	5	10	40	(P4-$10,000 S&H/yr)
MOH REGIONAL & DISTRICT					
National Staff					
Regional Communication/Trg Officer (3)	108	18	18	72	(P8-$6,000 S&H/yr 3 pers)
District Community Officer (3)	90	15	15	60	(CEO/PO-$5,000 S&H/yr 3pers)
BLANTYRE OFFICE					
Resident Expatriate					
AIDS Unit Manager	1,040	200	200	640	budget thru LOP

National Staff

Administrative Assistant/Sec.	24	4	4	16	(CEO/PO Grade: $4,000 S&H/yr)
Research Assistant	30	5	5	20	(PO-$5,000 S&H/yr)
Driver	12	2	2	8	($2,000 S&H/yr)

TECH ASST: Short term (STAFH plus AIDSCAP core-funds)

Condom logistics (6 months LOP)	100	-	-	100	Core-funded @ $25,000/Mo.
STD (6 months LOP)	-	-	-	-	"
Communication (12 months LOP)	100	-	-	100	"
Policy development (6 mo LOP)	-	-	-	-	"
Monitor & Eval (6 months LOP)	-	-	-	-	"
From Core-Short Term TA	-	-	-	-	$925,000 - Core Budget

OPERATING COSTS

Reg & District Offices

Operating costs for RCOs	30	5	5	20	budget till LOP
Reg costs/implementation	40	5	7	28	"
Operating costs for DCOs	40	5	7	28	"

AIDSCAP Project Office

Lilongwe Office:					
Rent/utilities	68	8	12	48	budget thru '96
Local transport: fuel	39	4	7	28	"
Local transport: maintenance	27	3	4	20	"
Local transport: insurance	14	2	2	10	"
Other recurrent office costs	30	5	5	20	"
Blantyre Office:*					
Rent/utilities/renovation	46	6	8	32	"
Local transport: fuel	18	3	3	12	"
Local transport: maintenance & insurance	28	3	5	20	"
Supplies	25	5	4	16	"

* Funds to be used preferentially for renovating office space in RHO offices to accommodate AIDSCAP staff; if not feasible, then for separate office rental.

Other recurrent office costs	24	4	4	16	budget thru '96
International travel: staff	25	5	5	15	"
Internat'l travel:Invitational	40	8	8	24	"
Equipment (See Annex P)					
Personnel/Office Totals	3,546	568	589	2,389	

TARGET GROUP PROGRAMS

YOUTH: AIDS curriculum

Production: teachers guides	8	2	2	4	2000 per year @$1/book x 4 yr
Train'g: TOT workshops	48	8	8	32	2/reg/year @ $4000*2yrs
Train'g: Teacher workshops	100	0	25	75	Mackie "Notes for AIDSCAP"
Travel/PD: monitoring visits	30	5	5	20	
Textbook reprinting	50	10	10	30	10,000 bks/yr (10% of tot bks)
Revisn/Prod: modified curric	150	0	30	120	Mackie "Notes for AIDSCAP"
Revisn/Prod: facilitators guides	50	5	15	30	Estimated from Mackie
Train'g: Trainer workshops	12		4	8	1/reg/yr*3yrs
Train'g: "Teacher" workshops	48		24	24	6/yr @$4000*2yrs
Travel/PD: Trainers	40		20	20	
Travel/PD: monitoring visits	12		3	9	$3000/year 4 years

YOUTH: National mass/little media

Formative research	50		20	30	
Radio soap op: script/pretest/prod	33	3	6	24	1 15 part series/year*8 years
Radio soap op: placement	18	3	3	12	$3000/year*6
Monitoring research	20	4	4	12	Four years
Radio talk shows: res/prep/prod	12	2	2	8	Six years
Radio talk shows: placement	15	0	3	12	Five years
Audio casette duplication	10	2	2	6	Six years
Companion little media: prod	145	15	50	80	2 posters/1 comicbk/hndouts/etc
Video productions	95	20	25	50	

YOUTH: Youth Centers					
Condom study: baseline/followup	20	10	0	10	
Formative research	40	10	10	20	
Youth IEC mat: pretest/prod	100	20	20	60	
Community organizing meetings	15	0	3	12	$250/meeting * 10/year for 5 yr
Train'g: Community volunteers	58	8	10	40	1(15p) wrkshp/reg*5years
Minor renovations/incidental expen	20	0	10	10	
NGO subgrants (2)	200	0	100	100	$100,000/avg * 2
Radios/casette players	8	0	4	4	300*$35
TOT: MOH/CHAM refer'l workshops	54	0	18	36	6 teams*4 pers@2 rnds/yr for 3 yr
Train'g: MOH/CHAM health staff	120	0	40	80	10 (15p)workshops/team * 3 years
Radios/casette players	12	0	4	8	300 * $35
				0	
SUBTOTAL: Youth	1,593	127	480	986	
EMPLOYED MALES					
Males: worksites					
Outreach & orientation	40	10	15	15	3 per year for 2 years
IEC mat: pretest/prod	105	15	30	60	10 posters, broch/decals @ 30k/run
Model trainers guides	25	5	5	15	
Subgrants: urban & agr (2)	100	0	50	50	2 @ $50,000 ea
Males: Partner services @ worksites					
Cost-effectiveness studies	0	0	0	0	core-funded $100,000
Train'g: counseling workshops	56	0	28	28	7 (15p)wkshps+ 1 round follow-up
Counseling guides	30	0	10	20	pre-test production
IEC materials: partners	30	0	10	20	2 posters/handouts/stickers
Males: Community initiatives					
NGO sub-grants (2)	100	0	50	50	2 @ $50,000 ea
Formative/baseline/followup resrch	50	10	20	20	
Male-to-male IEC mat: pretest/prod	70	10	30	30	4 posters/1 video/handouts
Train'g: community leaders	112	0	28	84	6 (30p) wkshps*4 yrs

Facilitators guides	18	0	6	12	180 Ldrs*4 wkshps*$25/bk
Community center support	20	0	5	15	
SUBTOTAL: Employed Males	756	50	287	419	
MALE STD CLIENTS					
Male/STD: Upgrading STD services					
Train'g: TOT trainers workshop	10	2	2	6	3 teams@3pers*4dys*5yrs
Train'g: Reg/Dist health providers	120	24	48	48	(180DHIs)=3(15p)wkshps/team+3 flups ea
Training guides for DHIs	5	0	5	0	200@$25/DHI
Train'g: parahealth providers	48	0	24	24	(100 paras)=6(15p)wkshps + 12 [illegible]
Waiting room IEC equipment	18	6	6	6	
Male/STD: Community outreach					
Train'g: peer leader outreach	24		6	18	200 peers*20*6 workshops
Workshop costs	10		2	8	
Peer ed field costs	25		5	20	
IEC Mat reproduction	20		10	10	
Social marketing of STD services					
Train'g: NGO staff	20		10	10	
Set-up local costs	175		75	100	
NGO-sub grant (1)	50		50		
SUBTOTAL STD Males	525	32	243	250	
BARGIRLS/BAR OWNERS/FREELANCERS					
Bargirls: Peer education					
Form/baseline/followup research	45	15	15	15	
Prototype materials: pretest/prod	100	10	30	60	10 post/2videos/little media
Subgrant: Peer education by PVO	150	0	50	100	$400,000 from core funds
Train'g: alterntve skills bargirls	40			40	private sector

DHI program upgrading					
Incidental DHI Bargirl prgrm costs	30	5	5	20	
STD protocol guidelines	32		8	24	Handouts/little media
OR study: spermicides	20		20	0	
OR study: mass treatment	30		30	0	
Other studies	25			25	see annual wkplans
Bar managers education					
Train'g: Bar managers	8		2	6	20 owners*$25*5 1day ses/yr for 4 yr
Incidental Workshop costs	5		1	4	
Incidental field costs	15		3	12	
Condom only bar mat: pretest/prod	30		10	20	
Freelancers					
Train'g: Peer educators	60		30	30	(100CSWs)6(15p)wksp+2 f/up *2yrs
Incidental Workshop costs	20		10	10	
Peer ed field costs	9		3	6	
IEC Mat reproduction	15		5	10	Handouts/bags/etc
SUBTOTAL Bargirls/owners	634	30	222	382	
PROCUREMENT (THROUGH A PSA)					
Commodities see Annex P	1,787	475	350	962	
CAPACITY BUILDING					
Train'g: communication skills	90		30	60	workshops, materials
Train'g:skills upgrading condom log	40		10	30	
Train'g: STD system upgrading	60		20	40	
Behavioral Research grants (CORE)	0	0	0	0	$500,000 from core funds

POLICY DEVELOPMENT

Invitational travel for polcymkrs	30	5	5	20	
Public relations	18	3	3	12	
Modeling updates	45	0	15	30	
Policy analyses/assessments	15	0	5	10	$90,000 from CORE funds
SUBTOTAL Capacity & Policy	298	8	88	202	
AIDS/HIV/STD PROGRAM SUBTOTAL	9,139	1,290	2,259	5,590	
Less subgrants minus mgmt fee*	(722)	(181)	(271)	(271)	$800,000 for sg's less $78,000 mgmt fee
Less commodity procurement (PSA)	(1,787)	(475)	(350)	(962)	
SUBTOTAL TO WHICH G&A IS ADDED	6,630	634	1,638	4,357	
G&A (34.7%)	2,300	220	568	1,512	
TOTAL AIDSCAP ADD-ON	11,439	1,510	2,827	7,102	

* G&A is only charged on the first $25k of subgrants regardless of total cost

NOTE: NO INFLATION FACTORED IN; NO UNALLOCATED FUNDS (CONTINGENCY)

CHILD SPACING ACTIVITY BUDGET

	TOTAL EXPENSE	EXPENSE YEAR 1	EXPENSE YEAR 2	EXPENSE YRS 3 - 6	CALCULATION
I. INSTITUTIONAL CONTRACTOR					
TECH ASSISTANCE TEAM:					
Chief of Party	1,000	0	200	800	5 person/yrs
Community Services Specialist	900	0	180	720	5 person/yrs
Communications/Social Marketing Advisor	900	0	180	720	5 person/yrs
Clinical Services Specialist	600	0	200	400	3 person/yrs
20 person/months ST TA	360	0	100	260	@ $15,000/mo.
LOCAL HIRE POSITIONS:					
Financial Manager*	250	0	50	200	
Logistics/MIS Specialist*	200	0	40	160	
Bookkeeper	30	0	6	24	(P8 $6,000 S&H/yr)
Admin Assistant	20	0	4	16	(CEO/PO Grade - $4,000 S&H/yr)
Secretary (2)	40	0	8	32	(D1 $4,000 S&H/yr)
Driver (3)	30	0	6	24	(3 pers - $2,000 S&H/yr)
* Assume local hire					
MGMT INFO SYSTEMS:					
Computer supplies/data collection	60	20	5	35	ADP supplies, sub-contract, analysis
MIS development	80	0	15	65	5 P/MS @ $20,000 per month
SUB-GRANTS & SUB-CONTRACTS:					
CS (+AIDS) small Sub-grants (16)	2,000	0	500	1,500	16 CS (AIDS) grants @ $125,000 avg
USPVO lg CS grants (3)	2,100	0	700	1,400	3 sub-grants @ $700,000 ea
IE&C Mtls - Child Spacing	250	0	75	175	
CORE CS SERVICES UPGRADE & EXPANSION:					
CHAM: expand core CS 80 new sites	154	18	58	78	19 sites/yr @ $2,000 per site
Private Commercial at 35 sites	70	0	14	56	7 per yr @ $2,000 ea
Private offices at 20 sites	60	0	15	45	5 per year @ $3,000 ea
OPERATING COSTS:					
Fuel & maint (4 vehicles)	109	0	19	90	
Per diem & allowances	225	0	45	180	7 IC staff @ 140/day * 50 days/yr
Local office (rent & util)	108	0	18	90	with FHI/AIDSCAP in LL & Blyre
Overhead & admin	1,270	0	220	1,050	
Int'l travel	66	6	12	48	6 trips @ $6,000 ea over LOP

SOCIAL MARKETING PGM					IC picks up after SOMARC in 94
Advertising/Promotion	285	0	85	200	
Market Research	240	0	90	150	
Packaging/local costs	200	0	50	150	
COMMODITIES (see Annex P)	1,442	0	430	1,012	
SUB-TOTAL	13,049	44	3,325	9,680	

II. COMPREHENSIVE CS SERVICES:

Possible sub-contract from IC for expansion and upgrading of comprehensive CS services at MOH 22 new sites, 3 3 existing; CHAM 2 new sites, 8 existing ('92)

MOH: Minor renovations 22 sites	66	12	12	42	3000/Site * 22 @ 4 per yr
CHAM: Minor upgrades 2 new sites	14	0	7	7	@ $3,500 new site: 2/yr 1st yr
Provide Equip/furniture	96	0	24	72	@ $4,000 new site 6/yr * 4yrs
Do 25,000 ML/LAs - med supplies	150	20	30	100	25,000 @ $12 case x .5 (MOH gives .5)
Norplant 13,550 cases - med supls	136	7	10	119	13,550 @ $10 case - reimbursement
Do 1,100 vasectomies - reimburse	13	1	3	9	1100 cases @ $12/case
Training (MOH & CHAM):					
Surgical/Norplant/Vasect	55	10	15	30	ref AVSC ppl - below thru 96 only
TOT (Basic & in-service)	108	21	29	58	"
Quality Assurance and Management	115	10	35	70	Local CHAM costs, vehicle
SUB-TOTAL COMPREHENSIVE	753	81	165	507	

N.B. Does not include cost of Norplant sets or contingency

III. CORE CS SERVICE EXPANSION

MOH (PILs) expansion of core CS at 178 sites, 40/yr:					
Local costs - for Reg's/districts	356	0	120	236	40 sites/yr @$2,000/site for 4.45 yrs
Project Coord. & Acct (MOH/NFWC)	114	0	30	84	P8($11,728 S&H yr) (CEO/PO$7,600 S&H yr)
Training costs: per diem	210	0	42	168	$25*15p*28 days *4/yr begin 93
Training: travel & transp	100	0	20	80	4 courses/yr
Training: mtls * supplies	50	0	10	40	NOTE: PHICS covers until 94
Workshops & Qual Assurance	50	0	10	40	

MOLG upgrade 40 sites (PIL)	80	0	20	60	10 per year @ $2,000 ea
Other Ministries, NFWC, NGOs, (PIL) upgrade core CS at 50 sites	100	0	20	80	10 per yr @ $2,000 ea
NFWC (PIL) Quality Assurance (Training, Services, IE&C, Supervision)	500	100	100	300	
SUB-TOTAL OF GOM CORE UPGRADES	1,560	100	372	1,088	sub-total core CS

IV. COMMUNITY-BASED DISTRIBUTION CS SERVICES

A. MOH Facilities: CBD Services	PIL to NFWC, TA from the IC				
1. Train 1000 HSAs in CBD	180	0	30	150	5 days @$30/day x 200 yr begin '94
2. Retrain 200 HSA/VHWs in CBD	191	0	18	173	3 days @$30/dy * 200(yr2); 400 (yrs3-6)
3. Train 360 TBAs for 1 week	76	0	19	57	7 dys * $30/dy * 90 yr for 4 yrs
4. TBA retraining of 90 per yr	39	0	0	39	3 dys * $30/dy * 90/yr yrs 3-6
B. Other GOM, Parastatals	PIL to NFWC, TA from the IC				
1. Train 300 CBD agents	48	9	9	30	5 dys * $30/dy *60/yr for 6 yrs
2. Train 30 supervisors	5	1	1	3	5 dys * $30/dy * 6/yr for 6 yrs
3. Retrain 60 ag/supervs /yr	40	0	6	34	3 dys * $30/dy * 60 for 6 yrs
SUB-TOTAL CBD WITH GOM	579	10	83	486	sub-total CBD services

V. OTHER USAID CONTRACTS/GRANTS/BUY-INS:

A. Maternal Health & Research Grants	800	100	250	450	USAID grants to local & US researchers
B. DHS Buy-in	1,000	0	500	500	Repeat DHS in '94/95 & '97/98
C. RAPID IV Buy-in	500	0	150	350	
D. LT trg 10 Grad degrees + ST trg	1,100	60	200	840	4 Doctorates; 6 master's + st trng
E. Personal Services Contractor	720	120	150	450	
F. Audit & Evaluation	350		150	200	
SUB-TOTAL	4,470	280	1,400	2,790	

CS PROGRAM TOTAL * (ACTIVITIES I – V)	20,411	515	5,345	14,551
ADD AIDSCAP BUDGET	11,439	1,510	2,827	7,102
VI. USAID PROCUREMENT OF COMMODITIES For detailed list see Annex P – Commodities List				
USAID Procurement	11,426	2,000	1,500	7,926
Inflation & Contingency	1,724	–	200	1,524
TOTAL BUDGET	*45,000*	*4,025*	*9,872*	*31,102*

* INCLUDES OTHER USAID-PROCURED TA

PRELIMINARY POSITION DESCRIPTIONS

I. AIDSCAP

A. Expatriate Staff

1. **AIDSCAP Chief-of-Party:** The resident advisor/chief of party will have overall management and technical responsibility for the AIDSCAP team. S/he will report to the designated USAID Project Officer and will work closely with USAID, the IC, the AIDS SEC, and other implementing organizations on coordinating AIDSCAP technical, implementation and managerial assistance for AIDS prevention programs in Malawi. This person should have a general AIDS/Health background, strong managerial experience, Master's level education in a relevant field, and prior development experience in Africa. This is a six year position.

2. **STD/HIV Specialist:** A resident STD/HIV expert will be required for the first 18-24 months of the project to assist with the proficient start-up of the GOM's STD prevention and control program. S/he will be responsible for finalizing STD treatment protocols, assessing technical and clinical skill levels of relevant health staff, developing training programs and procedures to strengthen those skills, recommending laboratory and clinic equipment/supply needs, and assisting with the design of sentinel surveillance and STD reporting systems. S/he will be an experienced epidemiologist, preferably at the MD or PhD level, with field experience in Africa or other developing country setting.

3. **AIDS Unit Manager:** The AIDS Unit Manager will have management and technical responsibility for the Blantyre satellite office. S/he will report to the AIDSCAP Chief of Party and will work closely with staff from USAID, the IC, the AIDS SEC, and other implementing organizations. The AIDS Unit Manager will be responsible for identifying community based organizations interested in undertaking CS and AIDS prevention activities, coalescing new groups of interested parties at the community level around the issues of CS and AIDS prevention, and strengthening these groups and organizations to assume a major role in the country's AIDS and CS programs. S/he will have a Masters degree in organizational or community development or other relevant professional/social science degree, shall have experience in management and in working at the community level with PVOs and NGOs.

B. Host Country National/Third Country Expatriate Professional Project Staff

1. Communication Specialist: The communication specialist will be responsible for coordinating and providing technical assistance in the analysis of formative and baseline research and the development of IEC materials and counseling programs for the project. S/he will be counterpart to the IEC and counseling staff at the AIDS SEC and relevant private sector collaborators and will be responsible for organizing and/or arranging for training of counterparts and implementing organization staff. The advisor will be required for the full duration of the project; the candidate will have an MPH, advanced degree in health education, communications, adult education or other relevant degree.

2. Research Assistants: The project will support three entry level positions for university graduates in such areas as behavioral research, operations research, communications, data/statistical analysis, and epidemiology. These individuals will receive on-the-job training to enhance their academic instruction with solid project implementation experience. The interns will be hired for the duration of the project.

C. Host Country National Project Support Staff

1. Accountant: This person will be responsible for managing the on-site AIDSCAP accounts, office, etc. S/he will report to the Resident Advisor and will supervise the support staff.

2. Other Support Staff: Other support staff will include two Administrative Assistants who report to either the Resident Advisor or the AIDS Unit Manager and two secretaries.

D. Project-Funded Contract Positions in the Public and Private Sector

The three professional positions described below will be placed on a contract basis. Malawians living outside of the country and other east Africans will be aggressively recruited to fill these positions in the hope of expanding the professional pool of the country as appropriate.

1. Training Officer (AIDS SEC): This full time position will be added to the AIDS SEC to establish a national training capacity including training planning, training design (for master trainers, peer educators, community organizers, modern

and traditional health care providers), and model training curriculum design. The person will collaborate closely with the Malawi Institute of Education, relevant government ministries and the private sector to develop a cadre of highly skilled trainers at the regional and district levels to ensure quality of training delivery and evaluation of trainings. The training officer will have an advanced degree in adult education or other relevant background and experience in African training settings.

2. **STD Clinical Officer (AIDS SEC):** This full-time position will be added to the AIDS SEC to assist the AIDSCAP STD/HIV Specialist in establishing a GOM STD prevention and control program. S/he will be responsible for institutionalization of STD treatment protocols, continuing assessment of technical and clinical skill levels of relevant health personnel, continuing training programs and procedures to strengthen those skills, recommending needed laboratory and clinic equipment and supplies and maintaining a continuing sentinel surveillance and STD reporting system. S/he will have an advanced degree in the health field or other relevant background and experience.

3. **Regional Communication/Training Officer (3):** One full-time contract, non-established position will be hired for each of the three regions. This person will be responsible for collaborating with the Regional AIDS Coordinator (existing MOH position) to provide oversight of district activities regarding community organization, counseling and training. These individuals will also work to establish a regional and district capacity to adapt model materials and training programs developed at AIDS SEC to local needs and, as appropriate, to decentralize materials design/pretesting/development, training and counseling at the regional and district levels through the use of resident computer hardware and software.

4. **District Community Officer (3):** Individuals will be recruited to work in three model districts to facilitate outreach through community-based organizations by providing technical assistance and support to community groups (e.g., audiotape and materials distribution, equipment maintenance and minor repair, monitoring and supporting community group leaders). These individuals will work closely with the project-funded Regional Communication/Training Officer to expand the reach and intensity of such assistance to public sector and volunteer resources in three districts. Graduates of Chancellor College in humanities or social sciences will be recruited for these full-time, non-established contract posts.

II. INSTITUTIONAL CONTRACTOR (IC)

A. Expatriate Staff

1. Chief of Party/Family Planning Management Advisor: See attached Statement of Work.

2. Community Services Specialist: See attached Statement of Work.

3. Information-Education-Communications (IEC)/Social Marketing Advisor: See attached Statement of Work.

4. Clinical Services Specialist: See attached Statement of Work.

B. Host Country National/Third Country Expatriate Professional Project Staff

1. Financial Manager: See attached Statement of Work.

2. Logistics and Management Information Systems Specialist: See attached Statement of Work.

C. Host Country National Project Support Staff

1. Bookkeeper: This person will be responsible for managing the on-site IC accounts, office, etc. S/he will report to the Resident Advisor and will supervise the support staff.

2. Other Support Staff: Other support staff will include an Administrative Assistant who will report to the Chief of Party, two secretaries and a driver.

III. USAID-FUNDED CONTRACT POSITIONS IN THE PUBLIC SECTOR

1. Project Coordinator (MOH): This full-time position in the MOH Planning Section and Project Implementation Unit will be filled by an MOH staff person funded by the project. This person will be responsible for: (1) coordinating with EP&D and Ministry of Finance for sectoral budget preparation, local costs inclusion in the PSIP and development budgets, and phasing-in support for recurrent project costs under the revenue budget; (2) ensuring project activities are well

coordinated with those of other donors; (3) nominating and reviewing candidates for training and arranging trainers for scheduled training and workshops; and (4) participating in the Project Oversight Committee.

2. **Accountant (MOH):** This full time position in the MOH Accounts Section will be responsible for financial management, control and accounting for the MOH project-funded component.

IV. USAID FUNDED CONTRACT POSITION

1. **STAFH Project Manager (Personal Services Contractor):** See attached Statement of Work.

CHIEF OF PARTY/FAMILY PLANNING MANAGEMENT ADVISOR

STATEMENT OF WORK

A. Objectives

The Chief of Party/Family Planning Management Advisor will be responsible for ensuring that the Institutional Contractor (IC) functions effectively and efficiently, and provides the required technical, financial and material resources to counterpart institutions in a timely and effective manner. Thus, the Chief of Party is utimately responsible for ensuring that the OUTPUTS of the Child Spacing components of STAFH are met. As the Family Planning Management Advisor, s/he will have responsibility for providing technical assistance to the NFWC, MOH and other service delivery organizations in accomplishing the following:

- o development of service delivery strategies and plans appropriate for effective child spacing services, including management of a subgrant program for PVOs and NGOs;
- o procedures and systems for on-going project and subgrant monitoring to track project progress;
- o development and implementation of effective mechanisms for coordinating child spacing and HIV/AIDS prevention activities at the national and sub-national levels;
- o development and implementation of strategies for dissemination of information about project successes (and failures); and
- o adaptation of effective and relevant approaches, systems and methods to other organizations and subgrantees working in aspects of the STAFH project.

B. Outputs Required

In collaboration with the MOH, NFWC, FHI/AIDSCAP and subgrantees, s/he will be responsible for all workplans, financial, progress and other reports required by the contract; and documentation of relevant management systems in guidelines and procedures manuals, and other management tools required for effective national and sub-national coordination and management of the child spacing program, and for effective dissemination of effective strategies for service delivery.

C. Activities

As Chief of Party, s/he will undertake the following activities:

- o supervise, coordinate and monitor work of all long-term and short-term advisors under the IC;
- o supervise all procurement and related logistical support managed by the IC;
- o maintain liaison with USAID, the MOH, the NFWC, FHI/AIDSCAP and the IC's home office;
- o coordinate planning and programming of technical assistance, workplans and budgets with FHI/AIDSCAP, NFWC, MOH and USAID;
- o prepare annual work plans and budgets in close collaboration with interested parties, and secure necessary review and approvals;
- o develop and coordinate the child spacing/HIV/AIDS prevention subgrant program with FHI/AIDSCAP, USAID, and NFWC, manage the award process, and provide management oversight to subgrantees financed by the IC;
- o establish internal office procedures for local staff, e.g., personnel procedures and internal communications procedures;
- o take action to resolve project implementation problems and bring those of importance to the attention of the STAFH Project Manager and HPN Officer;
- o ensure coordination and communication with FHI/AIDSCAP, counterpart staff and other technical consultants (DHS, RAPID IV, AVSC, SEATS) operative in Malawi's child spacing program;
- o assist with planning and conducting Project Oversight Committee meetings;
- o meet all reporting and other requirements of the contract; and
- o provide any other assistance which might be necessary to successfully implement activities under the contract.

As the Family Planning Management Advisor, s/he will undertake activities to achieve the desired objectives/outputs, including:

- o work with senior level staff of collaborating agencies and organizations (e.g., NFWC, CHAM, MOH) to develop strategies for national level expansion of child spacing services;

- o collaborate with senior staff and relevant technicians of the NFWC, MOH, CHAM and other service provider organizations to implement national level monitoring of child spacing program implementation, including utilization of the management information system, and take action using the results;

- o in liaison with other technical advisors and national implementing organizations, develop and implement adequate and appropriate management systems (including supervision and quality assurance procedures) and procedures for application by all service provider organizations and subgrantees;

- o assist the NFWC and related national level management and service delivery orgganizations in the development and implementation of coordinating procedures for child spacing resources, activities, and projects at the national and sub-national level;

- o assist counterpart technicians in the preparation and production of appropriate procedures manuals, guidelines and other tools for effective management of child spacing services, and assist with developing plans for their dissemination;

- o plan and implement in-service workshops for managers of child spacing service delivery organizations;

- o identify additional technical assistance needs of subgrantees, prepare scopes of work, and engage and guide selected, appropriate consultants; and

- o assist in disseminating information about STAFH and project results.

D. Roles and Relationships

The Chief of Party is directly responsible to the STAFH Project Manager and the USAID HPN Officer, and as Director for the Institutional Contractor, reports to a senior manager in the IC's home office. S/he will coordinate closely and frequently with the MOH Project Coordinator amd Executive Secretary of the NFWC as well as with his/her counterparts in FHI/AIDSCAP. S/he

will supervise all expatriate team members and local-hire staff financed by the IC. In his/her role as Family Planning Management Advisor, s/he will work closely with senior level staff in the NFWC, MOH, CHAM and FHI/AIDSCAP, and directly supervise the work of long-term and short-term technical specialists.

E. Qualifications

1. Required

Education: Masters Degree in management, public administration, public health or related field with complementary training or experience in health and family planning management; doctorate in a relevant field preferred.

Experience: Eight to ten years with a broad range of experience in design and management of family health/family planning service delivery programs in developing countries, preferably in Africa. Experience in planning and developing management systems. Experience in managing technical teams.

Language: English (Native speaker)

Specific Skills: Proven ability to work with other people (counterparts and expatriates); ability to adapt easily to difficult living and working conditions; flexibility to adapt ways and means in order to meet selected objectives; proven supervision skills; ability to write clearly and concisely in English; and computer literate in word processing and data base management.

COMMUNITY SERVICES SPECIALIST

STATEMENT OF WORK

A. Objectives

The Community Services Specialist (CSS) will serve as the resource person for the development of effective and sustainable child spacing services (integrated where appropriate with HIV/AIDS prevention services) at the community level. More specifically, s/he will provide technical assistance to the Ministry of Health, and other ministries with community-level workers, the Christian Health Association of Malawi (CHAM), parastatal and private sector enterprises, and non-governmental organizations to accomplish the following:

- o expansion of child spacing and, where appropriate, HIV/AIDS prevention services, through community-based agents.

- o adaption and implementation of the EIL/SHARED system of grantee assessment and subgrant award and management to the requirements of the family planning and AIDS subgrant program under STAFH.

B. Outputs Required

The CSS will work closely with counterparts from the NFWC and the MOH in planning for and conducting project activities - with particular attention to efforts aimed at increasing access to affordable and acceptable family planning services.

Outputs include: 1) documentation and utilization of a subgrants application, review and management system; 2) award and implementation of three US PVO grants and 16 smaller NGO grants for child spacing (and, where appropriate, integrated with HIV/AIDS prevention education); 3) community-based service delivery subprojects, managed and implemented through structures and community agents of the Ministry of Health and other government ministries, parastatals, CHAM, private sector providers and NGO/PVOs; and 4) development and application of packages of materials (IEC, training, service delivery forms and management guides) suitable for use in implementing community-based child spacing in Malawi.

C. Activities

The CSS will implement the following activities to achieve the objectives and outputs cited above:

- meet with all interested parties, including the NFWC, EIL/SHARED, MOH and FHI/AIDSCAP, to obtain ideas on effective procedures for subgrant application and approval; appropriate criteria for award; rapid assessment procedures for NGO candidates; and likely NGO candidates;

- assess likely NGO candidates regarding interest, ability to implement clinic and/or community-based child spacing services, issues related to service delivery, such as logistics and supervision, and overall management capability;

- assist most appropriate NGO candidates to prepare subgrant proposals, workplans and budgets, giving guidance on relevant elements for child spacing program implementation;

- assist in linking NGO candidates with organizations able to develop and produce IEC materials and provide appropriate training;

- prepare guidelines for initiating subgrants, e.g., procedures for getting first disbursement of funds, commodities, etc.;

- assist in providing timely support to grantees, after subgrants are approved;

- develop guidelines for monitoring subgrantee performance;

- with the MOH, NFWC, the Chief of Party/Family Planning Management Advisor and Clinical Services Specialist, develop appropriate quality assurance guidelines for community-based family planning services and a plan to implement them;

- assist the NFWC and logistics/MIS advisor in refining the child spacing services reporting and application to community- based services;

- assist the MOH, other ministries and CHAM in developing and implementing pilot CBD projects in selected districts;

- assist the MOH, other ministries and CHAM in expanding CBD pilot projects to selected districts;

- assist private sector organizations, such as tea estates, tobacco estates, etc., to integrate child spacing (and AIDS prevention services) into their health services programs;

NARRATIVE SUMMARY	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
OUTPUTS: **AIDS Control Component:** A. Increased access to condoms and condom education services. B. Increased access to high quality STD drugs and correct STD case management services. C. Increased access to education, counseling, and AIDS prevention materials among high risk groups (e.g. youth, STD patients, bargirls) and the general population.	**AIDS Control Component:** A. Percent of MOH and CHAM hospitals providing comprehensive STD prevention and control services for female and male clients increased from nil in 1992 to 50% in 1998. B. Percent of large private sector companies and estates (over 300 employees) with effective AIDS prevention and condom distribution programs increased from 10% in 1992 to 90% by 1998. C. Percent of schools providing AIDS prevention education increased from 0% in 1992 to 80% in 1998. D. AIDS prevention education programs established for bargirls, STD patients, out-of-school youth and other at-risk men and women. E. Number of condoms sold through social marketing increased from 0.5 million/year in 1992 to 4.0 million/year in 1998. F. Number of condoms distributed free increased from 3 million/year to 6 million/year in 1998. G. GOM commitment of human and financial resources for AIDS prevention increased.	A. GOM AND OTHER MIS/HIS STATISTICS B. DHS DATA C. PERIODIC SPECIAL SURVEYS D. PROJECT MONITORING AND EVALUATIONS E. HIV/STD SURVEILLANCE SYSTEM DATA F. PROJECT GRANTEE REPORTING SYSTEM G. NON-GOVERNMENTAL ORGANIZATIONS' SURVEYS	A. INCREASED GOM COMMITMENT TO CHILD SPACING AND HIV/AIDS PREVENTION B. CONTINUED INTEREST BY NGO/PVO AND GOM COMMUNITY TO UNDERTAKE CBD SERVICE DELIVERY C. BEHAVIORAL CHANGE CAN BE MEASURED

NARRATIVE SUMMARY	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Child Spacing Component: **Increased access to child spacing information and services.**	**Child Spacing Component:** A. Number of MOH hospitals providing comprehensive child spacing services increased from 3 in 1992 to 25 (100%) in 1998. B. Number of CHAM hospitals providing comprehensive child spacing services increased from 8 in 1992 to 10 in 1998. C. Number of clinics providing core child spacing services increased from 230 in 1992 to 549 in 1998. D. Number of MOH health surveillance assistants (HSAs), GOM and PVO field agents, TBAs, and volunteers providing child spacing services via community-based distribution (CBD) increased from 200 in 1992 to 1860 in 1998. E. Number of cycles of oral contraceptive pills sold annually through social marketing increased from 0 in 1992 to 1,400,000 in 1998. F. Number of users of modern methods of child spacing (orals, condoms, foaming tablets, injectables, female sterilization, Norplant and other) increased from 68,000 in 1992 to 437,000 in 1998. G. NFWC established and functioning as the national leadership and coordinating body for child spacing activities and providing full-range of support services to providers. H. GOM commitment of human and financial resources for child spacing increased.	A. GOM AND OTHER MIS/HIS STATISTICS B. DHS DATA C. PERIODIC SPECIAL SURVEYS D. PROJECT MONITORING AND EVALUATIONS E. PROJECT CONTRACTOR REPORTING SYSTEM F. NON-GOVERNMENTAL ORGANIZATIONS' SURVEYS	A. MOH REVISES CHILD SPACING GUIDELINES TO LIBERALIZE ACCESS. B. MOH REVISES IN-SERVICE TRAINING CURRICULUM ON FAMILY HEALTH TO LESS THAN 6 WEEKS. C. MOH ADDS FAMILY HEALTH COMPONENT TO PRE-SERVICE TRAINING FOR CLINICAL OFFICERS, MEDICAL ASSISTANTS, ENROLLED NURSE-MIDWIVES AND OTHER APPROPRIATE MEDICAL PERSONNEL. D. WORLD BANK PHN SECTOR CREDIT SUPPORT TO THE NFWC CONTINUES THROUGH LOP.

NARRATIVE SUMMARY		VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
INPUTS:				
TECHNICAL ASSISTANCE	22,012		PILs	A. A.I.D. FUNDS AVAILABLE
COMMODITIES (USAID DIRECT)	14,655		VOUCHERS	B. GOM COUNTERPART FUNDS AVAILABLE AND
INFLATION & CONTINGENCY (10%)	1,924		CONDITIONS PRECEDENT	CAN MANAGE RESOURCES
LOCAL COSTS	1,939		COVENANTS	
TRAINING	1,100		EVALUATIONS & REVIEWS	
AUDIT & EVALUATION	350		AUDITS	
OTHER USAID DIRECT (GRANTS, BUY-INS, CONTRACTS)	3,020			
TOTAL	45,000			

Telegrams: FINANCE Lilongwe
Telephone: Lilongwe 731 311
Telex: 4407
Fax: 734 739

SECRETARY TO THE TREASURY
MINISTRY OF FINANCE
P.O. BOX 30049
LILONGWE 3
MALAWI

30th September, 1992

The Mission Director
USAID
P.O. Box 30455
LILONGWE 3

Dear Madam

RE: SUPPORT TO AIDS AND FAMILY HEALTH PROJECT (STAFH)

The Government of the Republic of Malawi , as part of its efforts to improve the overall health of the nation as stated in the current National Health Plan, and the Statement of Development Policies documents, requests the assistance of the United States Government through USAID to support financially and technically the AIDS and Child Spacing (Family Health) activities. Over the past few months USAID officials, and MOH officials have worked together in full consultation with and advice from Economic Planning and Development, Treasury and Justice to come up with the attached project proposal.

2. Based on the discussions and consultations that have taken place, Government of Malawi (GOM) is prepared to undertake the activities proposed in a manner that will positively contribute to the overall improvement of health of the nation. The GOM is fully aware that the project will be implemented in a number of organisations including MOH and that there are conditionalities that will have to be fulfilled such as: the appointment of a full time project coordinator and Accountant; Local cost contribution and the need to provide in Revenue budget the project-related recurrent costs.

3. The support to Aids and Family Health (STAFH) project provides $ 45.0 million which will be directly supportive to the control of HIV/AIDS problem together with the control of the sexually Transimitted Diseases (STD). The Project is also supportive to the expansion and intensification of Child Spacing Services or Family Health Services and thereby directly contributing to MCH activities in the country.

4. The project's focus and empasis will be the most economically productive age group of 15 - 44 years. This, therefore means, if implemented, the project's impact will be felt for a long time to come and throughout the economy. Specific key indicators of goal attainment are as follows:

a. A reduction in HIV prevalence among urban pregnant women 15 - 24 years of age by 10% by 1998.

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b. A reduction in maternal mortality from an estimated 500 = (per 100,000 live births) to 300 by 1998.

c. A recuction in the total fertility rate from 7.6 in 1992 to 6.8 in 1998.

d. An increase in the percentage of males age 15 - 24 years reporting condom use from 5 - 10% in 1992 to 30 - 40 in 1998.

e. A decrease in the percentage of urban and semi-urban pregnant women with positive sphilis serology from 8 - 14% in 1992 to 4 - 7% in 1998.

f. An increase in the contraceptive prevalence rate (CPR - Modern methods) among married women of reproductive age (MWRA) from 3 - 5% in 1992 to 20% in 1998.

g. An increase in the mean age at first birth from 19 to 21 in 1998.

h. A decrease in the percent of births spaced less than two years apart from 24% of all births to 15% in 1998.

5. Once again, these targets and indicators have been fully discussed in Government. The Govenment now looks forward to signing the agreement on STAFH as soon as possible and to collaborating with USAID in the implementation of this important project.

Yours faithfully

Harned P. Kawonga
FOR: SECRETARY TO THE TREASURY

ACTION: AID-3 INFO: AMB DCM/ECON

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E.O. 12356: N/A
TAGS:
SUBJECT: ABS REVIEW MALAWI

1. THIS MESSAGE REPORTS ON THE RESULTS OF THE AFRICA BUREAU INTERNAL REVIEW OF THE FY 1993 ABS FOR MALAWI. SUB-GEOGRAPHIC REVIEWS, CHAIRED BY AAA/DP, MARGE BONNIE, WERE HELD BETWEEN JUNE 21 AND JULY 3. BUREAU WRAP-UPS, CHAIRED BY DAA/AFR LARRY SAIERS, WERE HELD ON JULY 5 AND 10. WHILE A WIDE VARIETY OF MATTERS RELATING TO PROPOSED COUNTRY PORTFOLIOS FOR FYS 92/93 WERE DISCUSSED, THESE REVIEWS FOCUSSED HEAVILY ON ISSUES INVOLVING PROGRAM CONCENTRATION -- BOTH WITHIN AND AMONG COUNTRIES -- AND ON MANAGEMENT CONCERNS.

2. FOLLOWING SUBMISSION OF THE VARIOUS BUREAUS' CONSOLIDATED ABS'S THROUGH THE OPERATIONS DIRECTORATE (OPS) TO THE FINANCE AND ADMINISTRATION DIRECTORATE (FA), FA/BUD WILL CONVENE A SERIES OF REVIEWS OF EACH BUREAU'S BUDGET SUBMISSION - AT A COUNTRY/OFFICE LEVEL OF DETAIL - IN LATE JULY AND EARLY AUGUST. FA/BUD WILL CHAIR THE REVIEWS IN COORDINATION WITH OPS AND THE POLICY STAFF, WITH BUREAU REPRESENTATION AT THE PROGRAM/MANAGEMENT OFFICE OR DAA LEVEL. THESE REVIEWS WILL FOCUS IN

PARTICULAR ON THE AGENCY'S BASIC CROSSCUTTING PROGRAMMATIC THEMES FOR FY 1993: PROGRAM CONCENTRATION, PERFORMANCEBASED RESOURCE ALLOCATIONS, THE RELATIONSHIP OF PROGRAM TO OE AND WORKFORCE REQUIREMENTS, AND SUPPORT FOR THE ADMINISTRATOR'S PROGRAM INITIATIVES -- AS WELL AS BUREAUSPECIFIC ISSUES AND PRIORITIES. PIPELINE AND MORTGAGE ISSUES WILL ALSO BE CONSIDERED.

3. THE FACPS REVIEWS WILL IDENTIFY THOSE PROGRAM, OE, AND WORKFORCE ISSUES THAT NEED TO BE VETTED WITH AA/FA, AA/OPS AND POLICY AND, IF NECESSARY, WITH THE DEPUTY ADMINISTRATOR AND ADMINISTRATOR LATER THIS SUMMER.

4. DECISIONS ARISING FROM THIS AGENCY PROCESS WILL PROVIDE THE BASIS FOR DEVELOPMENT OF THE INTEGRATED FOREIGN ASSISTANCE BUDGET, IN CONSULTATION WITH THE STATE DEPARTMENT. TARGET DATE FOR SUBMISSION OF THE INTEGRATED BUDGET TO THE SECRETARY OF STATE IS SEPTEMBER 16, WITH TRANSMITTAL OF THE BUDGET TO OMB ON SEPTEMBER 30.

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DATE: 08/09/91

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5. AS MISSIONS READ THESE REPORTING CABLES, WE WANT TO EMPHASIZE THAT OUR FLEXIBILITY TO RESPOND TO WORKFORCE AND OE CONSTRAINTS IS EXTREMELY LIMITED. MISSIONS WILL NEED TO TAKE THESE LIMITATIONS CAREFULLY INTO ACCOUNT IN PLANNING THE SIZE, COMPOSITION, AND DESIGN OF FY 92/93 PROGRAM PORTFOLIOS, INCLUDING IN PARTICULAR THE NUMBER AND TYPE OF NEW STARTS.

6. MISSIONS SHOULD CONSIDER NPA IN PLANNING FOR FY 93 AND BEYOND, RATHER THAN AUTOMATICALLY LOOKING TO THE PROJECT MODE. IN DESIGNING AND DESCRIBING PROGRAMS WITH NON-PROJECT ASSISTANCE, MISSIONS SHOULD BEAR IN MIND THE COMMENTS ON SUCH ASSISTANCE CONTAINED IN THE HAC REPORT FOR FY 1992, WHICH REFLECT THE COMMITTEE'S CONCERN THAT NPA BE DESIGNED TO HELP THE POOR MAJORITY. THE HAC STATES THAT IT QUOTE WOULD LIKE TO SEE A.I.D. BECOME THE RECOGNIZED WORLD LEADER IN DESIGNING AND IMPLEMENTING NON-PROJECT ASSISTANCE IN A LIMITED NUMBER OF SECTORS, PARTICULARLY THE SOCIAL SECTORS UNQUOTE. IN THIS REGARD, THE REPORT GOES ON TO STATE THAT QUOTE TO HELP BETTER FOCUS NONPROJECT DFA ASSISTANCE, THE COMMITTEE EXPECTS SUCH ASSISTANCE TO BE LIMITED IN FISCAL YEAR 1992 TO THE SOCIAL SECTORS (BASIC EDUCATION, FAMILY PLANNING, AND HEALTH), THE ENVIRONMENT, AGRICULTURE (TO THE EXTENT THAT NONPROJECT ASSISTANCE CAN BE SHOWN TO HAVE DIRECT AND IMMEDIATE BENEFITS FOR SMALL FARMERS AND THE RURAL POOR), AND JOB CREATION MEASURES. END QUOTE. WHERE OTHER TYPES OF NPA ARE PROPOSED, MISSIONS WILL NEED TO MAKE A STRONG CASE IN THE CONTEXT OF THE COUNTRY PROGRAM AND ITS IMPACT ON THE POOR.

7. MISSIONS SHOULD BEAR IN MIND THAT THE INFORMATION THAT FOLLOWS IN THESE REPORTING CABLES IS TENTATIVE AND INFORMAL, PENDING COMPLETION OF THE EXECUTIVE BRANCH REVIEW/DECISIONMAKING PROCESS. IT SHOULD NOT BE CONVEYED TO THE HOST GOVERNMENT AT THIS TIME. FINAL PROJECT-SPECIFIC LEVELS WILL BE PROVIDED WHEN THE AGENCY REVIEWS HAVE BEEN COMPLETED, AND WE HAVE A BETTER FEEL FOR THE BUREAUWIDE PERFORMANCE IN COMPLYING WITH DFA AND AGENCY TARGET LEVELS.

8. APS ISSUES:

A. PL 480 TITLE III PROGRAM FOR FY 1993: IF MAJOR MANAGEMENT, WORKLOAD AND PROGRAMMATIC ISSUES WOULD NOT POSE SERIOUS PROBLEMS, THE AFR BUREAU SUGGESTS THAT THE MISSION MAY WISE TO INVESTIGATE THE FEASIBILITY AND
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DESIRABILITY OF INITIATING AND INTEGRATING A DOLS 15 MILLION PL 480 TITLE III PROGRAM INTO ITS PROPOSED FY 93 PROGRAM. THE AFR BUREAU UNDERSTANDS THE MANAGEMENT IMPLICATIONS OF THIS SUGGESTION, AND RECOMMENDS THAT THE MISSION'S MANAGEMENT OF A TITLE III PROGRAM WOULD NEED TO BE WEIGHED CAREFULLY AGAINST CONTINUING TITLE II EMERGENCY PROGRAMS. THE MANAGEMENT BURDEN CAUSED BY INTEGRATING A TITLE III PROGRAM WITH THE DFA PROGRAM SHOULD BE LESS THAN HAVING A SEPARATE FOOD AID ACTIVITY.

B. INCREASE IN MISSION'S FY 92 OE BUDGET: USAID/MALAWI'S FY 93 AAPLS ARE ALMOST DOUBLE THE LEVELS PROPOSED IN ITS APPROVED 1991 CDSS ACTION PLAN. STAFFING LEVELS HAVE INCREASED FROM 12 TO 15 USDH AND FROM 32 TO 63 FSN EMPLOYEES TO MANAGE THE CURRENT PORTFOLIO AND DESIGN FOUR MAJOR NEW PROJECTS WHICH, WHEN AUTHORIZED, WILL ADD ALMOST DOLS 80 MILLION TO THE MISSION'S PROJECT PORTFOLIO BY THE END OF FY 92. THE COST OF THE ADDITIONAL STAFF REQUIRED TO MANAGE THIS PORTFOLIO IS REFLECTED IN THE MISSION'S REQUEST FOR OE INCREASES IN FYS 93 AND 94 OF 20 PERCENT AND 25 PERCENT, RESPECTIVELY, OVER ITS FY 92 OE LEVELS. AT THE SAME TIME, THE MISSION'S PROPOSED FY 94 USE OF LOCAL CURRENCY TRUST FUND RESOURCES INCREASES ONLY SLIGHTLY FROM THE LEVEL IN FY 91. TRUST FUND REDUCTIONS BEYOND FY 94 WILL REQUIRE ADDITIONAL INCREASES IN OE DOLLAR FUNDING TO MAINTAIN STAFF AND MANAGEMENT CAPABILITY. THE BUREAU IS MAKING A COMPREHENSIVE ANALYSIS OF WORKFORCE AND OE NEEDS AND WILL PREPARE A COORDINATED PROPOSAL FOR PPC. YOUR REQUEST WILL BE CONSIDERED IN THAT CONTEXT.

C. DELEGATION OF AUTHORITY TO THE MISSION FOR PID APPROVALS: THE MISSION'S REQUEST FOR AID/W DELEGATIONS OF AUTHORITY TO APPROVE THE FAMILY HEALTH/AIDS AND SUPPORT TO ENTERPRISE TRANSFORMATION PROJECT PIDS IS APPROVED. IN THE FAMILY HEALTH AND AIDS PID REVIEWS, QUESTIONS OF RESOURCE ALLOCATION AND SUSTAINABILITY SHOULD BE CONSIDERED.

PID approval

9. THE AFR BUREAU AGAIN COMMENDS THE MISSION ON A THOROUGHLY PREPARED ABS THAT FULLY MET BOTH AGENCY AND BUREAU GUIDANCE. CONGRATULATIONS ON YOUR EXCELLENT WORK. WE AGAIN ANTICIPATE USING YOUR ABS AS A MODEL FOR OTHER MISSIONS IN AFRICA. BAKER

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STAFH - 612-0238

ACTION: AID-3 INFO: AMB DCM/ECON

VZCZCLG0331
PP RUEHLG
DE RUEHC #3507/01 0521402
ZNR UUUUU ZZH
P R 211359Z FEB 92
FM SECSTATE WASHDC
TO RUEHLG/AMEMBASSY LILONGWE PRIORITY 7124
INFO RUEHNR/AMEMBASSY NAIROBI 4743
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AIDAC, FOR REDSO/ESA, FISCHER, AND RLA

E.O. 12356: N/A
TAGS:
SUBJECT: MALAWI POPULATION AND AIDS PID REVIEW (612-0238)

REF: LILONGWE 5725

DATE: 02/24/92
ACTION TO: Newton - HDN
INFO:
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DUE DATE: 02/26/92
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File: STAFH 612-0238

1. ON WEDNESDAY, DECEMBER 11, 1991, THE AFRICA BUREAU AND THE RESEARCH AND DEVELOPMENT BUREAU MET INFORMALLY TO DISCUSS THE DRAFT MALAWI SUPPORT TO AIDS AND FAMILY HEALTH (STAFH) PROJECT PID. THIS REVIEW WAS NOT A PID APPROVAL MEETING. THE MEETING WAS CHAIRED BY AFR/SA, KIMBERLY FINAN, AND ATTENDED BY CAROL PEASLEY, THE USAID MISSION DIRECTOR; GARY NEWTON, THE USAID HEALTH OFFICER; AND REPRESENTATIVES FROM AFR/DP, AFR/ARTS, AFR/CCWA, RD/POP AND RD/H.

2. THE PURPOSES OF THE MEETING WERE THREE-FOLD:

-- A. THE MISSION REQUESTED DELEGATION OF AUTHORITY TO THE FIELD FOR PROJECT APPROVAL AND AUTHORIZATION. THIS PROJECT WAS ORIGINALLY PRESENTED AS A DOLLARS 22 MILLION PROJECT ACTIVITY IN THE FY93 ABS, AND DOA WAS GRANTED AT THAT TIME, WITH A RECOMMENDATION THAT THE PROJECT LOP SHOULD BE INCREASED. AS A RESULT OF RESEARCH CONDUCTED PRIOR TO PID PREPARATION, THE PROPOSED ACTIVITY HAS

EXPANDED ITS SCOPE AND CONTENT AND IS NOW AN EIGHT-YEAR HYBRID PROJECT/PROGRAM EFFORT WITH PROPOSED LOP FUNDING OF DOLLARS 45 MILLION--DOLLARS 37 MILLION PA AND DOLLARS 8 MILLION NPA (TO BE PROGRAMMED DURING THE FIRST FOUR YEARS ONLY);

-- B. GIVEN THAT THE MISSION IS PROPOSING A HYBRID ACTIVITY, THE QUESTION WAS POSED AS TO THE APPROPRIATE USE AND LEVEL OF NPA; AND

-- C. THE MISSION DIRECTOR AND HEALTH OFFICER WERE INTERESTED IN TECHNICAL INPUT ON FAMILY PLANNING AND AIDS FROM ARTS, RD/POP AND RD/H EARLY IN THE DESIGN PROCESS.

3. INCREASE TO PROJECT:

-- A. THE MEETING COMMENCED WITH AN INFORMATIVE

DISCUSSION OF WHAT HAPPENED BETWEEN THE ABS NARRATIVE AND CURRENT PID. HEALTH OFFICER GARY NEWTON EXPLAINED THAT THE MISSION UNDERTOOK SEVERAL PRE-PID ASSESSMENTS IN AUGUST, SEPTEMBER AND OCTOBER OF 1991. THE ASSESSMENTS MADE CLEAR THAT, AMONG OTHER THINGS, THE PRIVATE SECTOR IS READY TO PARTICIPATE IN THE IMPLEMENTATION OF FAMILY PLANNING AND AIDS ACTIVITIES, AND THAT STD CONTROL WILL BE FUNDAMENTAL TO REDUCING HIV INCIDENCE.

-- B. AT THE SAME TIME, SEVERAL POLICY DEVELOPMENTS IN MALAWI REMOVED CERTAIN CONSTRAINTS TO DONOR PROGRAMS IN FAMILY PLANNING AND AIDS. THESE INCLUDED AN AIDS NATIONAL COMMITTEE MEETING IN AUGUST WHICH ENDORSED AIDS PREVENTION AND CONTROL POLICIES. IN OCTOBER, A NATIONAL POPULATION POLICY MEETING OUTLINED THE ELEMENTS OF A FORMAL NATIONAL POPULATION POLICY. FINALLY, THE RESULTS OF A BASELINE POPULATION/AIDS SURVEY CONDUCTED IN APRIL, 1991, DOCUMENTED THAT AIDS KNOWLEDGE AND AWARENESS HAS LED TO SIGNIFICANT BEHAVIORAL CHANGE AND THAT CONTRACEPTIVE PREVALENCE RATES IN MALAWI HAVE ALREADY INCREASED DRAMATICALLY BETWEEN 1984 (FROM ONE PERCENT TO NINE-TEN PERCENT) AND 1991.

-- C. THESE ASSESSMENTS AND POLICY DEVELOPMENTS INFLUENCED THE MISSION'S THINKING ON PROJECT DESIGN, WHICH HAD IMPLICATIONS FOR THE SCOPE, CONTENT AND BUDGET. CONTRACEPTIVE COMMODITIES AND CONDOMS WERE ADDED, AS WELL AS DRUGS FOR STD CONTROL, AND PROVISION OF FAMILY PLANNING AND AIDS SERVICES THROUGH THE PRIVATE SECTOR. IN AIDS, THE EMPHASIS IS ON PREVENTION; IN POPULATION, ON SERVICE DELIVERY.

4. ADDITION OF AN NPA COMPONENT:

-- AN NPA COMPONENT CAN BE ADDED TO A LARGER PROJECT, PROVIDED THAT ALL THE NORMAL REQUIREMENTS FOR NPA ARE MET. SINCE THIS IS THE FIRST TIME THAT A PROPOSAL WHICH APPEARS AS IF IT CAN MEET THESE REQUIREMENTS HAS BEEN SUBMITTED, THIS CABLE IDENTIFIES THE REQUIREMENTS IN SOME DETAIL.

-- A. THERE NEEDS TO BE A FULL SECTOR ANALYSIS WHICH FULLY DISCUSSES THE APPLICABLE POLICY ENVIRONMENT. THE PID INDICATES THAT THIS HAS BEEN DONE. THE ANALYSIS ALSO NEEDS TO IDENTIFY AND RANK-ORDER THE MOST IMPORTANT SECTOR CONSTRAINTS, ESPECIALLY POLICY CONSTRAINTS.

-- B. THE NPA REFORMS NEED TO ADDRESS THE MOST IMPORTANT SECTOR POLICY/INSTITUTIONAL CONSTRAINTS, NOT JUST THOSE CONSTRAINTS WHICH ARE USEFUL OR EVEN MOST IMPORTANT TO ST
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ACHIEVING THE PROJECT PURPOSE. THE PID INDICATES THAT THE PROPOSED REFORMS MAY BE THOSE MOST IMPORTANT TO THE FP/AIDS SECTOR, NOT JUST THOSE USEFUL TO PROJECT IMPLEMENTATION, ALTHOUGH THE FINAL PP/PAAD WILL NEED TO FLESH OUT THE CONSTRAINT AREAS IN MORE DETAIL AND RANK-ORDER THEM. THE FACT THAT THE NPA COMPONENT, WITH ITS SECTOR-WIDE REQUIREMENTS, FITS WITH THE PROJECT MAY IN PART BE DUE TO THE SECTOR-WIDE NATURE OF THE PROJECT COMPONENT.

-- C. THE MISSION SHOULD PRODUCE A COMBINED PP/PAAD THAT FOLLOWS ALL THE OTHER REQUIREMENTS FOR SECTOR NPA. THIS INCLUDES ALL THOSE SECTIONS REQUIRED FOR NPA BY THE EXISTING BUREAU NPA GUIDANCE. THIS INCLUDES WITHOUT LIMITATION A SECTOR ANALYSIS, WITH PARTICULAR ATTENTION TO THE POLICY ENVIRONMENT, RANK-ORDERING THE SECTOR CONSTRAINTS AND ADDRESSING THOSE MOST IMPORTANT TO THE SECTOR, NOT JUST TO THE PROJECT, DISCUSSION OF THE MACROECONOMIC ENVIRONMENT IN WHICH THE SECTOR OPERATES, DISCUSSION OF WHAT OTHER DONORS ARE DOING, DISCUSSION OF HG CAPACITY AND WILL TO EXECUTE AND SUSTAIN THE REFORMS, PAAD FACESHEET, EXPLANATION OF DOLLAR TRACKING AND LOCAL CURRENCY MANAGEMENT, MEASURES PROTECTING VULNERABLE GROUPS NEGATIVELY AFFECTED BY THE REFORMS, AND M AND E PLAN IDENTIFYING AND MEASURING PEOPLE-LEVEL IMPACT FROM THE COMBINED PROJECT/PROGRAM.

-- D. PLEASE ENSURE THAT THE FP/PAAD CLEARLY EXPLAINS HOW THE ACTIVITY QUALIFIES FOR INCLUSION OF NPA WITH A LARGER PROJECT. WITH INCREASING FREQUENCY WE ARE SEEING PROPOSALS TO ADD A SMALL AMOUNT OF NPA TO "GREASE THE WHEELS" OF A PROJECT, WHERE THERE HAS NOT BEEN A SECTOR ANALYSIS AND THE PROPOSED REFORMS DO NOT ADDRESS HIGH-RANKING SECTOR CONSTRAINTS, AND WANT TO ENSURE THAT THIS SMALL ACTIVITY IS NOT CONFUSED WITH OR TAKEN AS PRECEDENT FOR THOSE PROPOSALS.

5. CONDITIONALITY RELATED TO PROCUREMENT AND CONSTRUCTION.

-- A. A SECOND ISSUE RAISED BY THE NPA COMPONENT OF THE PID IS HOW TO DISTINGUISH BETWEEN POLICY AND INSTITUTIONAL REFORMS THAT ARE APPROPRIATE FOR NPA AND DE FACTO PROCUREMENT OR CONSTRUCTION THAT SHOULD MORE PROPERLY BE PROJECT-FINANCED. IT WOULD BE APPROPRIATE TO REQUIRE AS ONE OF THE REFORMS THAT THE GOM SHIFT ITS BUDGET LINE ITEM FOR STD DRUGS AND CONTRACEPTIVES FROM THE DEVELOPMENT TO THE RECURRENT COST BUDGET, IF THE SECTOR ANALYSIS SHOWS THAT IT ADDRESSES ONE OF THE HIGHEST-RANKING SECTOR CONSTRAINTS. WHERE A REFORM IS CLOSE TO THE PROCUREMENT/CONSTRUCTION LINE, TO DEMONSTRATE THAT IT IS INSTEAD A POLICY/INSTITUTIONAL REFORM APPROPRIATE FOR NPA, THE PAAD SHOULD TAKE EXTRA CARE TO DEMONSTRATE ITS SUSTAINABILITY. THE INSTITUTIONAL REFORM SHOULD ALSO BE DELINKED FROM THE DOLLAR USES.

-- B. IT IS UNCLEAR WHAT IS MEANT BY THE PROPOSAL ON THE

BOTTOM OF P. 20 TO CONDITION DISBURSEMENT ON SUBMISSION OF DETAILED PLANS FOR CRITICAL EXPENDITURES SUCH AS RENOVATION OF HEALTH FACILITIES AND STD DRUGS. ON ITS FACE IT APPEARS TO BE STRAIGHTFORWARD PROCUREMENT AND CONSTRUCTION THAT IS MORE APPROPRIATE FOR PROJECT ASSISTANCE THAN NPA, BOTH BY ITS NATURE AND BECAUSE IT APPEARS SEPARATE FROM AND ADDITIVE TO THE PRIOR SECTOR CONSTRAINTS/REFORMS ANALYSIS.

C. TECHNICAL INPUT:

-, A. THE TECHNICAL DISCUSSION FOCUSSED ON THE CONTINUING DEBATE REGARDING THE INTEGRATION OF FAMILY PLANNING AND AIDS PROGRAMS AT THE FIELD LEVEL, COST RECOVERY IN SERVICE DELIVERY PROGRAMS, AND THE IMPORTANCE OF REVIEWING PROJECT ASSUMPTIONS IN ASSESSING THE NEED FOR A STRONG INFORMATION, EDUCATION AND COMMUNICATION ELEMENT WITHIN THE DESIGN. THE IMPORTANCE OF DONOR COORDINATION ON VARIOUS ELEMENTS OF THE PROJECTED DESIGN WAS ALSO STRESSED. THE PLANNED CONSOLIDATION OF THE EXISTING MISSION HEALTH, FAMILY PLANNING AND AIDS PORTFOLIO, WHICH CURRENTLY HAS 23 SMALL PROJECTS, WAS LAUDED. WHILE THE TECHNICAL DISCUSSION WAS ANIMATED, THERE WERE NO CONTROVERSIAL POINTS RAISED, NOR WEAKNESSES IN PROJECT

DESIGN IDENTIFIED.2

-- B. THERE WAS ALSO CONSIDERABLE DISCUSSION OF THE CRITICAL NEED FOR ONGOING EVALUATION AND MONITORING SYSTEMS TO BE DEVELOPED. PROBLEMS WITH MISSION STAFFING, PARTICULARLY IN THE HEALTH OFFICE, WERE HIGHLIGHTED. IN FACT, THE MISSION EXPLAINED THAT IF THE USDH HEALTH AND POPULATION OFFICER CANDIDATES WERE NOT IDENTIFIED BY THE END OF JANUARY 1992, THE MISSION WOULD NOT BE ABLE TO
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PROCEED WITH THE PLANNED PROJECT DESIGN. THIS REMAINS A VERY SERIOUS ISSUE TO BE RESOLVED.

-- C. IT WAS UNANIMOUSLY AGREED THAT THERE IS NO TECHNICAL NEED TO BRING THE PROJECT PAPER BACK TO AID/W FOR REVIEW.

7. AD HOC DELEGATION OF AUTHORITY

--612-0238: TO THE DIRECTOR, USAID/MALAWI TO AUTHORIZE AND IMPLEMENT A DOLS 45 MILLION SUPPORT TO AIDS AND FAMILY HEALTH COMBINED PROJECT/PROGRAM. THIS AD HOC DOA SHALL BE EXERCISED IN ACCORDANCE WITH ALL TERMS AND CONDITIONS OF DOA 551. THIS PROJECT CAN ONLY BE AUTHORIZED AFTER THE AMENDED IEE IS APPROVED BY THE BUREAU ENVIRONMENTAL OFFICER AND THE MISSION NOTIFIED THAT THE CN HAS EXPIRED. MISSION SHOULD NOTE THAT THE REQUIREMENT FOR AID/W OPS APPROVAL OF ALL CASH-DISBURSING PROGRAMS MUST STILL BE FULFILLED. BAKER
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- o in collaboration with the MOH Child Spacing Coordinator and NFWC staff, review existing IEC materials and, using short-term TA as required, plan for developing appropriate mass and small media materials; and

- o in collaboration with the MOH, NFWC, CHAM and other relevant organizations, review existing child spacing training curricula and materials and, using short-term technical assistance as required, prepare and implement plans for packaging and delivering training programs for clinic staff, community-based agents and supervisors for child spacing outreach programs.

D. Roles and Responsibilities

The CSS will work directly under the Chief of Party at the main office of the IC. S/he will work closely with representatives of the NFWC, MOH, FHI/AIDSCAP, other relevant individuals and the USAID Project Coordinator. S/he will assist in the supervision and performance appraisal of local staff hired to assist this advisor. If available, s/he may assist in the recruitment and selection of staff for these positions.

E. Qualifications

Education: Masters Degree or equivalent in Business, Public or Health administration or related discipline; complementary education in finance and accounting.

Experience: At least five years experience in providing technical assistance and/or management of clinical and community-based and private sector family planning services, with at least three years experience in developing countries, preferably in Africa. Experience with non-governmental organizations and/or private sector agency operations. Experience in grant management is highly desirable.

Language: English fluency, Chichewa helpful

Specific Skills: Proven ability to establish clear and concise policies and procedures and respond to requirement of a US government agency such as USAID; ability to work well with other people, including other expatriates and counterpart staff; ability to train and guide staff not completely familiar with Western bureaucratic procedures; able to respond to changing conditions; skills with computers and information systems; knowledge and skills in design and implementation of IEC programs; and experience in HIV/AIDS control.

VS DOC: 1835D

INFORMATION-EDUCATION-COMMUNICATION (IEC)/SOCIAL MARKETING ADVISOR

STATEMENT OF WORK

A. Objectives

The long-term IEC/Social Marketing Advisor will serve as a resource for all aspects of IEC for family planning and related HIV/AIDS prevention, and implementation of a social marketing program. The Advisor will provide technical assistance, as appropriate and necessary, directly to the MOH, CHAM, other public sector organizations, private sector enterprises and NGOs to accomplish the following:

- o design of a comprehensive IEC program for family planning agencies participating in STAFH;
- o development of management skills and procedures for planning, implementing, monitoring and evaluating the IEC activities;
- o establishment of a capability to conduct audience research to identify target audiences, media habits, patterns of contact with health workers and IEC messages;
- o capacity to design, pretest, produce and utilize a variety of IEC materials;
- o training of health and community agents in IEC skills;
- o design and implementation of IEC campaigns;
- o training support for social marketing sales and accounting staff (including development of a training manual and training materials);
- o social marketing expansion planning, implementation and product development;
- o commodity logistics management;
- o management information and reporting systems development;
- o monitoring (including financial controls, audit and project impact);
- o development, testing and finalization of sales training project; and
- o supervision of market research.

B. Outputs Required

The IEC/Social Marketing Advisor is responsible for: articulation of an overall IEC and social marketing strategy for STAFH; reports of audience research findings; samples of IEC materials (e.g., posters and pamphlets); guidelines, training modules and training materials on use of IEC and social marketing materials; and reports on findings of evaluations.

C. Activities

The IEC/Social Marketing Advisor will undertake at least these activities to achieve the objectives:

- on a daily basis work with the staff of implementing organizations to plan, program, monitor and evaluate the IEC and social marketing activities;
- assist in planning and conducting audience research in target areas, and proceed with IEC and social marketing efforts in accordance with research findings;
- plan and implement training for the IEC and social marketing staff in service provider organizations;
- identify additional needs for technical assistance, prepare scopes of work, identify appropriate consultants and guide their work;
- work with IEC and social marketing staff in relevant organizations in designing, pretesting, producing and distributing IEC and social marketing materials and in mass media programs;
- provide technical guidance and, where necessary, on-the-job training to the staff of the various provider organizations in planning and implementing IEC and social marketing activities;
- adequately supervise to assure financial accountability consistent USAID standards; and
- assure that the management information system is adequate to provide timely and accurate statistical and other information to the IC and to permit adequate USAID oversight.

D. Roles and Relationships

The IEC/Social Marketing Advisor will work directly with the key staff of service provider organizations including the MOH, CHAM and the IEC coordinator at the NFWC as chief counterpart for IEC activities. S/he will report to the Chief of Party of the IC, and will directly supervise all short-term IEC and Social Marketing consultants financed by the IC.

E. Qualifications Required/Desired

Education: Masters Degree or equivalent in communications, management marketing, health education or a related field.

Experience: At least five years experience in the development of IEC and social marketing programs in family health/family planning or related field in developing countries. Experience in training/technology transfer of IEC and social marketing know-how to staff in a developing institution. Experience in the management of organizations engaged in communications programs.

Language: English, Chichewa desired.

Specific Skills: Proven ability to work well with other people (counterparts and expatriates); ability to adapt to difficult living and working conditions; flexibility to adjust to changing conditions; ability to communicate and work with nonliterate populations; ability to work well on his/her own. Skills in operations and maintenance of IEC equipment.

CLINICAL SERVICES SPECIALIST

Statement of Work

A. Objectives

The Clinical Services Specialist will serve as the resource person for issues regarding clinical aspects of family planning service delivery. More specifically, s/he will provide technical assistance to the Ministry of Health, the Christian Health Association of Malawi (CHAM), and other family planning service providers to accomplish the following:

- o establishment of training and demonstration sites for delivery of longer-term methods, i.e., Norplant, mini-laparotomy with local anesthesia, and vasectomy; and
- o expansion of service delivery points offering high quality services for long-term and permanent methods of contraception to all MOH regional and district hospitals and all CHAM hospitals which have no religious proscription.

B. Outputs Required

The Clinical Services Specialist will produce: in collaboration with the MOH and CHAM, plans for expansion of sites for delivery of long-term and permanent methods of contraception; curricula for in-service training in clinical technique, counselling and IEC for ML/LA, vasectomy and Norplant; programs for training of trainers and plans for in-service training responsive to service expansion plans; guidelines for quality assurance for VSC and Norplant services; recording and reporting forms; and progress and evaluation reports.

C. Activities

The Clinical Services Specialist will conduct the following activities to achieve the expected outputs and results:

- o work with key staff in the MOH Child Spacing Unit, NFWC and CHAM to assess experience to date in Malawi with the delivery of long-term and permanent methods of contraception;
- o visit CHAM and MOH sites to further diagnose problems and identify aveneus for solving them and identify potential clinic sites for expansion and demonstration of longer-term contraceptive methods;

- using data collected regarding experience at sites providing services and needs of sites which may provide services, prepare a plan for strengthening services at present service delivery sites and for expansion of services to new sites per STAFH objectives;

- assist in planning renovation, equipment and materials procurements and procurement of expendable supplies for selected sites;

- prepare for and conduct the training of trainers for clinical procedure, counselling and IEC;

- prepare for and train staff at clinical practicum sites as preceptors;

- assist in training clinicians, counsellors and IEC agents;

- identify related technical assistance needs and prepare scopes of work for short-term assistance, e.g., for design and testing of IEC materials related to long-term methods;

- work closely with the Community Services Specialist in preparing and implementing service records and reporting forms, managing the logistics for Norplant and provision of expendable supplies, and referral, training, and supervision linkages with CBD and other clinical services;

- work with clinical counterparts in the development and implementation of procedures for monitoring the quality of care; and

- provide clinical input to the development of standards and guidelines for community-based and clinical services, training materials, curricula, and programs for for training IEC and CBD agents and clinic providers.

D. Roles and Responsibilities

The Clinical Services Specialist reports to the Chief of Party of the IC. S/he works with the appropriate operational and technical staff of the MOH, NFWC and CHAM on a day-today basis. S/he will supervise Short-term consultants financed by the IC to provide assistance on expansion of long-term and permanent contraceptive methods to the Ministry of Health and CHAM.

E. Qualifications Required/Desired

Education: Advanced training in the health field (medicine, nursing, midwifery) with complementary training in public health and/or public administration or related field.

Experience: At least three years experience in clinical management of ML/LA, vasectomy and Norplant; experience in the implementation of family planning programs through government infrastructures in developing countries; experience in field-level assessment of quality of care and addressing problems effectively.

Language: Fluency in English; Chichewa helpful.

Specific Skills: Strong clinical skills in ML/LA and vasectomy, and good skills in Norplant insertion; strong skills in training and counselling. Proven ability to work well with other people and to adapt to difficult living and working conditions; ability to work well on his/her own.

FINANCIAL MANAGER

STATEMENT OF WORK

A. Objectives

The Financial Manager will have principal responsibility for all financial, administrative and logistical activities to accomplish the following:

- Establishing and maintaining financial and internal control and reporting systems for the IC and for all subgrants managed by the IC;
- Developing financial management assessment instruments for use in certifying financial management capabilities of potential subgrantees;
- Developing systems, procedures and internal controls pertaining to financial operations of the IC; the receipt, disbursement and control of project funds; and the writing of an IC Financial Management Systems and Accounting Procedures Manual; and
- Assisting personnel of selected organizations in developing, maintaining and improving financial management/accounting systems and procedures, including bookkeeping.

B. Outputs Required

The Financial Manager is responsible for: developing and maintaining financial systems and preparing requisite financial reports on financial status of the IC and financial status, capabilities and expenditures of subgrantees.

C. Activities

The Financial Manager will undertake at least these activities to achieve the objectives:

- Preparing financial reports to IC's home office and to USAID as required;
- Assisting in the development and review of subgrant proposals, especially addressing the financial and reporting plans;
- Reviewing the financial management capability and systems of each potential subgrantee; certifying that the subgrantee NGO has adequate control and management systems prior to approval of subgrant;

- Assisting in training workshops, seminars and conferences for NGOs requiring training to establish and maintain adequate financial management systems. Assists in planning, logistics and execution of Project training activities;

- Assisting in the planning, design and curriculum of workshops for NGOs and their staff in skills development areas involving finance, management and administration;

- Responsible for all IC administrative matters including personnel, procurement, rental and maintenance of facilities, insurance, service contracts, etc.;

- Responsible for disbursement of subgrants and accounting for these disbursements;

- Responsible for supervision of all financial and administrative staff including the bookkeeper; administrative assistant, clerical staff and other support staff;

- Assisting in developing scopes of work, identification, interviewing, selection, contracting and management of subcontractors;

- Maintain project accounts including ledgers and journals related to checking and petty cash accounts; and

- Prepare monthly financial statements and quarterly financial reports to confirm with IC requirements and in accordance with USAID regulations.

D. Roles and Responsibilities

The Financial Manager will report directly to the Chief of Party and work directly with actual and potential subgrantees.

E. Qualifications Required/Desired

Education: Masters Degree or equivalent in financial management, accounting or a related field.

Experience: At least five years experience in financial management, accounting or a related field in developing countries. Experience in training/technology transfer of financial systems expertise to staff in a developing institution.

Language: English, Chichewa desired.

Specific Skills: Proven ability to work well with other people (counterpart and expatriates); ability to adapt to difficult living and working conditions; strong skills in management, training and preparation of instruction manuals; ability to work well on his/her own; computer expertise in financial and accounting systems.

1835D

LOGISTICS AND MANAGEMENT INFORMATION SYSTEMS SPECIALIST

STATEMENT OF WORK

A. Objectives

The Logistics and Management Information Systems Specialist (LMISS) will serve as the resource person for management of contraceptive procurement and distribution and the implementation of an effective management information system in the public and private sectors. More specifically, s/he will provide technical assistance to the Ministry of Health, the Christian Health Association of Malawi (CHAM), and private sector and non-governmental family planning and HIV/AIDS prevention service providers to accomplish the following:

- development and implementation of a contraceptive procurement and distribution system which assures adequate supplies of contraceptives (and related expendable supplies) to all public, private and non-governmental sector service delivery points; and

- development and implementation of a management information system for all public, private and NGO service providers, which permits effective monitoring of performance at the national and sub-national levels and information regarding contraceptive distribution and progress in meeting STAFH objectives.

B. Outputs Required

The LMISS will produce: data collection and reporting forms for the management information system at all levels; manuals with instructions on how to fill in and manage the data collection system, and contraceptive and expendable supplies; guidelines for utilization of data from the management information system to identify and resolve problems; materials (curriculum modules and handouts) for training service providers and supervisors in the implementation and use of the MIS and management of contraceptive supplies.

C. Activities

The LMISS will conduct the following activities to achieve the expected outputs and results:

- in collaboration with the MOH and NFWC, establish a working group for the development of an MIS and logistics system for child spacing and HIV/AIDS prevention;

- o assess the contraceptive procurement and distribution situation, needs and problems in the public sector, i.e., Ministry of Health;
- o conduct a needs assessment regarding future needs for contraceptive procurement and distribution for other prospective service providers, such as other ministries, parastatals, private sector enterprises and NGOs;
- o prepare a strategy for up-grading contraceptive procurement and distribution in the public, private and NGO sectors, and to address the needs for the HIV/AIDS prevention program;
- o develop prototype management information system forms for discussion at the national and subnational levels;
- o prepare and implement a strategy for pre-testing the MIS forms and reporting procedures and, based on pre-test results, revise the forms;
- o prepare a strategy for large-scale implementation and training for the MIS and contraceptive logistics systems;
- o assist key implementing agencies, e.g., NFWC, MOH, private sector entities and NGOs in implementing the MIS and logistics system;
- o assist policy-makers, managers and other decision-makers in utilizing information from these systems;
- o identify related technical assistance needs and prepare scopes of work for short-term, complementary assistance required; and
- o assist in systems monitoring and resolving problems.

D. Roles and Responsibilities

The LMISS reports to the Chief of Party of the IC. S/he works with the appropriate operational and technical staff of the MOH, CHAM and other service provider organizations on a day-to-day basis. S/he will supervise consultants financed by the IC to provide assistance in contraceptive logistics and MIS.

E. Qualifications Required/Desired

Education: Advanced training in management in the health field (public health, public administration with public health, MBA with public health experience).

Experience: At least three years experience in contraceptive logistics management in developing countries, preferably in Africa; experience in the implementation of family planning programs through government infrastructures in developing countries; experience in field level assessment of management systems and effective resolution of problems.

Language: Fluency in English; Chichewa helpful.

Specific Skills: Strong skills in management and logistics systems; strong skills in training and preparation of instruction manuals. Proven ability to work well with other people and to adapt to difficult living and working conditions; ability to work well on his/her own.

VS DOC: 1835D

STAFH PROJECT MANAGER

(Personal Services Contractor)

STATEMENT OF WORK

A. Objective

The STAFH Project Manager will assist USAID/Malawi in carrying out its responsibilities for implementation of STAFH, the procurement of goods and services, and in monitoring project activities and accomplishments being carried out by the Ministry of Health, FHI/AIDSCAP, the Institutional Contractors, and other Ministries, para-statals, private sector organizations and NGOs implementing project components.

B. General Duties

The STAFH Project Manager will work under the supervision of the Mission Health and Population Officer and manage the day-to-day implementation and coordination of all project elements. S/he will monitor and guide the performance of all STAFH project implementation agents, with particular priority on the Institutional Contractor and FHI/AIDSCAP.

C. Specific Duties and Responsibilities

1. Develop and reach agreement with the responsible parties on format and content for strategies, annual workplans and reporting requirements. Review workplans and give feedback on needed changes.

2. Monitor STAFH project progress in relation to work plans and budgets, as well as overall project objectives, through progress reports, regular meetings with Chiefs of Party and frequent site visits.

3. Provide guidance to responsible officials and keep GOM, FHI/AIDSCAP, the Institutional Contractor and USAID officials appraised of actions required by STAFH.

4. Compile technical specifications and arrange for procurement of goods and services required under the project.

5. Prepare required USAID project implementation documents, including Project Implementation Letters (PILs), project amendments, PIO/Ts, PIO/Ps, PIO/Cs, and OYB transfer documentation.

6. Coordinate the schedule of activities of all parties with STAFH implementation responsibilities, e.g., IC, FHI/AIDSCAP, RAPID IV, AVSC, and DHS.

7. Assist GOM, FHI/AIDSCAP, the Institutional Contractor and USAID in completing timely financial and program reporting through frequent contact with offices implementing STAFH activities. Monitor financial reports and track expenditures per MACS.

8. Arrange and coordinate technical reviews and scheduled project evaluations.

9. Prepare and respond to letters, faxes, cables and other requests for information or assistance as necessary.

10. Monitor project files and records per USAID regulations.

11. Assist the Mission in maximizing the impact of A.I.D. support to the health sector by helping to coordinate USAID bilateral assistance with other donor-funded assistance to the health sector.

12. Other duties pertaining to the operations of the HPN office as assigned.

D. Reports

The STAFH Project Manager will have primary responsibility for drafting the biannual Project Implementation Reports (PIRs), including the collection and analyses of information pertaining to all project outputs, and preparing special reports as required.

E. Qualifications

1. Education: At least masters level degree in public health or related, relevant field.

2. Experience: Three to five years experience working in health or social sector projects in the developing world, with preference for Africa. Demonstrated competence in management and technical work in the health sector. Residential experience in the developing world with public sector project management and implementation, preferably working in the health sector on AID-funded projects. Experience with A.I.D. in-house project implementation and documentation highly desired.

3. Special Skills: Expertise in planning, management and evaluation of health service delivery systems. Word and data processing expertise. Ability to write clearly and concisely in English. Ability to work well with a wide variety of people.

VS DOC: 1811D

COMMODITIES LIST

ITEM	QTY	PROBABLE SOURCE/ ORIGIN	PROCURING ENTITY	AMOUNT IN U.S. DOLLARS
Residential Furniture, appliances and equipment for LT technicians and PSC	8 sets	000/899	USAID-1 IC-4 FHI-3	272,000
Executive Desks, wooden, 30" x 60", with computer height returns	17 ea	000/899	USAID-1 FHI-8 IC-8	8,500
Secretarial Desks, wooden with typewriter height return	4 ea	000/899	FHI-2 IC-2	2,000
Executive Swivel Chairs	17 ea	000/899	USAID-1 FHI-8 IC-8	4,500
Visitor Chairs	40 ea	000/899	USAID-2 FHI-20 IC-18	8,000
Operator Task Chairs	4 ea	000/899	IC-2 FHI-2	800
Conference Tables	2 ea	000/899	IC-1 FHI-1	1,400
Conference Room Chairs	30 ea	000/899	IC-15 FHI-15	4,500
File Cabinets, metal, 4 drawer, legal size, locking	20 ea	000/899	USAID-2 IC-10 FHI-8	5,000
Printer stand with paper basket, 30" x 30"	19 ea	000/899	USAID-1 FHI-8 IC-10	3,800
Calculators, desk top, printing	19 ea	935	USAID-1 IC-10 FHI-8	1,900

Photocopiers, 220V/50HZ high capacity with reduction/enlargement, 10 bin collator, stapler, color copying and automatic document feeder, European trays	2 ea	935	IC-1 FHI-1	21,000
Typewriters, electric, English keyboards, 220V/50HZ	8 ea	935	USAID-1 FHI-4 IC-3	8,000
Computers, 386DX, IBM compatible, 120MB, 1.2 MB 5.25" and 1.44 MB 3.5" diskette drives, 25 MHZ, 8 MB RAM, Color VGA monitors, latest DOS, 220V/50HZ software (includes replacements)	24 ea	000	IC-14 FHI-10	96,000
Computers, 386 SX, IBM compatible, 80MB hard disks, 25MHZ 1.2 MB 5.25" and 1.44 MB 3.5" diskette drives, 4 MB RAM, VGA or SVGA color cards and monitors, latest DOS, 220V/50HZ (includes replacements)	14 ea	000	USAID-2 FHI-6 IC-6	42,000
Printers, letter quality, dot matrix, equal to Epson LQ 1500 with printer cables, 220V/50HZ (includes replacements)	24 ea	000	IC-14 FHI-10	19,200
Printers, Laser, 4 MB RAM equal to Hewlett Packard LJ IIID with printer cables and printer sharer cables, 220V/50HZ with font collection (includes replacements)	14 ea	000	USAID-2 IC-6 FHI-6	35,000
Uninterruptible Power Supplies, 1000 watt capacity, 15 min. supply, 220V/50HZ	19 ea	000	USAID-1 IC-10 FHI-8	17,100

Wordperfect, V 5.1, or latest (includes updates)	19 ea	000	USAID-1 IC-10 FHI-8	7,600
Lotus 1-2-3, latest version	18 ea	000	USAID-2 IC-8 FHI-8	9,500
Anti-Viral Software D-Base IV or equal Graphics package	10 ea 10 ea 10 ea	000	USAID-2 IC-4 FHI-4	1,000 5,500 5,000
Vehicles, utility, RHD, 4 door, 7-9 seats, 4 x 4 manual, diesel or T-diesel, air/heat, equal to Mitsubishi Pajero (includes replacements as and when needed)	18 ea	935	USAID-10 IC-4 FHI-4	430,000
Vehicle, wagon, 5-6 passengers, gasoline, 4 cylinder manual, air/heat equal to Toyota or Subaru or Ford (includes replacements as and when needed)	8 ea	935	USAID-4 IC-2 FHI-2	120,000
Minibus, 15 passengers, diesel, PS, PB (includes replacements as and when needed)	4 ea	935	USAID-2 IC-1 FHI-1	60,000
Motorcycles & spare parts	6 ea	935	IC-3 FHI-3	24,000
Bicycles & parts	600 ea	899	IC	150,000
Misc. Office and ADP supplies	Various	000/935	USAID-1 IC-2 FHI-2	60,000
STD Drugs & Controlled Laboratory Supplies, Equipment	3 lots	000	AID/W-1 VA or UNIPAC FHI-2	1,288,000
Laboratory, Clinical and Medical supplies, equipment and furnishings-CS	3 lots	000	IC	431,000

Oral Contraceptives cycles		000	AID/W	1,149,000
Norplant Kits	200 kits	000	AID/W	14,500
Norplant Implants	15,000	000	AID/W	375,000
Foaming Tablets	900,000	000	AID/W	107,000
Condoms (52mm Non-colored)	4 lots	000	AID/W	6,225,000
TOTAL				$11,012,800*

* This total is slightly different than that derived from simple addition of the total costs per individual procuring entity due to rounding off numbers.

N.B. As other contraceptive methods are approved for use, e.g., Depo-Provera, the project may provide these as well.

TOTALS BY PROCURING ENTITY

	USAID	FHI	IC
Estimated Cost of Goods	$ 8,656,130	$1,304,200	$1,052,700
Estimated Shipping, Handling and Insurance (25%)	2,164,033	326,050	263,175
Estimated PSA/RPSO Fees (7%)	605,929	91,294	73,689
Contingency/Inflation (5%)	432,807	65,210	52,635
TOTAL	$11,858,899	$1,786,754	$1,442,199

TOTAL ALL COMMODITIES: $15,087,852

STAFH COMMODITIES LIST - USAID DIRECT PROCUREMENT

ITEM	QTY	END-USER	PROCUREMENT DATE (FY)	AMOUNT (US$)
Residential Furniture, appliances and equipment for PSC	1 set	PSC	93	34,000
Executive Desks, wooden, 30" x 60", with computer height returns	1 ea	PSC	93	500
Executive Swivel Chairs	1 ea	PSC	93	270
Visitor Chairs	2 ea	PSC	93	400
File Cabinets, metal, 4 drawer, legal size, locking	2 ea	PSC IC-2	93	500
Printer stand with paper basket, 30" x 30"	1 ea	PSC	93	200
Calculators, desk top, printing	1 ea	PSC	93	100
Typewriters, electric, English keyboards, 220V/50HZ	1 ea	PSC	93	1,000
Computers, 386 SX, IBM compatible, 80MB hard disks, 25MHZ 1.2 MB 5.25" and 1.44 MB 3.5" diskette drives, 4 MB RAM, VGA or SVGA color cards and monitors, latest DOS, 220V/50HZ (includes replacements)	2 ea	PSC	93	6,000

Printers, Laser, 4 MB RAM equal to Hewlett Packard LJ IIID with printer cables and printer sharer cables, 220V/50HZ with font collection (includes replacements)	2 ea	PSC	93 96	5,000
Uninterruptible Power Supplies, 1000 watt capacity, 15 min. supply, 220V/50HZ	1 ea	PSC	93	900
Wordperfect, V 5.1, or latest (includes updates)	1 ea	PSC	93	400
Lotus 1-2-3, latest version	2 ea	PSC	93	1,060
Anti-Viral Software D-Base IV or equal Graphics package	2 ea 2 ea 2 ea	PSC	93	200 1,100 1,000
Vehicles, utility, RHD, 4 door, 7-9 seats, 4 x 4 manual, diesel or T-diesel, air/heat, equal to Mitsubishi Pajero (includes replacements as and when needed)	10 ea	PSC-2 IC-4 FHI-4	93 96	239,000
Vehicle, wagon, 5-6 passengers, gasoline, 4 cylinder manual, air/heat equal to Toyota or Subaru or Ford (includes replacements as and when needed)	4 ea	IC-2 FHI-2	93 96	60,000
Minibus, 15 passengers, diesel, PS, PB	2 ea	IC-1 FHI-1	93	30,000
Misc. Office and ADP supplies	Various	PSC	93-98	4,000
STD Drugs and Controlled Laboratory Supplies, Equipment	1 lot	FHI	93	400,000

Oral Contraceptives	cycles	GOM	93-98	1,149,000
Norplant Kits	200 kits	GOM	93-98	14,500
Norplant Implants	15,000	GOM	93-98	375,000
Foaming Tablets	900,000	GOM	93-98	107,000
Condoms (52mm Non-colored)	4 lots	GOM	93 94 96 98	6,225,000
TOTAL:				$8,656,130

STAFH COMMODITIES LIST - IC DIRECT PROCUREMENT

ITEM	QTY	END-USER	PROCUREMENT DATE (FY)	AMOUNT (US$)
Residential Furniture, appliances and equipment for LT technicians	4 ea	IC	93	136,000
Executive Desks, wooden, 30" x 60", with computer height returns	8 ea	IC	93	4,000
Secretarial Desks, wooden with typewriter height return	2 ea	IC	93	1,000
Executive Swivel Chairs	8 ea	IC	93	2,100
Visitor Chairs	18 ea	IC	93	3,600
Operator Task Chairs	2 ea	IC	93	400
Conference Table	1 ea	IC	93	700
Conference Room Chairs	15 ea	IC	93	2,300
File Cabinets, metal, 4 drawer, legal size, locking	10 ea	IC	93	2,500
Printer stand with paper basket, 30" x 30"	10 ea	IC	93	2,000
Calculators, desk top, printing	10 ea	IC	93	1,000
Photocopiers, 220V/50HZ high capacity with reduction/enlargement, 10 bin collator, stapler, color copying and automatic document feeder, European trays	1 ea	IC	93	10,500
Typewriter, electric English keyboards, 220V/ 50HZ	3 ea	IC	93	3,000

Computers, 386DX, IBM compatible, 120MB, 1.2 MB 5.25" and 1.44 MB 3.5" diskette drives, 25 MHZ, 8 MB RAM, Color VGA monitors, latest DOS, 220V/50HZ software (includes replacements)	14 ea	IC	93 96	56,000
Computers, 386SX, IBM compatible, 80 MB hard disks, 25MHZ 1.2 MB 5.25" and 1.44 MB 3.5" diskette drives, 4 MB RAM, VGA or SVGA color cards and monitors, latest DOS, 220V/50HZ (includes replacements)	6 ea	IC	93 96	18,000
Printers, letter quality, dot matrix, equal to Epson LQ 1500 with printer cables, 220V/50HZ (includes replacements)	14 ea	IC	93 96	11,200
Printers, Laser, 4 MB RAM equal to Hewlett Packard LJ IIID with printer cables and printer sharer cables, 220V/50HZ with font collection (includes replacements)	6 ea	IC	93 96	15,000
Uninterruptible Power Supplies, 1000 watt capacity, 15 min. supply, 220V/50HZ	10 ea	IC	93	9,000
Wordperfect, V 5.1, or latest (includes updates)	10 ea	IC	93	4,000
Lotus 1-2-3, latest version	8 ea	IC	93	4,200
Anti-Viral Software	4 ea	IC	93	400
D-Base IV or equal	4 ea			2,200
Graphics package	4 ea			2,000

Vehicles, utility, RHD, 4 door, 7-9 seats, 4 x 4 manual, gasoline engine, diesel or T-diesel, air/heat, equal to Mitsubishi Pajero (includes replacements as and when needed)	4 ea	IC	96	95,600
Vehicle, wagon, 5-6 passengers, gasoline, 4 cylinder manual, air/heat equal to Toyota or Subaru or Ford (includes replacements as and when needed)	2 ea	IC	96	30,000
Minibus, 15 passengers, diesel, PS, PB (includes replacements in year 4)	1 ea	IC	96	15,000
Motorcycles and spare parts	3 ea	IC	94	12,000
Bicycles & parts	600 ea	IC/GOM	93 96	150,000
Misc. Office and ADP supplies	Various	IC	93-98	28,000
Laboratory, Clinical & Medical supplies, equipment and furnishings-CS	3 lots	IC	93 95 96	431,000
TOTAL:				$1,052,700

STAFH COMMODITIES LIST - FHI DIRECT PROCUREMENT

ITEM	QTY	END-USER	PROCUREMENT DATE (FY)	AMOUNT (US$)
Residential Furniture, appliances and equipment for LT technicians	3 sets	FHI	93	102,000
Executive Desks, wooden, 30" x 60", with computer height returns	8 ea	FHI	93	4,000
Secretarial Desks, wooden with typewriter height return	2 ea	FHI	93	1,000
Executive Swivel Chairs	8 ea	FHI	93	2,100
Visitor Chairs	20 ea	FHI	93	4,000
Operator Task Chairs	2 ea	FHI	93	400
Conference Tables	1 ea	FHI	93	700
Conference Room Chairs	15 ea	FHI	93	2,300
File Cabinets, metal, 4 drawer, legal size, locking	8 ea	FHI	93	2,000
Printer stand with paper basket, 30" x 30"	8 ea	FHI	93	1,600
Calculators, desk top, printing	8 ea	FHI	93	800
Photocopiers, 220V/50HZ high capacity with reduction/enlargement, 10 bin collator, stapler, color copying and automatic document feeder, European trays	1 ea	FHI	93	10,500
Typewriters, electric, English keyboards, 220V/50HZ	4 ea	FHI	93	4,000

Computers, 386DX, IBM compatible, 120MB, 1.2 MB 5.25" and 1.44 MB 3.5" diskette drives, 25 MHZ, 8 MB RAM, Color VGA monitors, latest DOS, 220V/50HZ software (includes replacements)	10 ea	FHI	93 96	40,000
Computers, 386 SX, IBM compatible, 80MB hard disks, 25MHZ 1.2 MB 5.25" and 1.44 MB 3.5" diskette drives, 4 MB RAM, VGA or SVGA color cards and monitors, latest DOS, 220V/50HZ (includes replacements)	6 ea	FHI	93 96	18,000
Printers, letter quality, dot matrix, equal to Epson LQ 1500 with printer cables, 220V/50HZ (includes replacements)	10 ea	FHI	93 9	8,000
Printers, Laser, 4 MB RAM equal to Hewlett Packard LJ IIID with printer cables and printer sharer cables, 220V/50HZ with font collection (includes replacements)	6 ea	FHI	93 96	15,000
Uninterruptible Power Supplies, 1000 watt capacity, 15 min. supply, 220V/50HZ	8 ea	FHI	93 95	7,200
Wordperfect, V 5.1, or latest (includes updates)	8 ea	FHI	93	3,200
Lotus 1-2-3, latest version	8 ea	FHI	93	4,200
Anti-Viral Software	4 ea	FHI	93	400
D-Base IV or equal	4 ea		93	2,200
Graphics package	4 ea		93	2,000

300

Vehicles, utility, RHD, 4 door, 7-9 seats, 4 x 4 manual, diesel or T-diesel, air/heat, equal to Mitsubishi Pajero (includes replacements as and when needed)	4 ea	FHI	96	95,600
Vehicle, wagon, 5-6 passengers, gasoline, 4 cylinder manual, air/heat equal to Toyota or Subaru or Ford (includes replacements as and when needed)	2 ea	FHI	96	30,000
Motorcycles and spare parts	3 ea	FHI	93	12,000
Minibus, 15 passengers, diesel, PS, PB (includes replacement as and when needed)	1 ea	FHI	96	15,000
Misc. Office and ADP supplies	Various	FHI	93-98	28,000
STD Drugs & Controlled Laboratory Supplies, Equipment	2 lots	FHI	95 96	888,000
TOTAL:				$1,304,200

ANNEX J

CONTRACEPTION: COMMODITY NEEDS, COSTS AND USERS BY METHOD

CONTRACEPTIVE COMMODITIES NEEDS AND COSTS

	1992		1993		1994		1995		1996		1997		1998		1999		2000	
	# Needed	Cost $	# Needed	Cost $	# Needed	Cost $	# Needed	Cost $	# Needed	Cost $	# Needed	Cost $	# Needed	Cost $	# Needed	Cost $	# Needed	Cost $
ORALS	427,000	84,000	458,000	90,000	492,000	97,000	527,000	104,000	564,000	141,000	623,000	155,000	685,000	171,000	750,000	187,000	819,000	204,000
IUDS	3,000	4,000	3,000	4,000	3,000	4,000	3,000	4,000	3,000	4,000	4,000	7,000	6,000	9,000	6,000	10,000	7,000	11,000
CONDOMS	3,985,000	262,000	5,278,000	348,000	6,733,000	442,000	8,363,000	549,000	10,151,000	802,000	11,246,000	856,000	12,366,000	974,000	13,548,000	1,067,000	14,790,000	1,166,000
FOAMING TABLETS	583,000	77,000	646,000	85,000	714,000	94,000	788,000	103,000	867,000	137,000	958,000	151,000	1,054,000	166,000	1,154,000	182,000	1,260,000	198,000
TOTAL		427,000		525,000		637,000		760,000		1,084,000		1,169,000		1,320,000		1,446,000		1,579,000
GRAND TOTAL	96,976,000																	
INJECTIBLES (NOT INCLUDED IN STAFH)	93,000	97,000	117,000	123,000	144,000	151,000	174,000	183,000	208,000	279,000	243,000	326,000	281,000	376,000	323,000	433,000	370,000	496,000

COST INFORMATION		
	1992–1995	*1996–2000*
Cost per Cycle	*0.15*	*0.19*
Cost per Condom	*0.05*	*0.06*
Injectable	*0.80*	*1.02*
Foaming Tablets	*0.10*	*0.12*
IUD	*0.96*	*1.23*
Inflation Rate	*5.00*	*5.00*
Shipping/Handling	*25.00%*	*25.00%*

SOURCE: Atkinson, B., "Logistics Systems and Contraceptive Supply Status Review", Jan–Feb 1992

PROJECTED CONTRACEPTIVE USERS BY METHOD

ORALS

YEAR	ATKINSON	JOHNSTON LOW	JOHNSTON HIGH
1992	29,000	20,000	29,000
1993	31,000	23,000	33,000
1994	33,000	27,000	38,000
1995	35,000	31,000	45,000
1996	38,000	35,000	52,000
1997	42,000	39,000	59,000
1998	46,000	42,000	66,000
1999	50,000	46,000	73,000
2000	55,000	50,000	81,000

IUDs

YEAR	ATKINSON	JOHNSTON LOW	JOHNSTON HIGH
1992	7,000	2,000	7,000
1993	7,000	2,000	8,000
1994	7,000	3,000	9,000
1995	7,000	3,000	10,000
1996	8,000	4,000	11,000
1997	9,000	4,000	13,000
1998	10,000	5,000	15,000
1999	12,000	5,000	17,000
2000	14,000	5,000	19,000

CONDOMS

YEAR	ATKINSON	JOHNSTON LOW	JOHNSTON HIGH
1992	27,000	38,000	34,000
1993	35,000	48,000	46,000
1994	45,000	60,000	59,000
1995	56,000	75,000	74,000
1996	68,000	82,000	93,000
1997	75,000	90,000	108,000
1998	82,000	100,000	122,000
1999	90,000	109,000	135,000
2000	99,000	120,000	149,000

FOAMING TABLETS

YEAR	ATKINSON	JOHNSTON LOW	JOHNSTON HIGH
1992	5,000		
1993	6,000		
1994	6,000		
1995	7,000		
1996	8,000		
1997	8,000		
1998	9,000		
1999	10,000		
2000	11,000		

INJECTABLES

YEAR	ATKINSON	JOHNSTON LOW	JOHNSTON HIGH
1992	20,000	12,000	19,000
1993	25,000	16,000	25,000
1994	31,000	20,000	34,000
1995	38,000	24,000	45,000
1996	45,000	29,000	57,000
1997	53,000	33,000	70,000
1998	61,000	37,000	85,000
1999	70,000	41,000	100,000
2000	80,000	46,000	116,000

FEMALE STERILIZATION				
YEAR	ATKINSON	JOHNSTON LOW	JOHNSTON HIGH	AVSC
1992	6,000	2,000	6,000	
1993	7,000	2,000	7,000	2,000
1994	9,000	3,000	9,000	2,000
1995	11,000	3,000	12,000	3,000
1996	13,000	4,000	15,000	3,000
1997	14,000	4,000	18,000	4,000
1998	16,000	5,000	21,000	5,000
1999	19,000	5,000	25,000	6,000
2000	21,000	5,000	28,000	7,000

MALE STERILIZATION				
YEAR	ATKINSON	JOHNSTON LOW	JOHNSTON HIGH	AVSC
1992	0			
1993	0			0
1994	0			0
1995	0			0
1996	0			0
1997	0			0
1998	0			0
1999	0			0
2000	0			0

NORPLANT				
YEAR	ATKINSON	JOHNSTON LOW	JOHNSTON HIGH	AVSC
1992		0	0	
1993		0	0	0
1994		0	0	0
1995		1,000	1,000	1,000
1996		1,000	1,000	1,000
1997		1,000	2,000	2,000
1998		2,000	3,000	3,000
1999		3,000	4,000	3,000
2000		4,000	6,000	4,000

SOURCE: Atkinson, B., "Logistics and Contraceptive Supply Status Review". Jan–Feb 1992
SOURCE: Johnston, A., "Costs and Benefits of the Child Spacing Programme in Malawi", Feb 1992
SOURCE: Lynam, P., "Malawi Child Spacing Program: Permanent and Long–Term Contraception, AVSC Input to USAID Planning to the Year 2000", April 1992

Projected Contraceptive Prevalence Rate (Modern Methods) by the Year 2000:

SOURCE: Johnston, A. : 17.6%
SOURCE: Atkinson, B. : 14%

TRAINING PLAN

AIDSCAP and the institutional contractor are expected to prepare annual detailed training plans after consultations with the Ministry of Health, NFWC and AIDS SEC. The plans will be the result of collaboration with these agencies and will incorporate, to the extent possible and practicable, both AIDS and CS components.

Training needs that have been identified to date include the following, broken down by component or target group.

I. AIDS/HIV/STD COMPONENT

YOUTH

Teacher training in introducing AIDS curriculum.

Skills training for community-level workers in youth outreach (communications, counselling, correct condom use, STD definition and referral, program management and condom logistics management).

Skills training for staff at MOH and CHAM hospitals and clinics (communications, counselling, correct condom use, STD diagnosis and treatment skills, as well as social marketing skills and program management skills).

EMPLOYED MALES

Train educators in prevention education and counselling skills for males in the workplace.

Train counselors in couple counselling, including facilitating behavior change in primary relationships.

Train materials developers in developing, pretesting and producing materials for low-literacy audiences.

Train private sector clinics in condom logistics management.

Train worksite clinic officers, and staff and counselors in STD management skills upgrading.

Train volunteers and community leaders in community-based AIDS education and counselling through a peer education model, including skills upgrading (personal motivation, trusted persuasion, using local resources).

MALE STD CLIENTS

Training of trainer (TOT) skills upgrading of regional health teams for STD management.

Train lab technicians in skills upgrading of STD diagnosis based on symptoms rather than laboratory testing.

Train hospital parahealth professionals in AIDS prevention education.

Train community outreach peer educators in STD/HIV management and treatment.

BAR GIRLS/BAR OWNERS/FREE LANCERS

Training of trainers in peer education communications and counselling skills development, including condom negotiation skills, self-care and correct condom use.

Train District Health Inspectors to improve skills in STD case management, counselling and communications.

Train business management in condom logistics and marketing of "condom only" bars.

Training of trainers for peer educator training for community outreach to unregistered bar girls and free lancers.

CAPACITY BUILDING

Training of trainers to develop training capacity within the AIDS SEC and regional/district health management teams (training, planning, design, delivery systems and evaluation).

Training of trainers within AIDS SEC and regional/district health teams to establish HIV prevention counselling capacity (managed system of counselors, risk history assessment, facilitating risk reduction, strategic planning for behavior change and individual and group support).

Training of trainers within AIDS SEC and regional/district health teams to establish community mobilization capacity to develop grassroots community-based organizations, sustain networks of peer leaders and educators, facilitate support groups and plan outreach capacity.

Training of trainers within AIDS SEC and Central Medical Stores to improve condom logistics management and reporting at the district level.

Train on-the-bench lab technicians for STD diagnosis and epidemiological surveillance.

Conduct an operations research workshop for the Malawi Medical School and Chancellor College Center for Social Research.

Conduct policy analyses and develop strategic policy planning.

II. POPULATION/CHILD SPACING COMPONENT

A. Overview

The expansion of child spacing service delivery points envisioned in this project will require a large volume of training activities. To the extent feasible, most training will occur in-country and as close to the workplace as possible. Given staffing constraints, training courses must be efficient and focus on the most essential knowledge and skills so staff and trainers are absent from their service delivery responsibilities for a minimum amount of time. At the same time, to ensure high quality services, training must be competency-based and periodic refresher training must be provided.

B. General Strategy

To facilitate implementing competency-based training critical to a rapid expansion of child spacing services, the project will initially develop standard training materials for use by all organizations interested in implementing child spacing services.

The project will support preparation of training modules in such areas as counselling skills, standards of care, contraceptive technology, management of clients for various methods contraceptive logistics and record-keeping, etc. Modules would include evaluation procedures to ensure competence in key skills. Trainers would select modules relevant to specific trainee needs, although child spacing curricula would always include one or more modules on STD/HIV prevention. Modules would include audio-visual materials, handout suggestions and tips to trainers. STAFH TA will also help develop and institute modules for training of trainers (TOT) for NGOs, private sector, and district and regional levels, and prepare methodologies and training in adapting modules to meet particular needs. In addition, as systems are developed, e.g., for logistics and MIS, then training modules would be prepared and added to the "bank" of training materials.

C. Components of this Strategy

1. Curriculum Development for CS Provider Training: In collaboration with PHICS, STAFH will support integrating child spacing into the pre-service curricula of all health service providers through curricula revision and training of tutors, and revise the in-service child spacing training curricula for mid-level service providers with a view towards reducing the course duration from twelve weeks to four weeks. This will increase the number of trainees who can be trained during the year by any one center. IEC skills, counselling, VSC and Norplant information will be emphasized in these revisions.

2. Support Service Provider Training: The project will support in-service training for core and community service providers. Some cadres will also need specialized training and refresher training, such as pharmacists, supervisors, program managers and central and regional staff responsible for contraceptive management.

3. U.S. and Third Country Training: STAFH will reserve resources to support specialized professional training in the U.S. or a third country over the LOP. Surgical contraception training will be managed and conducted within the add-on to AVSC. STAFH will utilize CAFS/Nairobi to train senior program managers from various ministries and NGOs. Specific mid-level program manager technical training (data management, MIS, logistics, planning, etc.) will be considered annually within the project training plan.

D. Summmary of Training Requirements for Core CS Services

1. In order to staff new service delivery points with two trained providers, and train at least one other staff member for already functioning sites (staffed only with one trained provider), it is estimated that the MOH will require 360 staff to be trained in core child spacing services (four-week program). In addition, each staff will require two one-week refresher training programs.

2. Organizations which will integrate core child spacing into their present health service sites (other Ministries, CHAM, NGOs and private sector) will need to train at least two service providers per site. These staff, as well as those already trained and providing services, e.g., in the 18 CHAM sites, will also need refresher training, estimated at two over the LOP.

3. During the LOP, if 15 providers are trained in each course, at least 50 four-week training courses would be required to train all of the fixed facility providers identified above. Given that there are four family health training centers, and that they will also be delivering refresher training courses, as well as involved in curriculum development (module preparation) and training of trainers, it is unlikely that these centers will be able to meet all of the needs for core training. The project will explore providing assistance to several CHAM training centers to conduct up to two courses per year, to relieve the burden on the MOH centers.

E. Summmary of Training Requirements for CBD CS Services

1. STAFH will provide assistance to test CBD models using TBAs. Once an appropriate model is identified, CBD agents, their supervisors and their trainers will require training to expand the program for an estimated five teams per district, with ten CBD agents per team. A total of 1,200 HSAs as male motivators and 360 TBAs as distribution agents would be trained or retrained. An AIDS/STD/HIV training component will be included in the CBD training sessions. It is anticipated that these agents would be trained by their supervisors, the EN/Ms and/or MAs, with the assistance of the DHO MCH/CS supervisor (also trained as a CS CBD trainer).

2. In addition, two to three days of refresher training would be needed each year.

3. Supervisors will be trained as trainers by the district and regional level trainers (master trainers and/or resource trainers) and assisted to use the modules to prepare a training course appropriate to the particular needs of the community workers. Supervisor/trainers would then plan and implement training program(s) for CBD agents in specific areas. Service providers will assist in training these agents during afternoons when work load is considerably lighter. CS CBD will be complex and difficult and will require much thought on how to proceed during the initial 18 months of the project.

4. Through its subgrant program, this project will support CBD training for interested community members by CHAM, NGOs and the private sector. The numbers trained will depend on grant submissions. STAFH will also support CBD training for up to 300 agents in other ministries.

5. Most CBD agents, particularly those trained for private sector and NGO programs, will be trained and supervised by staff linked with the Ministry of Health static facilities. Following the model used at Ekwendeni, homecraft workers would also be trained as field supervisors. Staff and District MCH/CS supervisors will be trained at Family Health centers as trainers and supervisors, and will need refresher training during the course of the project. Once the CBD program gets started, each district will have responsibility for basic CBD agent training and refresher training programs over a six-year implementation period (year one of project for pilot testing and preparation).

RESEARCH PLAN

I. AIDS/HIV/STD COMPONENT

A. PRE-IMPLEMENTATION

1. Baseline KAP survey of students.
2. Develop and test STD protocols and treatment regimens.
3. Case-control study of men presenting at STD clinics.
4. Rapid qualitative assessments of youth and employed males as a pre-requisite to developing implementation strategies.

B. IMPLEMENTATION

1. Rapid formative and baseline research to develop radio programs and print materials for condom use/behavior change study.
2. Rapid formative and baseline research of male KAPB about AIDS/HIV/STD to guide materials and program development including interpretations of casual sex, patterns of alcohol use, and motivators and barriers to low-risk sexual behaviors.
3. Rapid formative and baseline research on employed males to guide program development.
4. Economic cost-benefit analysis of upgrading STD service delivery.
5. Rapid formative and baseline research on characteristics of STD patients.
6. Rapid formative and baseline research to guide materials and program development for bar girls (registered and non-registered) and free lancers.
7. Study the effectiveness and impact of regular spermicide use among bar girls.
8. Test simple, inexpensive and field-appropriate STD diagnostic laboratory tests, evaluating performance charateristics and cost effectiveness.

9. Evaluate impact of HIV infection on the presentation, natural history, diagnosis and response to therapy of specific STD.

10. Controlled trials of STD patients using clinics as the unit of randomization to test the impact of comprehensive prevention programming in promoting client access, return, compliance with treatment and contact tracing.

11. Interaction of alcohol in obtaining commercially available sex and practicing high risk sexual behavior.

12. Study the impact and effectiveness of periodic mass treatment of bar girls.

II. POPULATION/CHILD SPACING COMPONENT

Operations research will be conducted in collaboration with external technical advisors and local Malawian counterparts. The following listed topics have been identified as research needs.

A. Male involvement in child spacing.

B. Community-based distribution motivation for child spacing (incentives).

C. Patient flow/clinic operations.

D. Integration of child spacing and HIV prevention and control.

E. Assessment of child spacing program impact (e.g. Demographic and Health Surveys).

F. HIS/MIS development.

G. The role of the physical examination requirement in discouraging use of oral contraceptives.

III. Integrated

A. Social soundness research

1. The incidence and prevalence of adolescent and out-of-wedlock pregnancy (there is clearly some overlap between these two categories), with particular attention to the social and economic position of unwed, teen-age mothers. In this context the extent to which young women who are neither bar girls nor (free lancers seek and accept financial inducements in exchange for sex should be documented.

2. The implications of polygamy and frequent divorce and remarriage, as well as leviratic marriage and the institution of the "hyena", implying multiple sexual partners within legally-constituted marriage, and the risks these institutions impose for HIV/STD transmission and unwanted pregnancy.

3. The extent of economic and sexual transactions between Malawians and Mozambican refugees. Both marriage and commercial sex should be examined and the potential for HIV/STD transmission to both genders in both populations explored.

4. The dimensions of the potential population of AIDS orphans and strategies for assisting orphaned and fostered children at the community level. The Ugandan experience with war and AIDS orphans has shown systematic discrimination against fostered children; for example, even in high-resource households these children are deprived of educational opportunity and exploited for their labor. Since there are likely to be 400,000 children in Malawi by the end of the century who will have lost one or both parents to AIDS, assessment of the capacity of rural households to absorb additional dependents, and the evolving attitudes of adults towards foster children, is an urgent issue.

5. Intensive, high-quality ethnographic research on the knowledge, roles and responsibilities of asinganga, anankungwi, and alangizi is needed, as a basis for establishing the extent to which these practitioners can become part of an HIV/child spacing IEC network. Information is also needed on the type of clientele they serve (age groups, gender, ethnicity) and the kinds of treatments they provide, particularly for STDs and other reproductive problems.

6. Although it will be extremely difficult to assess, in view of the anxieties expressed by parents and teachers that the availability of child spacing and HIV-preventive commodities contributes to promiscuity, particularly among young people, this putative relationship must be explored. Perhaps a controlled comparison between two rural areas, one with reasonable access to an extisting service-providing facility and another without such access but comparable in socio-economic and ethnic characteristics could provide the basis for research strategy.

7. More information is needed on decision-making privileges and responsibilities for men and women, particularly with reference to sexual, reproductive, and child spacing matters.

8. Research in Kenya has suggested that the sexual partners of teenage mothers are most likely to come from among their agemates and classmates than from among older men. Nonetheless, popular stereotypes of the "sugardaddy" as the "spoiler" of adolescents remain. The extent to which young girls are impregnated by older, affluent men, and also the extent to which accepting financial rewards for casual or long-term sexual relationships in urban and rural areas needs to be examined.

9. Research on the capabilities of NGOs in Malawi as research organizations, service providers, and channels for IEC on child spacing and HIV/STD should be undertaken, perhaps in conjunction with EIL or the SHARED project.

B. Other

1. Assess private sector and MOH capacity to produce IEC/health education materials.

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INVENTORY OF DONOR ASSISTANCE FOR AIDS PREVENTION AND POPULATION/CHILD SPACING ACTIVITIES in MALAWI

I. UNITED NATIONS AGENCIES

A. United Nations Fund for Population Assistance (UNFPA)

1. Population/Child Spacing

UNFPA is the designated lead donor in the population sector, particularly regarding population policy issues. However, recent funding constraints have led UNFPA to curtail some elements of its planned program.

UNFPA provides, in its 1992-1996 Country Programme Plan, for activities in three main areas: Information, Communication and Education (IEC), policy issues and research, and support to both the Ministry of Health and the National Family Welfare Council (NFWC).

UNFPA has budgeted between $2 to 3.2 million for 1992-96 to various IEC projects, including support to MOH, the Ministry of Women, Children and Community Services (MOWCCS), the Department of Information, the Ministry of Agriculture, and the Ministry of Education and Culture.

Two projects are within MOWCCS: one in parent education and one incorporating family life education into the curricula for adult literacy teachers and homecraft workers. The Department of Information has developed materials on family life education in a variety of media (from comic books to videos) targeted to parents, adult males and adolescents. These materials will be part of a communications campaign conducted by the Department and will be used by other agencies conducting IEC activities.

A pilot project at the Ministry of Agriculture introducing population education into agricultural extension activities demonstrated the validity of this approach and will be extended into the pre-service training programs for agriculture and forestry extension workers. In-service training will prepare extension workers in six districts, the six UNDP Local Impact Areas, to incorporate population education in their activities.

In 1989 the Government of Malawi approved population education in the formal school curricula and, with the Ministry of Education and Culture, UNFPA is developing a project to introduce population and environment education beginning in the primary grades.

With regard to policy issues and research, UNFPA has budgeted approximately $500,000 for 1992-96 for the Population Human Resources Development Unit (PHRDU) of the Economic Planning and Development office within the Office of President and Cabinet. This funding is meant to assist in coordinating population activities and integrating population variables into development research and planning. PHRDU is charged with development of a written population policy in 1992.

For research purposes, UNFPA has allocated approximately $200,000 for 1992-96 to the Demographic Unit at the University of Malawi. This Unit conducts research on various aspects of child spacing and has introduced demography to three institutions within the University.

With regard to NFWC, UNFPA has allocated approximately $500,000 for 1992-96. For 1992-93 UNFPA support will be for local professional and support staff, staff development and training.

At MOH, UNFPA is funding a one-year project in 1992 with a $300,000 allocation. Funding includes support for one Technical Advisor, one Health Educator, TBA training, two days of training for each region (one day on child spacing and one day on safe motherhood) and one UN Volunteer statistician. Using funds committed in 1991 but as yet unspent, UNFPA funding will also support training District Health Officers (funded by UNICEF) and conducting male motivation seminars for civil servants.

UNFPA intends to develop a four-year program of support to MOH's MCH/CS program (1993-1996) to, among otner things, fund continued technical assistance, training, health education and a safe motherhood initiative. Support may be at the $550,000 per year level for a total of $2.2 million. A one year project was developed for 1993 pending revision of the MOH contraceptive guidelines, review of the training for child spacing providers, implementation of NFWC's program and MOH/USAID's specification of activities to be supported by the STAFH project.

B. United Nations Childrens Fund (UNICEF)

1. AIDS Prevention

In the past two years UNICEF has focused on: (1) providing sterilization equipment; (2) developing and producing IEC materials (posters, booklets, leaflets, videos, murals); (3) educating youth in schools (producing school curricula materials and training headmasters and teachers); (4) social mobilization (education of community leaders at the area and

village level, drama group training and performances); (5) training health staff in communication skills and ability to deal with different audiences; (6) developing family and community based care systems for orphans; and (7) education for bar girls.

UNICEF has pledged $1,170,000 for 1992-93 to support IEC production, social mobilization, orphans enumeration and needs assessment, support to NGOs and churches to establish orphan care projects and youth peer groups, and continuing support for the adoption of AIDS school curricula materials.

To date, $239,380 from general resources have been allocated to AIDS and are being utilized while UNICEF is waiting for confirmation of its budget to seek supplementary funding. In the meantime, UNICEF's focus is being re-directed more specifically to two major areas: in-school and out-of-school youth and orphans.

Apart from AIDS control and prevention, the UNICEF 1992-96 program will increase its emphasis on primary health and nutrition, focussing on MCH/CS. UNICEF has planned a budget of $56.8 million for its five year program, with $16.5 million from general resources. Of this total amount, the AIDS program for these five years is allocated $5.85 million ($1,050,000 from general resources and $4.8 million from supplementary funding or, on an annual basis, $210,000 from general resources and $960,000 from supplementary funding).

2. Population/Child Spacing

UNICEF plans to use its area-level briefings and social mobilization officers to disseminate child spacing messages and include child spacing in its Expanded Programme for Immunization (EPI) efforts. Approximately $20,000 has been allocated in 1992 for the Ministry of Health's Health Education Unit to develop and produce appropriate messages. IEC efforts and materials production within the Safe Motherhood/Child Spacing initiative have been allocated $80,000 annually and $50,000 has been allocated to training health provider staff. Training will include instruction in child spacing techniques.

C. United Nations Development Programme (UNDP)

1. AIDS Prevention

UNDP has funded the salaries of national staff and operating costs of the Ministry of Health's AIDS Secretariat. It has pledged $1,230,000 over the next five years to continue support of the National AIDS Control Programme. It will also fund home-based care of persons with AIDS in six local impact areas.

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2. Population/Child Spacing

UNDP has made a small grant to Banjo La Mtsogolo's outreach child spacing program. UNDP has also identified a need to modify and upgrade various health centers to enable them to better provide child spacing activities. As a result of making this determination, UNDP is attempting to locate funding for this activity and, although the United Nations Capital Development Fund has been identified as a potential donor, its participation has not been confirmed.

D. World Health Organization (WHO)

1. AIDS Prevention

Since 1988 the WHO/GPA has supported Malawi's Short and Medium Term Plans for the National AIDS Control Programme. This has included: short-term and long-term technical assistance for laboratory services, administration, epidemiology, counseling and IEC activities; reagents and equipment for HIV testing; vehicles and office equipment; training activities; and support for general and targeted IEC campaigns. For 1992 WHO has committed $968,000 in support of Malawi's AIDS Control Programme, IEC activities, surveillance and control, and continuing laboratory support. Of this commitment, approximately $400,000 is from the annual USAID/Washington grant to the WHO/Global Programme on AIDS.

E. World Bank

1. AIDS Prevention

The Population, Health, and Nutrition (PHN) Sector Credit, negotiated between GOM and the Bank in February 1991 and launched in July 1991, provides $74.3 million over a five year period to support activities in the health sector through co-funding with the European Community, the Netherlands/WHO and GOM. Out of the total amount, approximately $400,000 will be available for the following AIDS control activities: an acceleration of education efforts, acquisition of blood screening equipment, training of health care workers, drugs for treating HIV-related conditions and strengthening the Health Education Unit. An additional $450,000 will be available under a combined malaria/ AIDS control line item for vehicle purchase.

2. Population/Child Spacing

The PHN Sector Credit provides approximately $1,198,000 for population/child spacing in 1991-96 for the following activities: support to the NFWC, including construction of a

building for NFWC; three personnel for the MOH headquarters, although these slots have not yet been filled; upgrading clinic facilities, although the amount allocated is insufficient to upgrade the 12 selected clinics so a smaller number may actually be upgraded; and equipment needs (these are current, not prospective, needs). This funding is broken down into two components: $679,000 for NFWC construction and support and $519,000 for the other activities.

F. European Community (EC)

1. AIDS Prevention

The European Community will continue to support the EC AIDS Control Project within the National AIDS Control Programme. For 1990-93, $740,000 will support the following activities: targeted IEC campaigns for bar girls, truck drivers, STD patients, illiterates and traditional healers; production and distribution of HIV/AIDS materials for the Adult Literacy Programme; production of HIV/AIDS educational materials for the general public; and production of a Peer Educators Manual.

The EC intends to continue to support Malawi's AIDS Control Programme, especially the IEC component, from Lome IV resources. EC has pledged $200,000 for 1992-93 for targeted IEC activities for Traditional Birth Attendants, estate workers and Malawi Young Pioneers.

2. Population/Child Spacing

For 1989-94 EC has budgeted $3 million for child spacing in rural areas through development and dissemination of child spacing messages. This will be accomplished through MOWCCS which established a training activity in child spacing for Community Development Assistants. Six hundred thousand dollars for population/IEC activities were also allocated to the Department of Information. For the future, EC envisions support under the Lome IV Convention (1991-95) for population activities within its commitment to rural agricultural development.

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II. BILATERAL DONORS

A. British Overseas Development Administration (ODA)

1. AIDS Prevention

Via the "multi-bilateral" channel, ODA pledged 250,000 Pounds Sterling for AIDS prevention activities for each of the three years 1989-90, 1990-91 and 1991-92. ODA anticipates contributing 250,000 Pounds Sterling in undesignated funding for HIV/AIDS control activities in 1992-93.

2. Population/Child Spacing

ODA has been providing considerable funding to Banja La Mtsogolo, a Malawian NGO providing contraceptive and other family planning services. Through Marie Stopes International, ODA had designated
162,873 Pounds Sterling for 1988 through 1991/92 for the organizations's original Blantyre clinic. ODA has designated an additional 458,531 Pounds Sterling for 1991 through 1993/94 for an expansion of Banja La Mtsolgolo's services through satellite clinics and 281,412 Pounds Sterling for 1991 through 1993/94 for its expanded male awareness campaign about child spacing.

ODA will also continue supplying contraceptives to the value of 250,000 Pounds Sterling for the next three to five years. This funding is intended to meet all injectable contraceptive needs and, if funds remain available, to meet the need for Norplant. For 1991/92, ODA designated 160,000 Pounds Sterling for contraceptive supplies and purchased Depo-Provera for MOH and a mix of methods for Banja La Mtsogolo.

For 1991 through 1992/93, ODA has pledged 110,311 Pounds Sterling for the NFWC although no call for funding by the NFWC has been made to date, presumably due to delays in NFWC staffing.

B. Japanese International Cooperative Agency (JICA)

1. AIDS Prevention

JICA has previously provided laboratory equipment for blood screening and storage, and vehicles and supplies for the AIDSSecretariat and Regional Health Offices. It has no current plans to support the National AIDS Control Programme.

2. Population/Child Spacing

JICA plans to start a technical cooperation project within the next two years and considers health and population activities priority areas. There are tentative plans for a small scale area-based or district-focussed MCH/FP pilot project with the MOH. JICA would provide technical assistance and training.

C. Canadian International Development Agency (CIDA)

1. AIDS Prevention

CIDA has previously provided funding for technical assistance in developing STD treatment strategies. It has pledged $155,000 to support confidential HIV counseling facilities, IEC materials development (videos) and continued technical assistance for STD control.

D. German Technical Assistance (GTZ)

1. AIDS Prevention

GTZ has previously supported laboratory services and will contribute $450,000 for 1992-93. This will fund one full-time laboratory technical advisor specializing in HIV diagnostics, training costs and laboratory supplies and equipment. The project will train laboratory technicians, develop and implement quality control protocols for HIV testing, establish reference laboratory capability for HIV testing, and support HIV-related research. This will strengthen laboratory testing for HIV and STDs at hospital-based laboratories throughout the country, especially at three sites: Queen Elizabeth's Central Hospital in Blantyre, the CHSU Research Laboratory in Mangochi and the main CHSU in Lilongwe.

SUPPORT TO AIDS AND FAMILY HEALTH

(STAFH)

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EXECUTIVE SUMMARY

This four week assessment of the HIV/AIDS and sexually transmitted disease (STD) situation in Malawi and design for prevention strategies was undertaken in April 1992 for USAID/Malawi as a resource in the design of their new population and AIDS prevention program (the STAFP Project).

HIV infection and AIDS have been reported from virtually every district in Malawi. Analysis of existing data indicates that the demographics of HIV infection in Malawi is similar to other African countries - high rates (over 10%) of HIV infection in urban and semi-urban areas, women infected at younger ages then men, and skilled workers more likely infected that unskilled workers. Cumulative adult AIDS cases are expected to reach 400,000 to 500,000 by the year 2000. The number of new annual tuberculosis cases is expected to increase five times by the year 2000. The population growth rate is expected to slow from about 3% per annum to 2.0 to 2.3% due to AIDS in the year 2000. The loss of potential income due to AIDS is estimated at 7% GDP in 1992 and 14 to 21% by the year 2000. The prevalence of STD is also high. Based on information from the Health Information System 1 in 5 adults nationally have an STD. Special surveys in urban pregnant women indicate that about 40% of the women have an STD at any one time.

Based on the current epidemiology of HIV infection in Malawi and the priorities identified by the Malawi National AIDS Control Programme, seven target groups were identified for AIDS control and prevention activities which include communication for behavior change, increased condom promotion, and improved STD control. Four of these groups, youth in and out of school, employed men, bargirls/bar owners, and male STD patients, represent the initial primary targets of the Project. These groups were selected using the criteria of risk of HIV acquisition and transmission, potential prevention impact, and ability to identify and reach with the proposed interventions. The second tier of targeted groups, unmarried women age 18 years and above, female STD patients, and males over 30 years of age, are somewhat harder to reach. Given the social and cultural practices in Malawi, women will be most effectively reached initially through their partners.

Project implementation will require collaboration and partnership among public, semi-private (i.e. parastatal) and private sectors. Where overlap exists, child spacing/family planning information and activities and service delivery mechanisms will be integrated. It is envisioned that responsibilities for implementation will correspond to national, regional, and district/community as follows: policy setting and oversight at the national level, systems building, coordination and management at the regional level, and service

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delivery/program implementation at the district/community level. Activities that are being conducted at the district level will be complimented by umbrella grant activities supported through the NGO/private sector consortium in collaboration with community-based and private organizations. Technical assistance will be provided by the Project through a buy-in to an AID/W cooperative agreement and other US-based organizations. A key constraint to the implementation of the proposed project is personnel. The project attempts to address these constraints through three related strategies: (1) institutionalizing training-of-trainer capacity with development of regional prevention counseling and training system within the AIDS Secretariat and the Ministry of Health to ensure regular training for new recruits, (2) developing community-based, volunteer programming to augment public sector staffing, and (3) supporting the delivery of AIDS prevention programming through the private sector.

A detailed implementation plan for the first three years of activity is provided as well as an illustrative budget for the first three years.

1.0 OVERVIEW OF PROBLEM

1.1 Epidemiology of HIV

Cases of AIDS were first recognized in Malawi in 1985, however, HIV infection probably began spreading among the Malawi population in the early 1980's. The best available data on the early spread of HIV is from testing pregnant women in Lilongwe and Blantyre (Miotti et al). It shows that in these two largest cities of Malawi, HIV infection progressed very rapidly during the years 1985-89, with incidence rates of 5% to 7% per year. By 1989, about 20% of pregnant women in both cities were infected. Data from October 1991 indicate that 26% of pregnant women in Blantyre were infected (personal communication, Miotti).

As shown in Table 1, the number of reported AIDS cases has increased from 17 in 1985 to about 15,700 through Feb, 1991. These numbers are undoubtedly serious underestimates since, despite Malawi's impressive laboratory-based surveillance system, suspected AIDS cases may not always be tested. Reasons for not testing include shortages or lack of reagents, AIDS patients dying before obtaining medical care, or having such a typical clinical presentation that a confirmatory lab test may not be conducted. In the United States, which reputedly has the best AIDS surveillance system in the world, it is estimated that only about 70% of AIDS cases are reported. By contrast, WHO/GPA has estimated that on average, only about 10% of AIDS cases are captured by African surveillance systems. Estimates of AIDS cases from modeling suggest there were about 15,000 AIDS cases in 1990 (compared with about 6,000 reported). This would suggest that 40% of cases are being reported. This high reporting rate compared to other African countries is probably due to the attention that has been paid to training laboratory technicians in HIV testing and establishing of HIV testing sites throughout the country.

TABLE 1: Reported AIDS Cases in Malawi, 1985-1991

Year	Number of Cases
1985	17
1986	127
1987	858
1988	3034
1989	3812
1990	6013
1991 (through February)	1787

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The next most important source of HIV data is from testing blood donors, a practice which is widespread in all districts of the country. Periodic analysis of blood donor data was begun with technical assistance from USAID/FHI in 1989. Results from blood donor testing have some severe limitations, e.g., bias due to donor selection and recruitment, lack of confirmatory testing and the lack of laboratory quality control -- but may still be useful in the absence of better, more representative studies. Tentative conclusions which can be drawn about the distribution of HIV infection in Malawi from the analysis of blood donor data include (1) that it is apparent that HIV infection is widespread throughout Malawi, (2) virtually no district of Malawi is spared, and (3) infection rates throughout urban or semi-urban areas of Malawi are consistently above 10% (unpublished MOH data). Additionally, when blood donor data are analyzed by age, sex and occupation, one can conclude that women are infected at younger ages than men, and that highly educated and skilled workers are more infected than unskilled workers (unpublished MOH data). These trends are very similar to results from other African countries such as Zaire, Rwanda or Uganda.

1.1.1 Future projections of HIV infection

Based on the above-described surveillance data, the AIDS Secretariat, with technical assistance from USAID, has developed national projections of the future level of HIV infections.[1] Both high and low estimates of the endemic incidence rate of new HIV infections were created. The high annual incidence rate used was 2%, the low incidence rate was 1%.

HIV and AIDS

Data from Lilongwe and Blantyre (Miotti et al, 1990) show seroprevalence levels of approximately 20% among pregnant women, with a very rapid rise in seroprevalence from 1985 through 1989. The estimated annual incidence rates during those years ranged from 4 to 7%. Rural seroprevalence levels among pregnant women in 1990 is estimated to be 8%. After weighting these estimates by age and rural-urban status, an overall seroprevalence of 9.6% among all persons over 15 years of age can be estimated.

Figure 1 shows a comparison of projections produced independently by three organizations, USAID/AIDSTECH/MOH, WHO/GPA (personal communication) and UNICEF (adapted from Preble, 1990). The UNICEF curve shown is the high scenario. The UNICEF low scenario (not shown) is nearly identical to the USAID/AIDSTECH/MOH high scenario.

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[1] For a complete discussion of the methodology and assumptions used for the projections used in this paper see Appendix A: Technical notes to HIV/AIDS projections for Malawi

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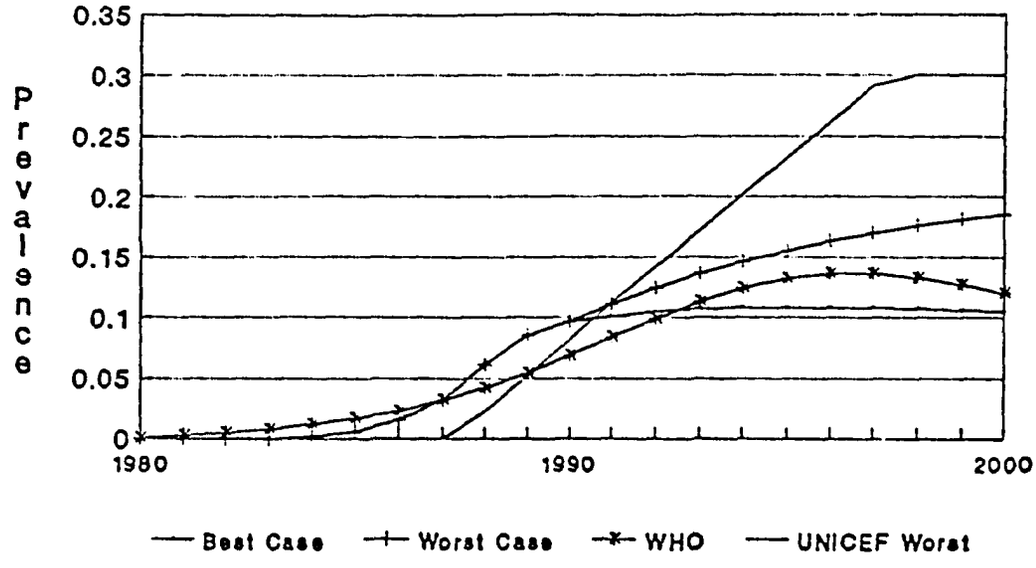
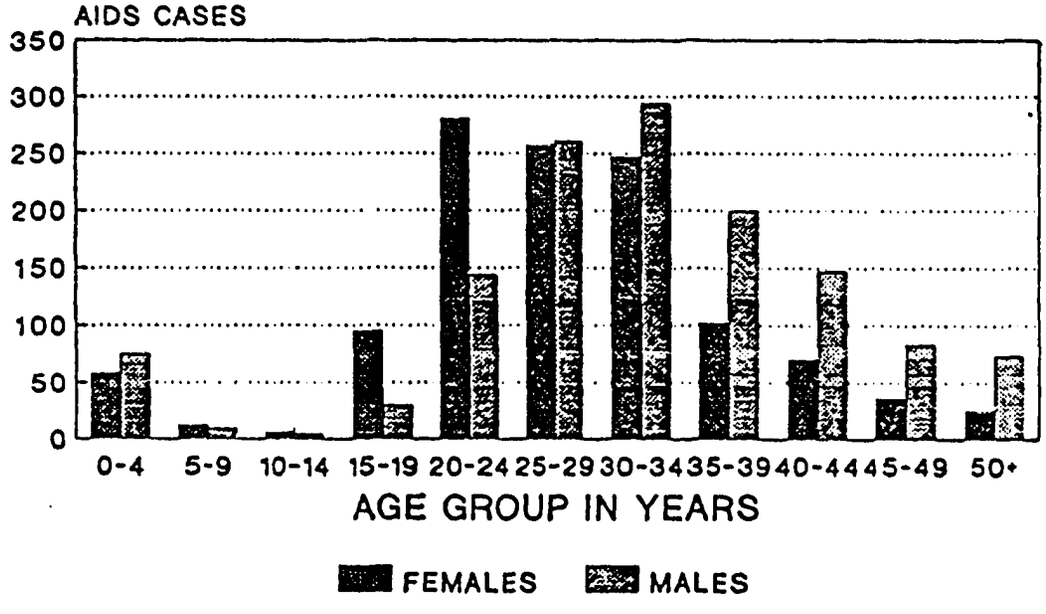
FIGURE 1: ADULT SEROPREVALENCE, MALAWI 1980 - 2000



One of the most destructive aspects of AIDS is that the majority of those dying are in the most productive years of their lives. Figure 2 shows the age/sex distribution of reported AIDS cases. Peak levels of AIDS among men occur between 30 to 35 years of age and among women between 20 to 25 years old.

FIGURE 2: AGE AND SEX DISTRIBUTION OF AIDS CASES IN MALAWI, 1990



Figures 3, 4 and 5 show projected annual and cumulative AIDS cases (both adults and children) in both low and high scenarios. By 1995, there will be an estimated total of about 50,000 new AIDS cases per year, while by the year 2000 the number of new cases will be between about 60,000 to 90,000 per year. Cumulative adult AIDS cases are estimated to reach 400,000 to 500,000 by the year 2000. This number is approximately equal to the adult population of Blantyre.

FIGURE 3: ANNUAL ADULT & CHILD AIDS CASES IN MALAWI - LOW SCENARIO

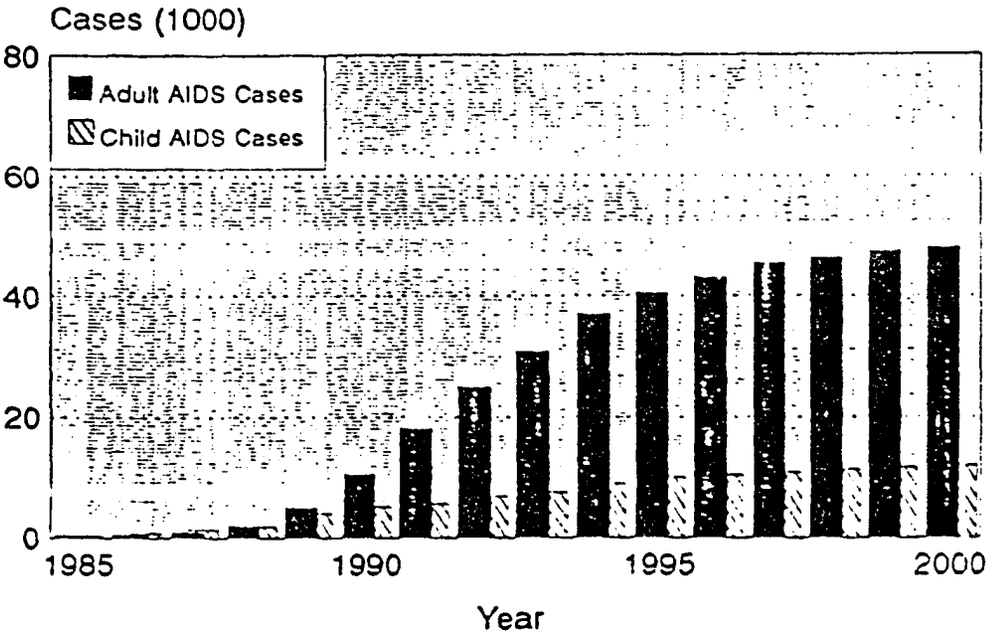


FIGURE 4: ANNUAL ADULT & CHILD AIDS CASES IN MALAWI - HIGH SCENARIO

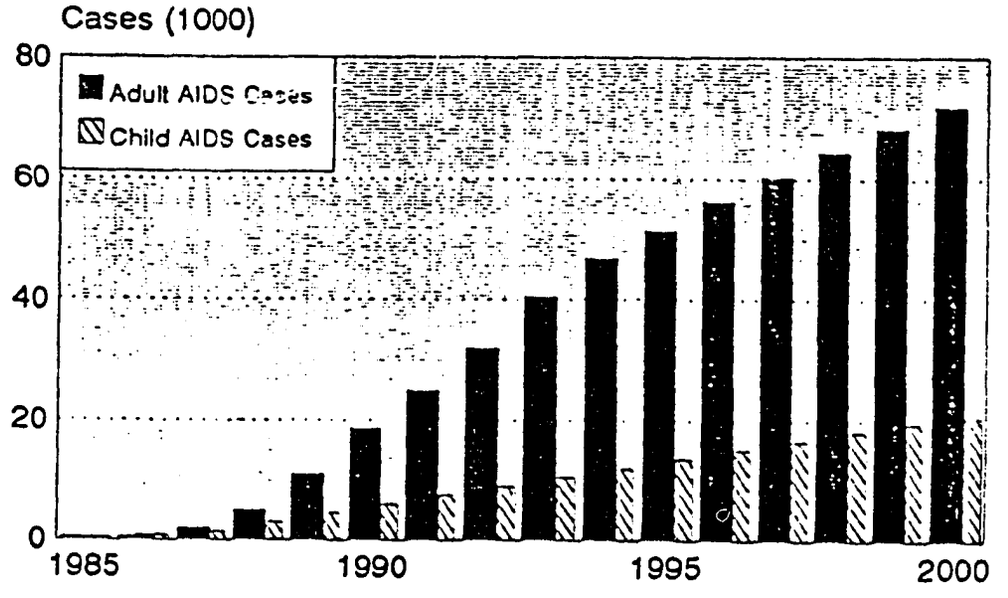


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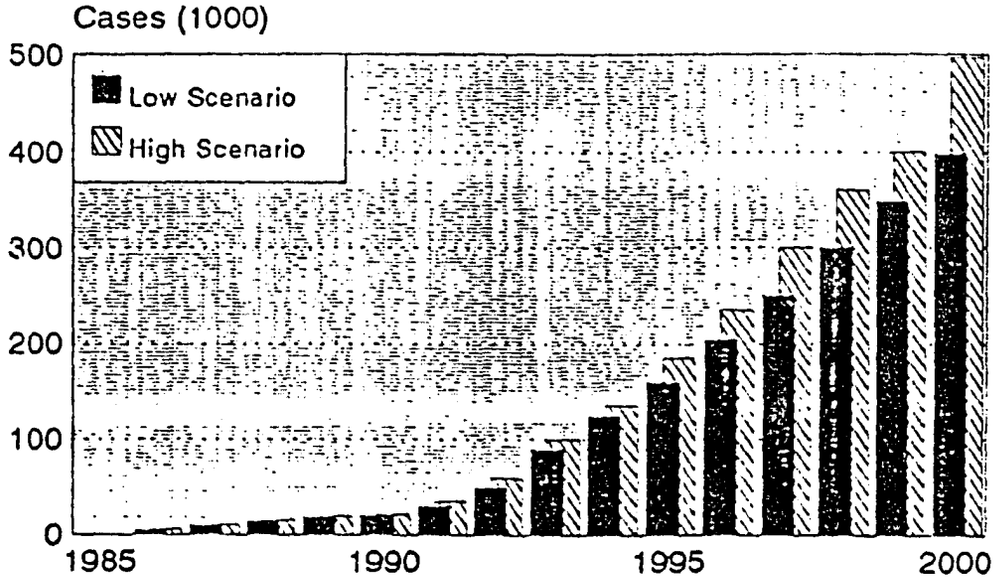
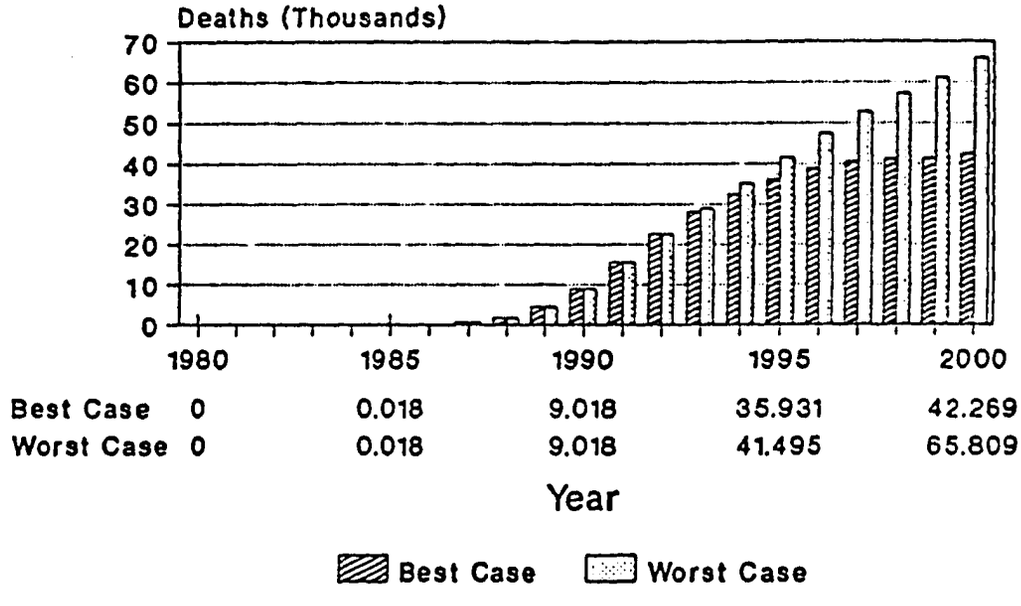
FIGURE 5: CUMULATIVE ADULT AIDS CASES IN MALAWI - LOW AND HIGH SCENARIOS.



The annual number of adult AIDS deaths under the low and high scenarios are presented in Figure 6. Although vital statistics are not officially recorded in Malawi, it is clear from hospital data (unpublished hospital reports) that AIDS is already the primary cause of death among adults in Malawi. By 1995, more than 100 adults will be dying each day of AIDS in Malawi.

FIGURE 6: NUMBER OF ADULT AIDS DEATHS PER YEAR, MALAWI 1980 - 2000



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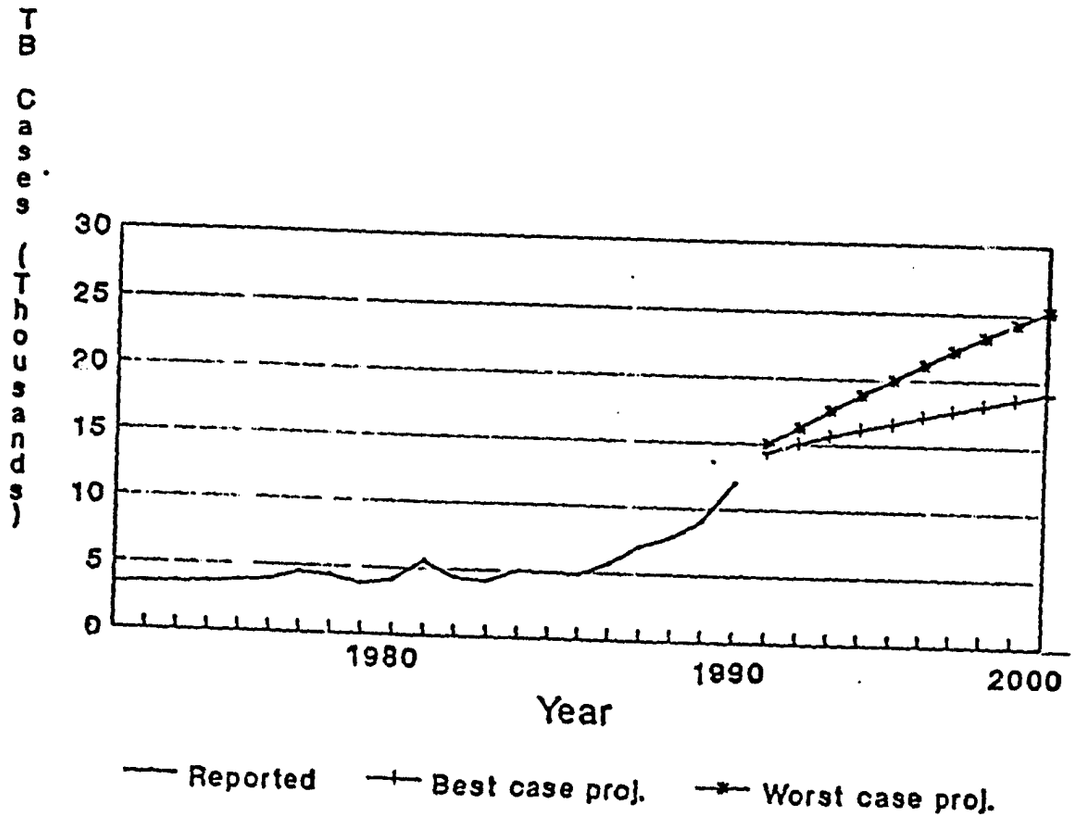
Tuberculosis

Conservative estimates show the number of reported TB cases growing from about 5,000 cases per year in 1985, to about 20,000 to 25,000 cases in 2000 (Figure 7). These figures do not take into account secondary cases of TB (i.e., new TB cases arising from HIV infected individuals) since there is some suggestive evidence that TB cases associated with HIV infection are less infectious than other TB cases. This lower infectivity occurs because the weakened immune system does not lead to cavitary disease, the most contagious type of TB. Nonetheless, there will undoubtedly be some secondary spread from HIV-associated TB which would increase the estimates provided in Figure 7.

Hospitals and health care workers will be put under increasing pressure as a result of the increase in both TB and AIDS cases. In addition, there will undoubtedly be a loss of a significant number of skilled health care personnel from AIDS. In the absence of community or home-based care, the real possibility exists that AIDS patients will overwhelm hospital facilities and care available, Including palliative measures, will be minimal.

FIGURE 7: PROJECT NUMBER OF TB CASES ATTRIBUTABLE TO HIV INFECTION



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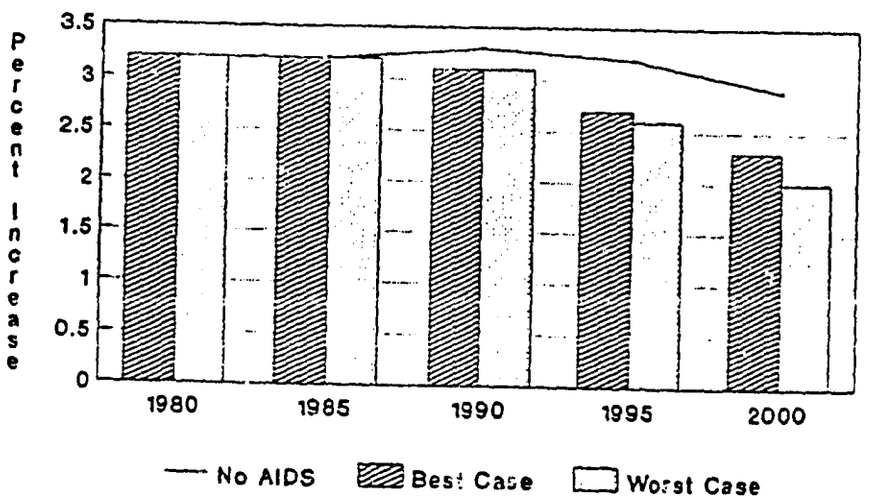
Demographic

While AIDS will have a significant impact on the rate of natural increase (RNI) of the population, there is little likelihood that population growth will become negative in the near future. Figure 8 shows the rate of natural population increase in the absence of AIDS and under the low and high scenarios. Without AIDS, demographers estimate that the RNI would decrease from 3.2% to 2.9% by 2000. With the AIDS epidemic, the RNI may decrease to about 2.0% to 2.3%, still a very rapid population growth rate compared to developed countries.

FIGURE 8: RATE OF NATURAL POPULATION INCREASE, WITH & WITHOUT AIDS



Figures 9 and 10 present the estimated changes in infant and child mortality rates with and without AIDS. While initial estimates showed a larger effect on infant mortality, recent data have suggested that survival of HIV-infected children is longer with perhaps only 25% of infants dying during the first year of life. Thus most children will die between the ages of 1 and 5, producing a greater impact on child mortality than on infant mortality. Thirty percent or more of infants infected at birth may survive past 5 years of age.

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FIGURE 9: PROJECTED INFANT MORTALITY RATES WITH AND WITHOUT AIDS

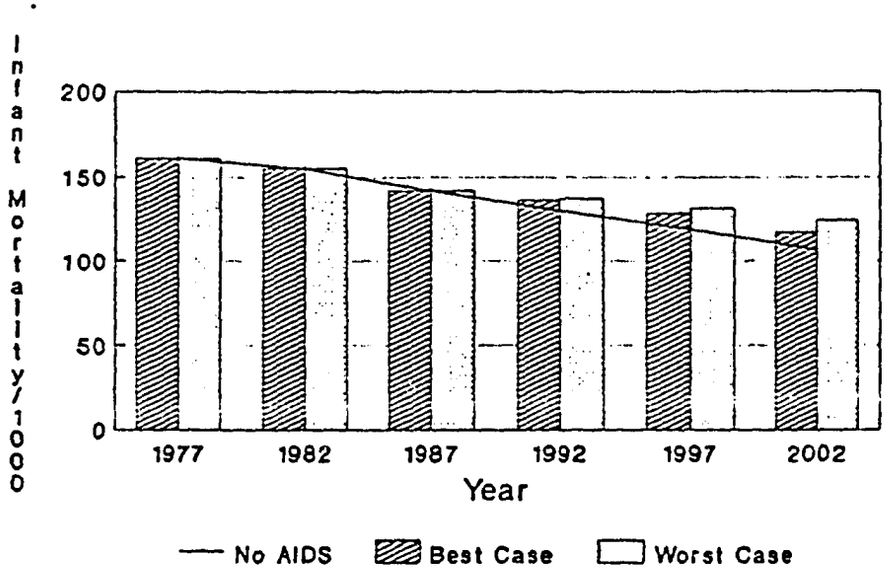
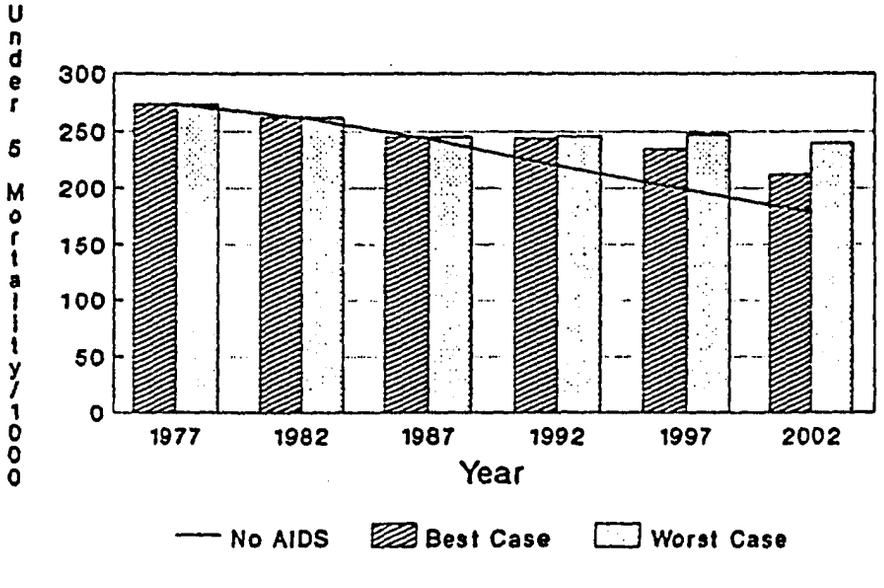


FIGURE 10: PROJECTED UNDER 5 MORTALITY RATES WITH AND WITHOUT AIDS



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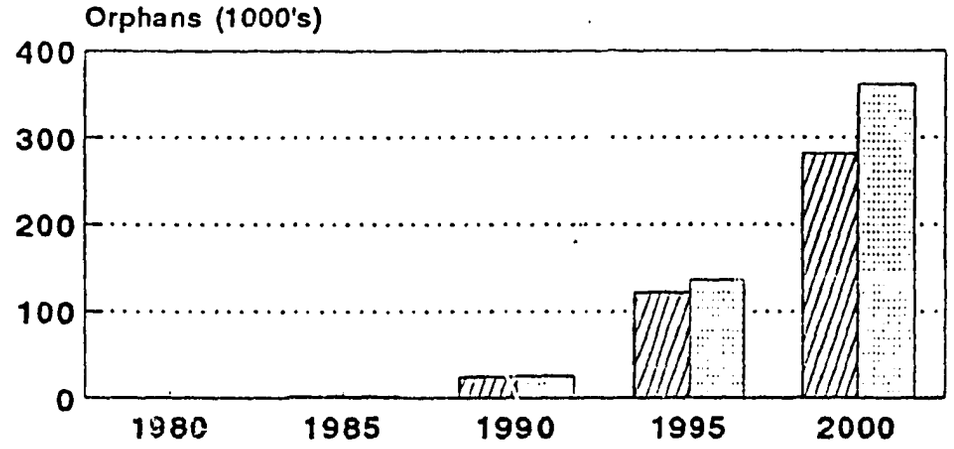
Recent unpublished data from UNICEF efforts in the Kagera region of Tanzania can be used to estimate the rate of orphans in the absence of AIDS: about 2 per 1000 total population. In the year 2000, this would suggest 20,000 non-AIDS orphans compared to about 300,000 AIDS orphans (Figure 11). While the traditional African extended family has in the past been renowned for its care of needy relatives, AIDS orphans will likely overwhelm this capacity. In addition to overwhelming numbers, many families may be reluctant to care for AIDS orphans because of the fear that the orphan him/herself may be infected with the AIDS virus.

FIGURE 11: PROJECTED NUMBER OF ORPHANS IN MALAWI, LOW AND HIGH SCENARIOS



	1980	1985	1990	1995	2000
Best Case	0	3	24	121	282
Worst Case	0	3	25	136	361

Economic

A recent USAID-financed study by AIDSTECH economist Steven Forsythe estimated the economic impacts of the AIDS epidemic based on the above projections of AIDS cases and deaths (Forsythe, 1992). Forsythe estimated the direct and indirect costs of AIDS from existing data in Malawi and from studies in other countries.

The estimates of the direct costs of health care suggest that the average (lifetime) cost of treatment for AIDS is about MK515 (US$ 190.00). At this rate, by the year 2000 AIDS cases could

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consume 27 to 38 percent of the MOH's budget for the recurrent costs of curative care. This is clearly not likely to occur, however, since the system is not likely to be capable of handling such a patient load. This estimate further supports the importance of developing systems of home care since most of the AIDS cases which will occur in the next few years are not preventable.

The indirect costs of AIDS cases are also high since HIV infection is more prevalent in urban areas and among individuals with greater levels of education and income. The average discounted lifetime income lost due to each case of AIDS is estimated to be MK 10,500 (US$ 3,800.00). At this rate, the loss of potential income due to AIDS is estimated to equal about 7 percent of Malawi's total GDP in 1992 and may rise to 14 to 21 percent by the year 2000. Even moderately successful prevention activities are thus likely to be extremely cost-beneficial.

Summary of the impacts of the AIDS epidemic

During the next 8 years, Malawi is going to experience unprecedented numbers of deaths of adults in their productive years with serious social and economic impacts as a result. The number of orphans, the child mortality rate and the number of new TB infections will all worsen substantially in the next few years. The growth rate of the population will slow due to the AIDS epidemic, but is not likely to become negative in the near to medium term under the current assumptions.

1.1.2 HIV/AIDS Treatment and Vaccine Projections

Two basic types of vaccines are presently under development along with innumerable types of drug treatments. While it is difficult to discount or predict a dramatic, unexpected breakthrough in treatment or vaccine research, some comment on the development of affordable vaccines or treatments over the next eight years can be posited. These projections are based primarily on the presentations made at the Dakar AIDS conference by researchers from the United States and Europe, and a report described at that conference concerning the work of the Walter Reed Army Institute of Research (Redfield et. al, 1991).

Treatment

While Dakar conference participants proposed that improved management of infections associated with HIV/AIDS should be a major priority and would improve the survival of HIV infected people, there was little optimism about major advances in treatment. Even in the United States, treatment strategies and survival statistics resemble those seen in severe, incurable cancers. The likelihood of the development of an effective and affordable treatment by the

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year 1997 is about 10%.

Vaccines

Two types of vaccines are under development: preventive and therapeutic. A preventive vaccine would protect an individual from primary infection with HIV; a therapeutic vaccine would be given to someone already infected to prevent the development or exacerbation of HIV disease, analogous to rabies vaccine. It is unknown whether a therapeutic vaccine would decrease the infectiousness of an infected individual, though it is hoped that it would.

Preventive vaccines. Although several preventive vaccines are under development, their testing will be difficult given the long incubation period of the virus, the difficulty of finding suitable populations for vaccine trials, and the sophisticated laboratory techniques which are needed to verify their efficacy. While four countries have been selected by WHO for field trials which are expected to begin in two to three years (Science, 1991) and there are some encouraging animal findings, it will be a long time before a preventive vaccine is released for widespread use. The likelihood of the development of an effective and affordable preventive vaccine by the year 1997 is about 20%.

Therapeutic vaccines. A promising preliminary trial of a therapeutic vaccine has already been conducted by a Walter Reed team (Redfield et al, 1991), and a larger, double-blind trial is underway. As many of the ethical and scientific difficulties associated with the development of a preventive vaccine are not relevant to work on a therapeutic vaccine, faster progress may be expected in this area. A preliminary report suggests that periodic injections of the vaccine slow the decline of the number of T-4 cells, strengthening an infected person's immune system. This should prevent the development of disease due to immune deficiency. While this appears to be a very promising approach, much additional work will be needed to reduce the number and frequency of injections needed to make it practical and affordable for developing countries. The likelihood of the development of an effective and affordable therapeutic vaccine by the year 1997 is about 40%.

Conclusions

While the likelihood of the development of an effective and affordable cure or preventive vaccine in the next five years is relatively low, the likelihood of the development of a therapeutic vaccine appears relatively good although cost will be a major issue. The major implication of vaccine development for prevention programs is that investments in increased testing and counseling capabilities might have a hidden benefit: the facilitation of the rapid introduction of a therapeutic vaccine if and when it becomes

available. This is due to the fact that it would be necessary to test people to identify infected people who would benefit from receiving injections of the vaccine.

1.2 Epidemiology of Sexually Transmitted Diseases (STD)

Data on sexually transmitted diseases (STD) in Malawi is scanty since the previous health information system of Malawi only records the number of individuals reporting to the outpatient departments with a "venereal disease". The new reporting system adopted in 1990 identifies "gonorrhea," "syphilis" and "other" for sexually transmitted disease reporting, a still imperfect but improved system. Data from the 1989 Health Information System Report, the last one completed, indicate that outpatient visits for STD was the eighth most common complaint in the northern region for individuals 5 years old and older (297/10,000), sixth most common for the central region (326/10,000) and fifth most common for the southern region (495/10,000). These data probably underestimate the magnitude of STD in outpatient departments as STD in women are either routinely not diagnosed or are likely to be categorized under "female complaints," "skin diseases," or "symptoms referable to the genito-urinary tract."

Data from Mangochi district hospital indicate that visits for STD are the third most common reason for individuals over age 5 following malaria and respiratory tract infection (personnel communication, DHO Mangochi). Moreover, outpatient visits for STD increased in Mangochi from 6% of the total in 1985 to slightly more than 9% of the total in 1990.

Data from specific research studies also provide information on the spectrum of STD in Malawi:

- A 1989 pilot study at Kamuzu Central Hospital in Lilongwe found an STD prevalence of 4.4% in un-selected outpatients (Kristensen, 1990) with 83% of the patients being male. Genital ulcer diseases accounted for 67% of the diagnoses and 62% of the STD patients were HIV positive.

- A chart review of STD patients in Queen Elizabeth Central Hospital in Blantyre showed that 80% of the new patients were male (unpublished data, Dallabetta). Among males, genital ulcer disease accounted for 66% of presenting complaints.

- Studies of antenatal women in Blantyre in 1989 indicated that the prevalence of gonorrhea was 5%, chlamydia 3%, trichomonas 32%, positive syphilis serology 13%, and genital ulceration 7% (Liomba, 1990).

- Studies of bargirls in Blantyre indicated that 29% had gonorrhea, 27% had trichomonas and 21% had positive syphilis serology, and 6% had genital ulcer disease (unpublished data, Dallabetta).

- Syphilis serology in antenatal clinic populations in Lilongwe (urban) and Mangochi (semi-urban) were 13% and 8%, respectively (personnel communication, Dr. Steketee and unpublished data, Dallabetta).

- Anecdotal reports from several clinical care providers describe that many of the outpatient visits for STD are return visits for STD that failed to respond to therapy. Several care givers reported many cases of "resistant syphilis" which presumably represents chancroid that is misdiagnosed or inappropriately treated.

These data indicate that STD account for a significant proportion of outpatient adult visits in all parts of the country. Outpatient visit data show that about 1 in 20 adults, mainly males, have a symptomatic STD in urban areas. STD are highly endemic among urban antenatal women, with gonorrhea, trichomoniasis, syphilis, chancroid or chlamydia infection present in 43% at any one time.

The spectrum of disease in males is similar to that reported in other African countries, i.e., a significant amount of genital ulcer disease with the most common etiology being chancroid. The data also indicate that bargirls (a core transmitter group) have a very high prevalence of STD in addition to near saturation (over 80%) with HIV-1 infection in the urban areas.

2.0 RESPONSE TO DATE

2.1 Government of Malawi

Shortly after the first cases of AIDS were diagnosed in 1985, the Government of Malawi mobilized activities under a WHO/GPA-assisted Short Term Plan for AIDS prevention. Early priority areas included establishing an STD/AIDS committee, expanding HIV screening activities from 3 to 11 sites, and beginning IEC activities for health staff, government leaders and the public.

The five-year Medium Term Plan (MTP) for AIDS Prevention was adopted in late 1988. Priorities for the first phase of the MTP (January 1989 - July 1990) were to establish program management capability in the AIDS Secretariat, to continue IEC efforts, to initiate condom promotion and distribution, and to expand testing

sites from 11 to 36 sites.

The first Annual Program Review, conducted in March 1990, noted significant accomplishments of the program (e.g., a number of training workshops for district level workers held, 80% coverage of screened blood for transfusions, and the completion of the MTP). It also identified a number of constraints to implementation including delays in hiring AIDS Secretariat staff and procuring equipment; funding constraints; the need for integration of the AIDS Secretariat with other MOH, other government, and non-governmental organizations; the need for decentralization of planning, budgeting and implementation of activities; and the need to share HIV/AIDS statistics with health care workers at all levels.

During the second year of the MTP (August 1990 - July 1991) many new activities were initiated. This included:

- significant numbers of orientations and training of trainers workshops for health care workers, political and religious leaders and the general public
- expansion of HIV testing sites to 52 throughout the country and establishment of a reference laboratory
- establishment of a computerized AIDS/HIV surveillance system, and counseling training for clinical officers and other health care workers on pre and post test counseling
- initial efforts toward decentralization (e.g., the assignment of Regional AIDS Coordinators, the identification of funds and development of protocols and procedures for district level IEC activities and health worker training)
- the distribution of 5 million condoms from the Central Medical Stores to district hospitals (for further outward distribution to health centers and worksites)

The second Annual Review noted the accomplishments above but also identified a number of continuing constraints including unresolved personnel classification issues and staff vacancies; and implementation delays in approvals for videos/films and other IEC materials, establishment of sentinel sites for STD and HIV prevalence and incidence, dissemination of STD management guidelines and client education, the establishment of the reference laboratory and Blantyre blood transfusion service and quality assurance protocols.

In October 1991, the AIDS Secretariat developed a two-year

workplan described in the Malawi National AIDS Control Programme Reprogramming Document, 1992-1993. The priorities for the current period as stated include:

- o expanding pilot efforts with specific target groups (e.g., in and out of school youth, bargirls, STD patients, truck drivers and men/women in the workplace)

- o improving program management (through greater attention to subproject monitoring and evaluation; expanding HIV testing capability; improving STD surveillance, diagnosis and management; improving the blood transfusion service; and expanding decentralization of current AIDS prevention and control efforts), and

- o improving care and management of PWAs and orphans

Staffing and other constraints (6.0 Key Constraints) at both the AIDS Secretariat, regional and district levels will continue to jeopardize the achievement of the priority efforts as stated in the reprogramming document. This will be particularly problematic for those which require institutionalizing new service programming such as STD services, condom supply and resupply, and interpersonal communication and counseling efforts for high risk behavior groups.

The AIDS Secretariat has enlisted the support of other governmental and non-governmental organizations in the ACP. Examples of such collaboration include the use of Central Medical Stores for condom distribution; the Ministry of Women, Children and Community Services for community based care; CCAM, Malawi Young Pioneers and the religious community for peer education; the Malawi Red Cross for blood transfusion services; and Private Hospital Association of Malawi (PHAM) for improved counseling services through their facilities. The lack of human resources available in the AIDS Secretariat for regularly monitoring these and other activities, however, suggests the potential for serious quality assurance slippage, miscommunication of critical messages, lost opportunities for assessing and improving the skills of educators and counsellors, and a perhaps unsubstantiated assumption that those who have been trained as peer educators and counsellors are in fact, aggressively carrying out the activities for which they have been trained.

2.2 USAID Efforts to Date

USAID/Lilongwe has supported a number of projects and activities addressing the AIDS epidemic in Malawi. Among the most important have been the school AIDS curriculum and IEC upgrading activities implemented by AIDSCOM; the SOMARC Malawi

Health Social Marketing Project; AIDSTECH's surveillance, economic impact study and blood donor survey; and Project HOPE's work with PHAM, other NGOs and in the workplace. The AIDS curriculum is currently being introduced in Standard 1-4 (grade 1-4). The SOMARC-sponsored condom social marketing project launched **Protector** condoms in August 1991; sales to date have topped 200,000 condoms. The Mission has procured over 11 million condoms for AIDS prevention activities to date to complement the 4 million provided by WHO.

In addition, the Mission's bilateral PHICS Project (Promoting Health Interventions for Child Survival) includes a major in-service training component for health care workers (e.g., health surveillance assistants and health assistants), strengthening of the MOH Health Education Unit, and support for AIDS-related health research, epidemiology and information. Four U.S.-based private voluntary organizations have incorporated various levels of AIDS prevention education into their child survival programming. Assistance from the A.I.D. centrally-managed Family Planning Logistics Management Project has been provided to assist in improving condom forecasting and supply management as well as to assess the potential for local manufacture of condoms. The Mission's decision to fold most of the above activities into the STAFP project will allow for consolidation and better coordination of these multiple activities.

2.3 Other Donor Efforts to Date

2.3.1 Canadian International Development Agency (CIDA)

The Canadian International Development Agency has previously provided funding for technical assistance in the development of STD treatment strategies. CIDA has pledged $155,000 to support confidential HIV counseling facilities, IEC materials development (videos), and continued technical assistance for STD control.

2.3.2 European Community (EC)

The European Community will continue to support the activities of the EC AIDS Control Project, within the National AIDS Control Programme. For funding year 92-93, US$320,000 will support the following ongoing activities: targeted IEC campaigns for bargirls, truck drivers, STD patients, and traditional healers; production and distribution of HIV/AIDS materials for the Adult Literacy Programme; production of HIV/AIDS educational materials for general public; and the production of a Peer Educators Manual. Baseline data have been collected on the target groups and follow-up evaluations have been performed on STD patients and truck drivers.

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In addition to these ongoing activities, US$200,000 will be used in 92-93 for targeted IEC activities for traditional birth attendants, tea and tobacco estate workers, Malawi Young Pioneers and to perform an assessment on utilization of condoms.

2.3.3 German Technical Assistance (GTZ)

The German Technical Assistance Agency has previously supported laboratory services and will contribute US$450,000 for the 1992-1993 funding year. This will fund one full-time laboratory technical advisor specializing in HIV diagnostics; training costs; and laboratory supplies and equipment. The project will provide training for laboratory technicians; develop and implement quality control protocols for HIV testing; establish reference laboratory capability for HIV testing; and support HIV related research. The project will strengthen laboratory testing for HIV and other STD's at hospital based laboratories throughout the country, with particular emphasis on three sites: Queen Elizabeth Hospital; the CHSU Research lab in Mangochi, and the main CHSU in Lilongwe.

2.3.4 Japanese International Cooperative Agency (JICA)

The Japanese International Cooperative Agency has previously provided laboratory equipment for blood screening and storage, and vehicles and supplies for the AIDS Secretariat and Regional Health Offices.

2.3.5 British Overseas Development Agency (ODA)

The British Overseas Development Agency has previously supported the National AIDS Control Programme through contributions to GPA/WHO. ODA will contribute US$450,000 as a multi-bilateral contribution to WHO/GPA, as undesignated funding for HIV/AIDS control activities in 92-93.

2.3.6 United National Development Programme (UNDP)

UNDP has funded the salaries of national staff and the operating costs of the AIDS Secretariat of the Ministry of Health. UNDP has pledged US$1,230,000 over the next 5 years, which will be used to continue to support this critical component of the National AIDS Control Programme and will also fund piloting of home based care models.

2.3.7 United Nations Fund for Population Assistance (UNFPA)

UNFPA will incorporate HIV/AIDS prevention messages into child spacing programs.

2.3.8 United Nations Childrens Fund (UNICEF)

UNICEF has focused on IEC material development (videos, posters, school curricular materials, leaflets, etc,) and social mobilization efforts, which include training and support to drama groups and bands.

UNICEF has pledged US$1,000,000 for 92-93 to perform an enumeration of orphans; further production of school curriculum and other IEC materials; and the development of models for peer support, home based care for persons with AIDS and orphan care.

2.3.9 World Health Organization (WHO)

Since 1988, the World Health Organization has supported multiple components of the Short Term and Medium Term Plans for HIV/AIDS Control. This has included: technical assistance for laboratory services, administration, epidemiology, counseling and IEC activities; reagents and equipment for HIV testing; vehicles and office equipment; training activities; and support for general and targeted IEC campaigns. For 1992-93, WHO has pledged US$500,000 for undesignated HIV/AIDS control and prevention activities.

2.3.10 World Bank

Through the Public Health and Nutrition Sector Credit, the World Bank will support training of health care workers, drugs for treatment of HIV related conditions and strengthening of the Health Education Unit.

2.4 Non-governmental Organization Efforts to Date

As noted above, a number of U.S.-based non-governmental organizations have begun activities in support of AIDS prevention. Often working through volunteer village health workers and other primary health care providers, Project HOPE (the child survival component), Save the Children (SCF), the International Eye Foundation (IEF) and the Adventist Development Relief Agency (ADRA) have integrated AIDS prevention with child spacing activities. AIDS activities have understandably played minor roles in the programs of these PVOs to date although pilot activities such as SCF's revolving drug fund and the IEF/ADRA workshop on "volunteerism" in the health sector have demonstrated significant potential for AIDS programming. The IEF/ADRA workshop, for example, has resulted in the development of operations research projects to address key questions related to volunteerism: e.g., training, motivation, retention and reward. The SCF revolving drug fund provides an opportunity for cost-recovery for STD drugs at the community level.

Unfortunately, these U.S.-based organizations do not have many indigenous counterparts. One noteworthy exception is Banja la Mtsogolo, a Blantyre-based NGO providing "man-to-man" counseling in child spacing and AIDS prevention in the workplace.

3.0 LESSONS LEARNED

3.1 Malawi Experience

Few research studies have been conducted in Malawi chronicling HIV transmission risk factors or reporting the impact of behavior change and other intervention efforts. Baseline research conducted in the formative stages of a number of interventions also provide some insights for consideration in project design. Additionally, one can obtain lessons from various approaches to health delivery or program implementation strategies that have been introduced. Evaluations and reviews of these programs have taken place in the past four years and these may serve as valuable sources of information on what has "worked" and what has not.

3.1.1 IEC Campaigns for HIV/AIDS Awareness and Behavior Change.

A KABP study of the general population, which was performed in 1989, demonstrated that after multifaceted general media HIV/AIDS campaigns, level of awareness concerning HIV and AIDS was high. However, perceptions of personal risk for acquiring HIV were still low and there continued to be misconceptions about HIV transmission. A targeted KABP using focus group methodologies and individual interviews was performed in 1990. The populations who were studied included bargirls, truck drivers, bar owners, and secondary school students. Again, level of awareness about HIV and the severity of the problem was high. However, in both of these studies there was no measurement of actual behavior change that may have resulted from the media campaigns.

3.1.2 IEC With Religious Leaders

In the Final Project Evaluation of the PVO HIV/AIDS Prevention in Africa (Project HOPE, November 1991) successes and constraints were presented. Christian churches and the Moslem community were eager to obtain information on the AIDS epidemic and open to training opportunities. However, secondary training by those who had received training was minimal. In addition, messages about condom use and vertical transmission of HIV from pregnant women to their newborns was censored from educational sessions held by the trainees. There was a critical need for improved support and monitoring of training activities to be performed by trainers. Disseminating information about condoms

may not be appropriate for some church leaders.

3.1.3 Targeted IEC activities for groups at "high risk" of HIV infection.

The EC AIDS Project in the AIDS Secretariat has initiated several studies, measuring the impact of targeted peer education interventions. Preliminary results are now available. In a draft article entitled, "Impact of Peer Education Training on Risk Reducing Behavior Towards HIV/AIDS Transmission in Truck drivers in Malawi," the data indicate that some behavior change may be occurring as a result of peer educator training. However, secondary training by the trainees is weak and there needs to be periodic policy dialogue with management to support the activities of the peer educators in the workplace.

"Differential Impact of Health Talk Versus Peer Group Educations on Risk Reducing Behavior Towards HIV/AIDS in Bargirls in Malawi" presents preliminary data comparing the efficacy of two different training methodologies on bargirl knowledge and behavior. Both didactic presentations and peer educator training seemed to induce some positive behavior change as indicated by self reported condom use and numbers of condoms used per week by the bargirls. However, the group that received only lecture style education exhibited no "multiplier" effect for secondary training of peers.

3.1.4 HIV/AIDS IEC Activities in the Workplace.

In summary reports from Project HOPE activities in workplace campaigns, certain lessons have become apparent. There needs to be a very flexible approach to different companies and agricultural estates. Management exerts varying levels of control on the training exercises.

3.1.5 HIV/AIDS Curriculum in Schools.

In a paper presented to the Annual Conference of the Confederation of African Medical Associations and Societies in March 1992, it was noted that delays in the development and introduction of the curricula could be attributed to several factors. These included the need to define at what grade level sexual information including the potential use of condoms should be introduced. Systems to monitor the implementation and impact of the curriculum are now critically needed.

3.1.6 STD Case Management.

Malawi has not created a formal program for STD prevention, treatment, and control but has addressed this need through its regular health delivery efforts. STD case management in the general population occurs in outpatient departments, where both men and women are seen. These services are limited in many sites, have high patient volume resulting in little time for patient evaluation and lack privacy and often equipment (e.g., speculums, tables, lamps) necessary for the physical exam. Diagnostic services are limited (even in hospitals with lab facilities) either due to lack of technician time, deficiency of laboratory reagents, and poor diagnostic skills in the clinical care providers. Shortages and poor use of appropriate antibiotics also contribute to a high percentage of repeat visits for persistent symptoms. Failures of correct therapy also result from complications due to undiagnosed HIV infection. Prenatal syphilis screening is also incomplete due to limitations of staff and other resources.

Malawi's major STD control effort has been the "food handler's clinic" where bargirls are evaluated regularly. The evaluation of the bargirls is variable depending on the district but all are limited by lack of diagnostic facilities. The bargirls are frequently evaluated by health care individuals not trained in STD recognition (e.g., lab or health assistants) and are subject to treatment based on inappropriate interpretation of tests. Follow-up of positive tests is infrequent due to lack of transport or poor communication between lab and clinic, or by the mobility of the bar girl. As Malawi currently requires girls to refrain from working for the duration of therapy (i.e., from 7 to 14 days) many bargirls move to avoid being forced to remain off work.

The lessons to be gleaned from the above suggest that STD control does not receive sufficient attention and suffers from inadequate planning and resources. Additionally one might conclude that the registration and the required check-up system of bargirls in Malawi is currently not meeting the public health objectives of the program.

3.1.7 The Social Marketing of Condoms.

The introduction of Malawi's first condom social marketing program through the Health Social Marketing Project has provided a number of lessons for future programming. Since the sales launch in August 1991, over 200,000 condoms have been sold. The project has achieved 21% of projected sales for the same time period with sales emanating primarily through major retail chains (e.g., PTC stores) in urban areas. The slow take-off of the project has been attributed by the marketing team to a number of factors including intense distribution of free condoms, reluctance by wholesalers to accept the product, lower than

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expected consumer demand, and delays in approvals of the advertising strategy and duty free status.

To date the project has also followed a conservative advertising strategy by limiting radio advertisements to early morning and late evening. Qualitative research regarding the broadcasting of the Protector condoms advertising campaign, however, suggests acceptance by the general public to tasteful brand-specific condom promotion and should provide the impetus for extending daytime coverage.

3.1.8 Risk Factors for HIV infection in urban pregnant women.

Studies in pregnant women in Blantyre indicated that all markers of higher socioeconomic status, namely high educational level of the husband (secondary school or more), high education level of the women (secondary school or more), electricity and water in the house, and the women with an occupation other than a housewife, were all risk factors for HIV infection. Additionally, all variables associated with heterosexual contact, history of STD, diagnosed STD, numbers of sexual partners, and reports of husbands will other partners were all significant risk factors; history of scarification, injections and transfusions were not. (Dallabetta et al, 1992).

3.2 Regional and International Studies

Few in-depth studies of risk factors for HIV infection have been conducted in Malawi. Data from studies conducted in eastern and southern African countries with similar epidemiologic characteristics also provide valuable insights and lessons.

One such study calls into question the estimation of HIV prevalence by simple "urban" and "rural" categorization. Initial studies of the AIDS epidemic suggested that it was largely an urban problem. In fact, WHO initially recommended that in the absence of hard data, one could estimate rural infection levels to be only about 10% of urban levels (personal communication Chin). This was later increased to 20%.

While truly rural villages may compare at about 20% of urban infection levels, recent data suggests that many villages should be considered "semi-urban," and are at substantial risk. A study of the Rakai region of Uganda (Wawer et al, 1991) has shown that it may be more useful to divide communities into three classifications: urban, semi-urban and rural. The study showed that semi-urban communities (trading villages) characterized as having some level of commercial activity (e.g., a market or a store), had levels relatively close to those in urban areas, while rural (purely agricultural) villages had much lower levels of infection. Levels in semi-urban areas were about 65% of urban

areas, while rural areas were only about 20%.

A number of studies have shown that certain risk behaviors are strongly associated with HIV infection including having a history of multiple partners, an above average income, and a history of STD as well as engaging in unprotected sex in exchange for money. Recent reports by Allen et al (1991) from a study of women in Rwanda and a study of men in Burundi (unpublished data, Buzingo, Sokal et al) have shed some additional light on the risk factors for infection in a more mature epidemic.

Both of these studies showed that recently married couples were at much greater risk than couples who were married before the spread of HIV began. The Rwandan study concluded that men were becoming infected before marriage then infecting their faithful and monogamous wives. The Burundi study concluded that women were becoming infected before marriage and infecting their faithful and monogamous husbands. It is undoubtedly true that both effects are occurring to varying degrees in different couples. A major conclusion of the Rwandan study was that most of the infections found among pregnant women were more strongly related to the high-risk behaviors of their husbands than to their own behaviors. Wives of men who reported outside partners, and especially men from higher socio-economic groups who drank alcohol, were at much higher risk than women whose husbands did not drink or did not have higher incomes.

Anecdotal reports from several countries suggest an increasing prevalence of another dangerous, counter-productive behavior by some men which -- unless rapidly reversed -- is likely to prolong and worsen the epidemic: they are searching for younger and younger women as safer partners for casual sex due to the likelihood of lower rates of infection among younger women. While difficult to quantify in field studies, modeling of the epidemic by Paloni et al (1990) has clearly shown the danger of an increasing age-gap among sexual partners.

Studies on the heterosexual transmission of HIV-1 infection have estimated that the risk of becoming infected with HIV through a single sexual intercourse with an infected person are between 1/100 to 1/1000 from male to female and 1/4 to 1/10 of that from female to male contact. STD that lead to genital sores, such as syphilis, chancroid and herpes, provide physical portals of entry and exit for the AIDS virus. The presence of an STD multiplies the efficiency of transmission of HIV from 5 to 20 times (Cameron et al, 1989).

Finally, studies report a wide variability in reported HIV-1 infection prevalence and incidence in antenatal clinic clients in Africa. Reasons postulated to explain these geographical differences include the variable period of circulation of the virus in different areas; different patterns of sexual contact

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relating to ethnic group practices, urbanization and migrant labor; or different levels of the proposed risk factors such as STD in the general population or male circumcision.

3.3 Modeling/Policy Dialogue

Numerous models are now available to project and analyze the HIV/AIDS epidemic. Models are important tools for policy dialogue with leaders and opinion makers (Section 5.2.4). Although modeling is valuable to estimate the future trends of the infection, to make estimates of impact, and to estimate the effects of a specific intervention they have limitations. Models are dependent on the variables used in the design of the model and the quality of data on which the estimates are made. Two major models -- the projection model (EpiModel) and a simulation model (SimulAIDS) -- have been used to prepare the following review of key program components and dynamics of AIDS prevention activities to date.[2]

3.3.1 Lessons Learned from AIDS Modeling

The importance of STD in HIV transmission. Studies from Nairobi and Kinshasa have suggested that HIV transmission is greatly accelerated by the presence of the classical STD, particularly genital ulcer diseases (GUD) such as chancroid (Cameron et al, 1989; Laga et al, 1990; Plummer, 1991). Based on the results of these small field studies, it is possible to model the effect of STD on the overall spread of HIV in a given population. The results show that if the field studies are accurate, then the prevalence of classical STD could be one of the most important factors favoring the spread of HIV. Figure 12 shows three curves which include the same behavioral parameters, but different levels of STDs. In the absence of STD, the epidemic progresses extremely slowly (similarly to its progress in the heterosexual population in the US) while in the presence of moderate or high levels of STD, the epidemic progresses much more rapidly (similarly to its progress in a number of African cities).

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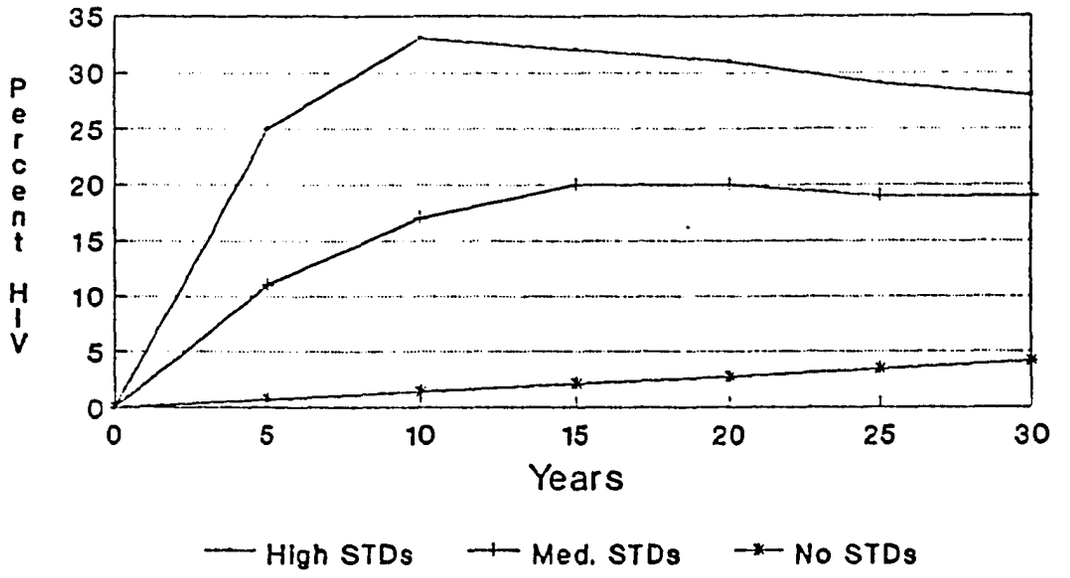
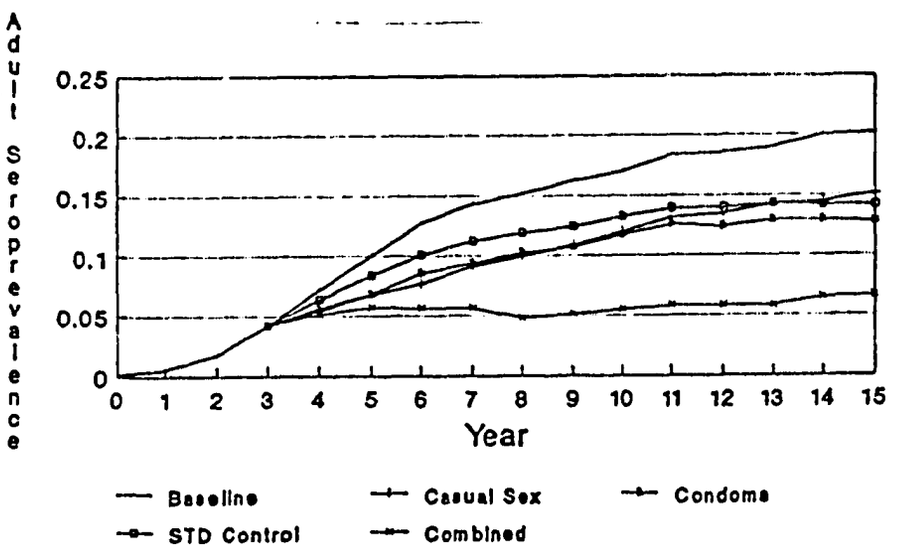
[2] For a complete discussion of these two models, refer to Technical Annex B: Modeling in AIDS Prevention.

FIGURE 12: EFFECT OF STD PREVALENCE ON HIV - PRELIMINARY RESULTS



The impacts of partner reduction, condom promotion and STD programs. Most interventions to prevent the heterosexual transmission of HIV can be classified under three headings: (1) Changing the rate and pattern of unsafe sexual contacts, (2) Changing the degree of condom use and (3) Changing the level of classical STD (which strongly promote the transmission of HIV). The preliminary estimates of the effectiveness of these three interventions (done separately) on the spread of HIV are shown in Figure 13, using the SimulAIDS simulation model.

FIGURE 13: EFFECTIVENESS OF INTERVENTIONS - PRELIMINARY RESULTS



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AIDSTECH, in collaboration with WHO, and with the iwgAIDS and INSERM modeling research groups, has begun an initial examination of the relative effectiveness of these interventions in a hypothetical African city with a serious AIDS epidemic. FHI plans to prepare a final report for WHO, which should be completed within the next year. The relative impact of any of these interventions in a specific situation depends on the prevalence of the risk factors in the population and the acceptance of each specific intervention. The models at least qualitatively suggest that each intervention will reduce the level of HIV infection.

Targeted interventions. It is well known from work on classical STD that preventing STD cases in the "core" group is much more effective than preventing cases in the noncore population. The core group is actually a theoretical construct, which is defined as the group of individuals whose high rate of sexual activity is responsible for the persistence of an STD in the population. While many prostitutes, military personnel and truck drivers are members of core groups, anyone who is "away from home" on a regular basis can be a member of the core group. This group is much easier to define in theory than in practice, and the size of the core group may differ depending on the characteristics of the STD in question. Nonetheless, it is clear that interventions are most cost-effective if they are targeted at core groups (Over et al, in press). For example, in the case of chancroid, Over and Piot estimate that preventing 100 cases in the core group members would result in averting 810 future cases, while preventing 100 cases in non-core group members would only prevent 83 future cases.

Costs of interventions. Before one can compare the relative cost-effectiveness of various interventions, it is necessary to know the cost required for a given impact. In the case of STD, and condoms, there are data available for the cost of STD treatments and for the cost of distributing condoms. There is much less data available on the cost of IEC activities, although estimates are starting to become available (personal communication, World Bank).

Data from early work with SimulAIDS (personal communication Auvert et al, 1991) have shown that one can quantify the savings of combining intervention strategies. For example, convincing people to decrease their casual sexual encounters will reduce the number of condoms and STD treatments consumed. In turn, increasing condom use will decrease the number of STD treatments needed.

Blood screening. Field studies have shown that transfusions account for a relatively small proportion of HIV

transmission and modeling of the epidemic has confirmed the futility of relying on blood screening to have much impact on the spread of the epidemic (Auvert, 1990).

3.3.2 Policy-related Information Needed by Policy Makers

Projection and Simulation models, as described above, can be extremely useful in policy dialogues with political leaders and opinion makers. The Projection models can graphically demonstrate the projected numbers of infected persons, AIDS cases, deaths, and orphans. The simulation models can present information comparing different types of control/prevention interventions and their impact on the epidemic.

In addition to the use of models to allow appropriate planning and allocation of resources, it is critical that policy makers also fully understand key issues that are unique to the AIDS epidemic. Some of these issues are:

Incubation (or latency) period. Perhaps the most diabolical aspect of HIV disease is the long period of time between HIV infection and the development of AIDS. In studies in the US and Europe, the median length of survival between an initial HIV infection and death from AIDS is at least 10 years. Several researchers in Africa have suggested that survival may be shorter due to (1) the earlier occurrence of AIDS (ref, Plummer; Konde-Lule, Kampala, personal communication) or (2) higher mortality from other infectious causes before the occurrence of full-blown AIDS (Gilks, Nairobi, personal communication). In any case, adult death from AIDS or other causes related to HIV infection occurs on average from about 7 to 10 years after infection.

Epidemic of HIV spread before large numbers of AIDS cases develop (including future cases with no new infections). HIV infection can spread so rapidly that a large proportion of a population can be infected before more than a handful of AIDS cases become apparent. In practical terms, this means that HIV can often spread so rapidly that it overwhelms a population before adequate control systems to combat it can be developed. Given the long incubation period of AIDS, the epidemic of HIV infection can develop an inexorable momentum before many AIDS cases occur. Even if all new HIV infections could be stopped as of today, the fact is that the epidemic of AIDS cases would continue to increase for years to come, because of the number of people already infected with HIV.

Transmission mechanisms and their relative efficiency. There are three fundamental ways that HIV can be transmitted: through sexual contacts, through blood or blood products, and from mother to infant during pregnancy or the perinatal period.

The rate of sexual transmission is difficult to summarize in a single figure, because it varies depending on at least two factors: the presence of other STD which cause genital inflammation; and the timing of contact relative to the level of virus in the body fluids which tends to be high in the early and late stages of HIV infection. In addition, transmission in the absence of risk factors seems to be more efficient from the male to female than vice versa. A rough estimate of the wide range of rates of transmission from vaginal intercourse would be 1/100 to 1/1000 contacts in the absence of any risk factor up to 1/10 contacts in the presence of an ulcerative STD and a person in the early or late stage of HIV infection.

Transmission through the re-use of unsterilized needles has been well documented in a number of tragic occurrences, but is probably rare in conventional medical settings. Of more concern is the re-use of needles by the traditional practitioners or "injectionists" that are common in many developing countries.

Several research teams in different countries are studying the rate of transmission from mother to infant, also called "vertical" transmission. The rate of vertical transmission reported seems to be higher in African studies (30 to 50%) compared to European studies (10 to 30%). The reasons for this difference are poorly understood, and speculation revolves around the possible importance of transmission at different stages of HIV disease or timing of transmission in relation to stage of pregnancy (intrauterine, perinatal, or postnatal).

Adult prevalence and the age/sex distribution of the HIV infected population. Statistics about the AIDS epidemic are usually given in terms of the percent of adults who are infected with HIV, or the "prevalence" or "seroprevalence" of HIV infection. Women are infected at a younger age than men due to the well known age difference in sexual partnerships. Most diseases attack the very young or the very old. HIV infection will have a more severe impact on society than other diseases because it kills men and women during their most productive years in both economic and reproductive terms. Their participation in the economy will be missed, and they will leave their children as orphans.

3.4 Summary

In summary, three key dynamics of HIV infection and their implications for AIDS control and prevention programs can be summarized as follows:

- Many young men and women get infected before marriage. Thus while they may cease their high risk behaviors after marriage, this does not necessarily prevent them

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from infecting their partners and eventually their children through vertical transmission.

Implications for prevention programs: It is imperative to target youth and prevent them from becoming infected before marriage. Preventing transmission between faithful marital partners is likely to be relatively expensive since it would require large scale programs of pre-marital testing and counseling. However, some argue that the promotion of voluntary pre-marital testing and counseling would send a strong message to young men and women.

- After marriage, a certain proportion of men (and probably a much smaller proportion of women) continue their high risk behaviors. These men get infected and in turn infect their wives. In addition, men in some countries seem to be seeking much younger women as sexual partners in the hopes of avoiding HIV infection in the course of their non-marital or extra-marital sexual encounters.

  Implications for prevention programs: The persistence in dangerous behaviors after marriage should be vigorously targeted. In particular, a study may be needed to determine whether older Malawian men are also seeking out younger and younger girls. Changing social norms through one-on-one interpersonal counseling and community-adopted sanctioning of such behavior should be emphasized.

- The spread of HIV is high in both urban and semi-urban areas. In the Malawi context, villages which include substantial numbers of migrant workers should probably be considered semi-urban. Given the relatively good transportation network in Malawi and the large number of migrant workers, many villages in Malawi are at high risk of HIV infection.

4.0 STRATEGY

4.1 Overall Project Strategy

The three broad strategies for HIV/AIDS control consist of communication for behavior change, condom promotion and distribution, and reduction of sexually transmitted diseases (STD). These three strategies are mutually reinforcing and will be fully integrated in the approaches proposed in the following sections.

In addition to the communication, condoms and STD strategies

noted above, however, the project will be grounded in five overall principles which are woven throughout the fabric of the project design. They are:

Collaboration. All programming will be designed as part of a national approach within the context of the National AIDS Control Program and will incorporate efforts from a wide range of sectors, organizations and individuals. This will expand and improve audience reach and relevance and thereby create more effective, sustainable programs.

Capacity building. The project will place significant emphasis on helping build local capacity to design, implement, and evaluate effective programming in behavior change communications, condom promotion and distribution, STD prevention and control, and quantitative and qualitative skills necessary to gather information necessary for program implementation and evaluation. Skills transfer efforts and technical support to consistently improve the ability of counterpart individuals and organizations to effectively carry out AIDS prevention programming and operations and scientific research will be of equal priority to the programs themselves.

Targeting. Drawing upon the expertise of both public health and marketing, communication, condom and STD programming will emphasize targeting ("audience segmentation"). This will allow the project to focus intervention efforts in ways which will maximize impact and cost-effectiveness.

Research will be an integral component of each of the three strategies. It will help shape subproject design, implementation and monitoring, and will be the basis for measuring its results and impact. Research will be conducted in collaboration using local resources whenever possible.

Monitoring and evaluation are critical steps of good project implementation. Both monitoring and evaluation strategies will be incorporated into each sub-project activity to ensure that sub-projects are implemented as well as they can be and that the results of these efforts will be captured and quickly disseminated to add to the body of world knowledge and lessons learned.

4.1.1 Communication

Communication for behavior change is one of the project's key technical components. The goal of communication program interventions and strategies is to initiate and support behavior change which will reduce the risk of HIV/STD infection. Particular emphasis is placed on behavioral aspects of the three major intervention areas, which when applied as a comprehensive

program, are thought to have the most overall HIV prevention potential.

The behavioral goals of communication programming are to:

- o increase condom demand, acceptability, and consistent use
- o increase STD-related symptom recognition and treatment-seeking behaviors, and
- o decrease numbers of sexual partners

The comprehensive behavior change communication programming developed during this project will be guided by the following principles:

Target audience involvement. Target audiences will be involved in all phases of communication program design. This is essential for the development of relevant, effective programming and to ensure that individual and community values, concerns, and needs are addressed and reflected in the program.

Multiple communication channels. The identification and use of multiple communication channels will enhance target audience reach and allow for more diverse and effective behavior change programming. Communication channels will be selected on the basis of reach, cost, feasibility, and potential effectiveness in changing behavior once target audience(s) and intended risk reduction behavior change actions have been identified.

Multiple, reinforcing messages. The project will design diverse messages to reach a given target audience. These messages will build upon one another, providing continuously reinforcing and directed support for change at both individual as well as community/normative environment levels.

Effective use of research. Communication programming strategies will draw upon ongoing behavioral, formative, operations, and evaluations research to enhance culturally appropriate and effective content, message, channels, and design. Lessons learned from in-country pilots as well as research conducted worldwide will be incorporated into relevant communication programs in Malawi.

Changing social norms. The overriding goal of this project is to change social norms related to risk-reduction behaviors so that low-risk behavior is seen as socially acceptable and desirable. This shift in norms is crucial if long-term behavior change is to take place at both individual and community levels.

4.1.2 Condom Distribution

Condoms represent the most effective means of preventing HIV transmission among sexually active individuals. Consistent, correct use of condoms not only protects individuals from HIV disease directly but also prevents the transmission and acquisition of other STD which themselves are co-factors for HIV transmission.

The goal for condom promotion and distribution is to strengthen the institutional capacity of Malawi including the encouragement of a policy environment that will lead to successful and sustainable condom intervention programs. To be most effective, condoms need to be accessible, affordable and acceptable to those who need to use them. The following key principles will characterize the project strategy for condom promotion and distribution:

Accessibility. Barriers to condom use can result from social, psychological, financial, cultural and geographic/logistical constraints. Strategically maximizing the number and type of distribution outlets and the skills of those responsible for dispensing condoms as well as educating and motivating potential users is critical for reducing those barriers and hence, increasing use.

Acceptability. Consumer acceptability can only be achieved through carefully developed, culturally sensitive and effective condom promotion. The delivery of well-researched, targeted, multi-channeled, and reinforcing condom promotion messages must be an integral component of the communication strategy.

Private sector participation. Upgrading private sector distribution through condom social marketing has proven to be a culturally acceptable way of making condoms available to people who want them. Further, it facilitates long term project goals of sustainability, efficient distribution, and greater private sector participation in health care delivery.

Long-term planning for supply sustainability. Increasing demands on donor-supplied condoms cannot be met indefinitely. Securing a long term supply will require prudent multi-year planning which must be fully integrated in AIDS programming and reprogramming efforts at the country level.

4.1.3 STD Control

Appropriate diagnosis and treatment of STD decreases the infectivity of an individual and interrupts the chain of transmission of STD thereby preventing further spread of STD/HIV. To be most cost-effective, STD interventions should be

prioritized to the following groups:

- o groups whose behavior put them at high risk ("core groups")
- o urban/high density areas with high STD prevalence
- o symptomatic individuals in urban/high density area.

The following key principles guide the project's efforts in STD control and prevention:

Targeted efforts. Individuals in the above groups often practice behaviors that put them at the highest risk of STD and HIV infection. Therefore interrupting STD and HIV transmission in these groups will have a larger impact on the overall STD and HIV infection levels in the general population than if services were specifically focused on them. The presence of sexually transmitted diseases, particularly genital ulcer disease, increases the efficiency of HIV transmission 5 to 20 times. In addition, IEC activities that target high risk "core transmitter groups", such as STD patients, can have up to eight times as large a preventive impact as those aimed at the general population (Over et al, in press). Thus, improving access to and quality of STD case management is an important intervention for decreasing the transmission of HIV.

Syndromic approach to diagnosis. Emphasis will be placed on the management of syndromes of genital ulcer disease and discharges, and specific STD most strongly associated with HIV transmission and for which diagnosis and treatment are most feasible.

Strengthening STD case management services at the point of first encounter is critically important as it may be the only contact and may influence future health-seeking behavior and costs. STD case management includes not only STD treatment, but the full spectrum of risk assessment, diagnostics, screening and behavioral interventions offered in the context of the provider-patient/client interaction. It also includes the promotion of early symptom recognition and appropriate health seeking behavior by men. Improving STD case management for women must involve the expansion of screening services for asymptomatic women and offering efficient, appropriate treatment. Information, education, counseling and condom promotion, should be fully incorporated into STD case management in the classical provider-STD patient setting.

Prompt treatment with highly effective drugs on the basis of a syndromic approach even when lab support (e.g., syphilis serology and gonorrhea culture) is available, is recommended so that treatment can be started at the initial clinic visit. Delay

of treatment for laboratory test results permits more specific therapy, but allows for the spread of STD (especially when patients fail to return), and causes client dissatisfaction.

The five "Cs". IEC and counseling should be an integral component of all STD services, incorporating "the five Cs" -- counseling, condom promotion, contact tracing and treatment, compliance and confidentiality.

4.2 Comparison of the cost-effectiveness and the immediate acceptability of various intervention strategies

Unlike population programming, there is at present relatively little data on the cost-effectiveness of various interventions in HIV/AIDS prevention and only elementary data-based comparisons between different types of strategies. The preliminary conclusions drawn from the findings to date reflect only in-country recurrent costs. The researchers have uniformly omitted the costs of expatriate technical assistance to better examine issues of sustainability and comparability among different strategies.

4.2.1. Communication

A draft report by the World Bank attempts to examine the relative cost-effectiveness of various IEC strategies. The approach is based solely on estimates of the relative effectiveness of different communication strategies and cautions that its estimates should be taken as relative estimates for comparison of different strategies, not as absolute estimates of the cost of changing behavior or preventing infections. The report suggests that it is very difficult -- if not impossible -- to estimate the cost-effectiveness of a particular IEC strategy in isolation, and that a combination of various approaches is needed.

4.2.2 Condoms

A study reported by Moses et al based on an intervention among commercial sex workers in Nairobi estimated that the cost of preventing a single new HIV infection through education and condom promotion among that group is on the order of $10.

The interventions described above differ in terms of immediate acceptability. In general terms, mass media messages calling upon abstinence and monogamy with one lifetime partner are the hardest for people to follow. Other types of communication and channels (e.g., dramas, small group discussions) aimed at reducing high risk behaviors through alternative strategies are likely to be relevant to a larger

number of people. These types of IEC efforts usually take time to develop and implement, however, and the use of condoms is resisted by many men, often until they are convinced of the existence of AIDS by the death of a friend.

On the other hand, improved, low-cost STD treatment is almost always sought after. The opening of a small STD clinic at Queen Elizabeth Central Hospital, for example, was instantly overwhelmed with patients, eventually treating approximately 15,000 patients per year.[3]

While STD treatment services are very acceptable to patients, health care professionals often consider STD services to be a low priority. From the point of view of AIDS control efforts, however, STD clinics provide a relatively efficient way to reach core group members and other individuals with high risk behaviors. They may also be used to provide education in risk reduction and condom use.

4.2.3 STD

The most interesting and useful analysis of costs has been published in a monograph by Over and Piot (in press) who have extensively analyzed the costs and benefits of various STD control strategies to estimate the cost per healthy life year saved of various interventions under varying conditions.

Their work is based on a relatively simple mathematical model of HIV prevention addressing two population groups (core and non-core) and an interaction between HIV and other STD. It assumed that genital ulcer diseases (GUD) such as syphilis and chancroid increase HIV transmission by a factor of 5, and the other major classical STD (gonorrhea and chlamydia) increase HIV transmission by factors of 3 and 2, respectively.[4]

Over and Piot compared both primary and secondary STD control strategies in core and non-core groups to estimate the likely ranges of the cost per discounted healthy life year saved. Their data lead to the following rough ordering of general intervention approaches from most to least cost-effective:

(1) IEC/condom promotion in core groups

(2) STD treatment in core groups

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[3] Clinic operations have been curtailed with the departure of the expatriate physician who directed it.

[4] It should be noted that the Nairobi research team feels that chancroid is relatively more important than GC or chlamydia in increasing the spread of HIV than Over and Piot.

(3) IEC/condom promotion in non-core groups

(4) STD treatment in non-core groups

(5) Palliative and home care of AIDS patients

(6) Antiviral therapy of AIDS (AZT)

The authors caution that their estimates of IEC/condom promotion programs are "less solidly based" than their estimates of STD treatment costs. Data for the cost of IEC/condom promotion programs, for example, were limited to the costs of condom social marketing programs in Zaire and Cameroon, both sites of very successful condom promotion efforts. Their estimates of IEC/condom promotion costs did not, however, include the costs of educational activities outside the social marketing efforts. This would suggest promotion costs are underestimates of total actual costs. It would therefore be difficult to apply their data to programs targeted at youth, for example, since an unknown proportion of youth are members of the core group, but educational campaigns in schools typically address all youth.

Their general conclusion is that activities aimed at core groups are significantly more cost-effective than activities aimed at non-core group members. The difficulty in operational terms is identifying which individuals comprise the core group. For example, while bargirls and their non-condom-using clients are part of the core group, there are undoubtedly many other individuals with high risk behaviors who are not members of any easily identifiable group. The best operational definition of a core group member is one who has multiple partners and has more than one STD illness within a given period of time, e.g. a year.

Over and Piot also evaluated the socioeconomic correlates of HIV infection. They found that there was a strong association between the level of HIV infections and the urban ratio of females to males (the lower the ratio the higher the HIV-1 infection level) and the level of female education (the lower percentage of women educated the higher the HIV-1 infection level). They conclude that one of the most promising ways to fight STD, including HIV, over the long run is to improve women's education (e.g. GABLE), increase the number of urban women, and reduce opportunities for separation of families.

5.0 PROJECT DESCRIPTION

The project description outlines two integrated purposes of the project components: (1) to reduce HIV transmission among target groups at highest risk of acquiring and transmitting HIV, and (2) to develop the capacity of the public and private sectors to implement effective HIV prevention programs in Malawi.

The objectives of the project components are to:

(1) Support behavior change which leads to lower risk of HIV transmission/acquisition

(2) Improve the delivery of STD services -- diagnosis, treatment and management through the public and private sectors

(3) Improve the distribution of condoms through the public and private sectors and to increase consistent correct use of condoms by those who need to use them

Expected outputs of the project include:

(1) The percent of schools providing STD/HIV education to the nation's youth and young adults from 0% in 1992 to 80% in 2000.

(2) 2 youth centers per district will be established, staff trained and delivering HIV communication programs to adolescents by 2000.

(3) Focused print and electronic materials created through formative research will be developed and disseminated to each target group as an integral component of each program intervention

(4) Number of condoms sold annually through social marketing increased from 1.1 million in 1992 to 2.6 million in 2000.

(5) Annual public sector distribution of condoms will increase from approximately 3 million in 1992 to 8 million in 2000.

(6) Effective STD drug therapy being employed by 80% of the existing private clinics, and 100% of urban and semi-urban public STD treatment centers by 2000.

(7) 90% of large private sector firms (over 300 employees) have effective family health programs in the workplace

(8) Percent of Health Surveillance Assistants (HSA) providing comprehensive child spacing and HIV/STD prevention services at the community level increases from 0% to 25% by 2000.

(9) National capacity for training in prevention counselling, community organization, and replication of

training established by 2000.

(10) An umbrella organization to coordinate and manage the full participation of non-governmental and other community-based organizations providing AIDS/STD prevention and child spacing services is established and effectively supporting a network of NGO and CBO programs.

(11) Laboratory facilities upgraded in 3 referral centers and sentinel surveillance established in 5 sites by 2000.

5.1 Specific Target Group Strategy

The project will support the design and implementation of multi-channeled, multi-dimensional intervention strategies with seven target groups. Four of these groups -- youth in and out of school, employed men, bargirls/bar owners, and male STD patients -- represent the primary targets of this project. These groups were selected using the criteria of risk of HIV acquisition and transmission, potential prevention impact, and ability to identify and reach these groups with behavior change communications, STD treatment and condoms.

A second tier of targeted populations -- unmarried women aged 18 and above, males 30+ and female STD patients -- are not only somewhat harder to reach but, given the social and cultural practices in Malawi, will be most effectively reached initially through their partners.

The first step in implementation for each of the target groups will be undertaking a comprehensive inventory and assessment of activities and materials produced to date by organizations participating in the implementation of the national AIDS control program. The purpose of these activities will be to clearly identify those areas which would benefit most from further support. A behavioral research agenda will be developed to ensure the existence of baseline data and to gather formative research data to guide the intervention activities.

5.1.1 YOUTH IN AND OUT OF SCHOOL

Target group risk profile:

Youth between 10-19 years old represent 43% of Malawi's population of 9 million (Demproj). They have relatively low school retention rates, poor literacy rates, and are difficult to reach with relevant HIV prevention messages. HIV prevalence among urban/semi-urban males 19 years old is estimated currently at 2-4%; and 8-12% among their female counterparts. High teenage pregnancy and STD rates obtain as a result of inadequate or erroneous information on reproductive and sexual health and contraception provided through initiation ceremonies and traditional teachers (nankungwi or alangizi).

Girls in particular lack communication and negotiation skills and instead are taught to avoid of all males. This early training and the threat of divorce puts Malawian females in weak negotiation positions in their relationships with men and around behaviors requiring approval of both partners (e.g., condom use). Further, economic-necessity often requires young girls to exchange sex for money or other commodities with older males (i.e., "sugardaddies").

Young men, alternatively, are encouraged especially by uncles and grandfathers to pursue sexual activity as a passage into adulthood. Boys are generally better prepared for the onset of puberty and have fewer negative attitudes about sex as they enter into adulthood and assume traditional decision-making power regarding initiation and frequency of sex, and numbers of sexual partners.

A 1990 study by Msapato, Kumwenda, Chriwa et. al. found that knowledge about condoms was relatively high -- 66.7% of urban school teenagers and 39% of rural school attenders. Approximately one-third (30.5%) of primary students and 85.2% of secondary students know that condoms prevent HIV transmission and 60.2% of school teens believe that condoms are an acceptable method of prevention HIV.

Communication

Target-specific communication goal.

Communication programming targeted to youth in or out of school will aim to reduce the potential for HIV infection by eliciting changes in the individual's behavior and the general beliefs and accepted behaviors of youth as a group. These will include:

- o encourage the teaching and learning about sexual health an accepted practice in adolescence, especially those sexual and other behaviors which increase risk for HIV infection; and symptoms and routes of acquiring STD

- o delay of onset (i.e., increase the age) of first sexual activity by 1 or more years

- o retention (or return) of youth in school

- o reduction in disparity between age of sexual partners (especially young sexually active females) to lower risk of being HIV infected

- o adoption of non-penetrative behaviors into "sexual behavior"

- o ability for both young sexual partners to postpone or reduce frequency of sexual activity (i.e., enabling young males and females to share in decisions about sex)

- o preference for initial and/or continuing sexual activity with only one partner who is also monogamous

- o consistent condom use during intercourse for those youth who are sexually active, even with one partner

Communication interventions:

The communication for behavior change program will build on previous and continuing activities to increase knowledge/awareness, explore attitudes/perceptions, and foster behavior change among youth. The program will consist of activities at both the national and community levels: national level activities will reach large segments of youth quickly but be supported and strengthened by parallel programming at the community level.

AIDS education. Support for the adoption and integration of the AIDS curriculum throughout the formal education system will continue under the project and be the prime vehicle for reaching in-school youth with education on AIDS prevention. Teaching materials, including trainers' guides and supporting materials for teachers will explore attitudes/perceptions and the development of positive social norms as part of this education program.

In year two discussions will be initiated with other potential audiences for this programming including the Ministry of Agriculture, the Ministry of Women, Children and Community

Services, the Malawi Young Pioneers, and others. The curriculum which may include issues in family planning will be assessed and modified as necessary to meet the needs of these diverse audiences.

Communications media to support attitude/perception examination. Focused use of both large and small media at the national and community levels will be used to support exploration of personal attitudes and perceptions related to AIDS. At the national level, focused use of large (mass) media will be used to begin changing ideas about initiation of sex and sexual practices, and to change perceptions among peers regarding the relative importance of sexual activity at early ages.

Targeted "small media" communication programming will be evaluated for effectiveness and, if efficacious, continue to be used to reinforce the objectives of the large media activities at the community level. Since different segments of youth may be both accessible and responsive to different methods, the communication programming approach with youth will be multi-channeled, and content will be reiterative and reinforcing. Materials will be designed to narrowly targeted segments of youth, according to such parameters as age, gender, and literacy levels.

Interpersonal communications for behavior change. Normative, peer group change will be supported through sustainable, community level programs designed to provide interpersonal counseling and peer education. Youth focused activities will incorporate communication channels and methods to establish and reinforce norms delaying onset of sexual activity, protected intercourse, non-penetrative intercourse, and sexual decision-making as an equitable and mutual process between partners. The institutional forums for such activities may include youth clubs (e.g., sports, religious, or agricultural), regular and alternative education systems (e.g., boarding schools and the Malawi Distance Colleges of Education), other community-based organizations (e.g., PTAs, women's groups), or result from the various social mobilization activities occurring at the community level (e.g., area level briefings, parent education panels emanating from community based discussions of the AIDS school curriculum, social service clubs, other emerging networks of concerned citizens). The particular organization or coalition of organizations will emerge from the specific community in which the intervention is established. Youth centered programs will be piloted and monitored closely in a number of communities early in the project using variety of community models.

Initially this intervention may be primarily targeted to young males as the most powerful sexual decision-makers and that segment of the youth population with most potential for disease

prevention impact.

Support for facilitators. The project will assist the community members and organizations which participate in these youth-centered interventions by providing skills upgrading as necessary in areas of program design, counseling, interpersonal communications, financial management, organizational development and management, evaluating message and condom distribution systems, problem-solving and community mobilization and motivation.

Condom promotion and distribution

Target specific condom goal.

In the best of all possible worlds, youth would be protected from the risk of sexually transmitted HIV infection through a delay in the onset of their sexuality until they are sufficiently capable of handling mature, sensible decision-making. In the real world, however, despite the advice and counsel of family, religious leaders and other key influentials in their communities, many Malawians do become sexually active at an early age. The results of their sometimes impulsive behavior are teenage pregnancies, abortions, early parenthood, and sexually transmitted diseases including HIV.

As outlined above, the primary focus of HIV prevention programming for youth will be to assist them in developing the skills to adopt less risky behavior -- including delay of sexual onset. For those who are sexually active, however, the goal of the condom distribution and promotion strategy will be to ensure access to and correct use of condoms.

Condom interventions and overall programming strategies

Working within the communication strategy outlined above, the condom strategy for this target group will be to (1) to conduct formative research regarding youth and condom use, (2) to improve and expand the currently available multi-channeled distribution systems at the community level for condoms, (3) to create support systems through which youth will have access to information on correct condom use and other pertinent issues, and (4) to conduct research which examines the impact of condom availability on initiation of first sexual experience.

Formative research. A targeted design of qualitative and quantitative research will be conducted to determine the knowledge, attitudes and practices of youth regarding condom use. This research will explore the facilitators, barriers, misconceptions and information gaps surrounding condom use by sexually active youth in and out of school. It will also

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identify the preferred and most effective distribution channels.

Multi-channeled distribution system. Based on the results of the research described above, the project will support the expansion of the efforts initiated under the ACP and MOH's child spacing program to deliver condoms through district hospitals and health clinics, health surveillance assistants, traditional birth attendants and traditional healers.

Support systems. Given the cultural and political sensitivities surrounding the issue of condom distribution to youth, the project will undertake a specific strategy for eliciting the support of those who have the responsibility for administering condom supplies and information to sexually active youth seeking these products. Training will be conducted to foster an understanding of the importance of providing condoms to sexually active youth, explore and resolve value-laden attitudes which may interfere with successful communication with this group, and to develop skills in non-judgmental counseling, information sharing and listening with this special audience

Particular condom skills anticipated to be required by youth will include partner communication skills, assessing condom quality, correct condom use, proper disposal and consistency in use. Training and IEC materials providing instructions on such topics will be developed to be incorporated into the larger communication training and counseling strategy for youth to ensure that these messages are communicated in the context of a full and open dialogue on risk reduction.

Parents groups, community groups and village leaders will also be targeted in a campaign to improve skills and reduce resistance to these efforts.

Research on condoms and sexual initiation. The project will support a study which examines the relationship between accessibility to condoms and the decision to become sexually active. It will seek to determine whether increased access to condoms leads to increased sexual activity by youth.

STD Control

Target specific STD control goal and strategic intervention:

The major strategy for the control of STD in this group will be to educate youth about the symptoms of STD and the appropriate location to seek treatment. Specific efforts will be made to educated school nurses on symptom recognition and to improve the service delivery of clinics near or in school and universities. These following messages will be incorporated into the HIV risk reduction teaching described above:

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- o those sexual behaviors which place youth at risk for STD including HIV infection;
- o symptoms and routes of acquiring STD;
- o potential consequences of STD;
- o knowledge of the importance of early, effective therapy and the appropriate location to seek therapy; and
- o responsibility to partner.

5.1.2 EMPLOYED MALES

Target group risk profile:

This target group is comprised of males employed at urban worksites, on rurally-located agricultural estates and those separated from their spouse at the worksite including truck drivers who have ready access to bargirls or other women who exchange sex for money. These men have disposable income, are sexually active and at risk for acquiring STD. Norms among this group are generally permissive.

Employee clinics report that STD are a common complaint of employees: The Stagecoach Line clinic in Blantyre serving about 800 employees reports about 15 new STD cases per months or about 23 cases per 100 person years (personal communication). SUCOMA estate in Ntchalo reports about 120 new cases of STD a month out of 7000 (5000 permanent and 2000 temporary) male workers for a 21% annual incidence (Clinical Officer, Sucoma estate, personal communication).

In three focus group discussions with truck drivers and five with laborers and factory employees (Kishindo, 1990) suggest attitudes and risk-associated behaviors conducive to HIV transmission exist among this target group. While AIDS was consistently recognized as a "serious health problem", and "promiscuous" sex was understood to be a transmission risk behavior, truck drivers noted the difficulty resisting casual sexual relationships; a preference for intercourse without a condom (due to reduction in satisfaction, condoms bursting, condoms causing bruises on the penis, and condoms becoming trapped in the female partner's body or uterus); the association of condom use with bargirls and new sexual partners; and the effect of alcohol on a man's ability to "resist opportunities" for having sex.

The Kishindo study and a 1990 baseline KAP study for the Health Social Marketing Project (RI/EAL, 1991) suggest the most prominent communication channels: 73% preferred the radio

particularly among truck drivers and 43% reported having a working radio. 55.5% obtain HIV information from health talks; 36.6% obtain HIV information from friends; and 25.2% from pamphlets (40% of all respondents were literate). Influential and religious leaders are cited as sources of information by only 7% of all participants.

The KAP study (RI/EAL 1991) also reported that 15.6% of young men always use condoms and 36% reported only using condoms when they expect their partner has an STD. Previous experience with a condom was identified as a predisposing factor for accepting condoms at a partner's request in intercept surveys conducted by Kishindo in October 1990: fully 84% of the men who had used condoms in the past said they would be willing to accept a partner's request while only 46% of the men with no condom experience would agree to use condoms. Most young men (85%) know that condoms are to be used only once (Kishindo).

Government hospitals (31%), clinics (28%) or friends (24.7%) are primary sources of condoms for young men while only 7% reported getting condoms from private hospitals and clinics. In focus group discussions (Kishindo, 1990) men said while hospitals were primary sources of condoms, it was inconvenient and embarrassing to obtain condoms there. 28% of young men cited unavailability as the main reason they were not using condoms (RI/EAL). Groceries and bottle stores are preferred outlets for young men and 2/3 of the respondents reported in the SOMARC study that 80 tambala for 3 condoms was a reasonable price.

Communication

Target-specific communication goal:

The overall goal is to maximize acceptance of individual risk, increase actions aimed at preventing HIV/STD transmission to sexual partners, and to create norms among men which support condom use, reduction in number of sexual partners, and protection of sexual partner(s). Though more needs to be studied about male sexual attitudes, communication programming may be able to reinforce men as responsible (disease preventive) decision-makers and may be able to foster support networks among men in different workplace settings including civil servants working for government, laborers at agricultural estates, and workers at urban worksites.

Communication interventions:

Using a successful model for one-on-small group prevention education and counseling of men by men, the communication for behavior change program will increase scope of affective and

behavioral learning among employed males at urban worksites and agricultural estates. It will especially target men who are away from their normal social milieu (e.g., transient factory workers, migrant workers, seasonal -- sugar, tobacco, and tea -- estate workers, and long-distance truck drivers).

Repeat prevention education/counseling sessions addressing individual behavior change within changing male social norms will be conducted at work sites. These sessions will be reinforced by workplace-organized support groups and by mass and "small" media messages which support replacement of high-risk behaviors with low-risk ones. A second phase of the program will provide counseling to assist couples to achieve low-risk sexual behavior patterns.

Communications media to change attitudes. Small print media (brochures for discussion groups; posters) will be designed and distributed where men congregate at worksites and where workshops, discussions or support groups are held. These materials will help to establish a context for behavior change through linking low-risk behaviors in relationship to other strongly held beliefs, values, or norms for these men.

Rather than direct appeals for reducing risk, these materials will identify low-risk behaviors (i.e.,condom use, protection of partners, early identification and treatment of STD) with currently accepted "lifestyles" and male images. They will also help address various myths and perceptions about infection, disease, and STD (e.g., "one can tell by looking at a potentially infected partner whether or not she has AIDS")

Small group male-to-male counseling. Working with worksite management, a skilled cadre of male trainers will assess knowledge, attitudes, and behaviors about HIV/AIDS among staff and laborers. With this information, facilitated discussion groups will be designed to: increase knowledge of and comfort with condoms, clarify interpretations of "promiscuous" or "casual" sex and how these relate to different sexual behaviors, identify patterns of alcohol use and sex, and help men identify motivators/barriers to low-risk sexual behaviors.

In a series of counseling sessions, small groups of men will be lead through a series of attitudinal changes leading to individually-adopted and group-supported behavioral change. The individual change might include: (1) risk assessment for acquiring HIV/STD from partners and transmitting it to them; (2) developing a sense of "protecting" one's partner against pregnancy or disease; (3) improved coping skills to address issues of loneliness/displacement during travel; (4) improved recognition of the link between displacement from "home", availability of commercial sex, alcohol drinking patterns, and

high-risk sexual behavior patterns; and 5) behavior change--with casual partners and with primary partner. The group work would include: 1) building a sense of belonging/contributing to the welfare of others--in the support group, in the couple, in the community; 2) identifying personal and group resources to support the step-wise process of behavior change.

Interpersonal communications for couple counseling. Following small group counseling sessions, employed men will be able to participate in "partnership" or couple counseling. This step will help to integrate individual decisions, coping skill development, and attempts at behavior change in the context of primary relationships. It will seek to initiate mutual (sexual) decision-making leading to couple norms supportive of low-risk behaviors.

Community action initiatives to further direct/support changing male norms. Using community leaders, workplace leaders, and other men of high status/authority as peer educators, social norms will be influenced. The use of natural leaders is part of the overall strategy specifically designed to provide multiple channels to continually reinforce support for wide adoption of low-risk behaviors.

Support for facilitators.

Intensive skills development training for NGO implementors in small group and couple counseling will be conducted. Additionally, training in personal motivation and persuasion will be targeted to male leaders to facilitate their use as trusted spokesmen.

Condom promotion and distribution

Specific condom goal and interventions:

The goal of the condom distribution and promotion strategy for employed men is to increase condom accessibility through private sector channels and to improve consistency and correct use.

Condoms still represent a relatively new technology in Malawi with which young men have begun active experimentation and use. Young men report both a high awareness of and personal interest in the product. For example, condom distribution to "non-registered" clients in government-supported child spacing programs clearly surpasses those distributed to "registered" (i.e., child spacing) clients. In fact, anecdotal reports suggest that some men are developing emerging small businesses selling condoms which they have managed to obtain free in large

enough quantities.

Employed men comprise the primary target audience for the condom promotion and distribution component of this project due to a number of converging factors:

- This age group is highly sexually active and has some amount of disposable income enabling them to visit bars, resthouses, and other places where high risk sex can and is negotiated.

- Indications are that use among this group would increase if condoms were more accessible and they have some amount of disposable income to exchange for convenience in source.

- As the primary decision-makers in a relationship, the one who is expected to bring condoms to a relationship, and the one who would personally use the condom in the sexual act, efforts to gain their support for condom use will make significant strides in the prevention of HIV and other STD.

- Acceptability of condoms is relatively high among this group; increasing acceptability could go a long way towards creating a social norm for male youth to emulate.

Efforts will focus on two areas: (1) expanding access through private sector condom social marketing and distribution through worksites, and (2) encouraging greater acceptability and trust in the product (less breakage) as a result of correct condom use.

Expanding access. Access will be expanded primarily through three distribution channels: social marketing in retail outlets, distribution to industrial workplaces and agricultural estates through community-based distribution by men.

Social Marketing. The project will provide continued support to **Protector** condoms and the efforts of the Health Social Marketing Project (HSMP) and its distribution firm(s) to expand the number and geographic reach of outlets for this brand. In the immediate term (year 1), HSMP will focus its efforts on strengthening distribution in urban and semi-urban retail outlets. It will expand to bars, resthouses, bottle shops, and nightclubs across the country through the collaborative efforts of beer distributors who service these outlets in the intermediate term (years 1 and 2) and over the long term (years 3 and 4) will phase-in to urban and rural workplaces (industrial and agricultural) and other institutions.

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More aggressive marketing including increased advertising and promotion, expanded retail and sales staff incentives, and regular marketing research to assess consumer acceptability of the packaging, pricing, promotion and distribution strategies will be conducted to maximize sales of **Protector**.

The HSMP will review the pricing strategies for the single, three and 12-pack presentations to revise the current incongruous pricing strategy resulting from the introduction of the promotional single pack introductory price.

Workplace condom distribution. The project will introduce a pilot community-based distribution activity for supplying condoms to industrial and service businesses through the local NGO, Banga la Mtsologo. Banja staff will be responsible for distributing the condoms to the industrial and service workplaces as a part of their AIDS in the workplace programming. Resupply will be effected as a component of regular follow-up of the peer education program. If successful, the pilot activity will be expanded throughout the southern region until the HSMP project is prepared to assume responsibility for condom distribution from the NGO in the workplaces.

Agricultural estate distribution. The CBD program will also be introduced on a pilot basis on a limited number of agricultural estates through an expansion of Project HOPE child survival activities. Under this scheme, estate workers resident on estate compounds or surrounding villages will be invited to participate as condom promoters/distributors for HIV/STD prevention, obtaining their supply initially through Project HOPE although a long term source of supply and resupply (perhaps via HSMP's **Protector** condom program) will need to be developed.

The distributors will be allowed to charge a small price (e.g., 5 tambala) per condom as an incentive for promoting the product, ensuring a constant supply, and keeping records of condoms distributed. Distributors will be trained in condom promotion and record keeping. Free condoms will also continue to be available through the child spacing efforts of Project HOPE in the estate clinics.

Improving correct condom use. In conjunction with the communication strategy for this target group, low literacy materials will be developed presenting explicit instructions for correct condom use. These materials will be tested for efficacy through small operations research studies which both test knowledge of correct condom use along with the understandability and acceptability of the materials. The materials will be disseminated through the workplace and estate programs as well as the estate clinics.

STD Control

Target specific STD goal and intervention:

The overall goal is to improve STD case management in the numerous (approximately 300) industries and estates that provide health care services to their employees. The project will attempt to improve STD management (diagnosis, treatment, counseling, condom promotion, and partner notification and treatment) in employee clinics currently providing health services. The project will attempt to initiate STD management services to those companies that do not currently provide them, especially those companies with a large number of male employees out of their normal social milieu (construction crews, transportation, mining).

Program strategies will include:

Educate employees on behaviors that put them at risk for STD including HIV infection; symptoms and routes of acquiring STD; the potential consequences of STD; and responsibility to partner.

Policy discussions with management to educate them as to the cost-effectiveness of appropriate STD case management and HIV education. Assistance would be provided to help management abandon ineffective drugs used for STD treatment (the reason employees are often seen repeatedly for the same problem) and to replace them with better therapy. Cost savings could be applied to expanding coverage to families at least for STD and other reproductive health management. Companies not currently providing services for employees will also be encouraged to initiate workplace programs as a good investment in decreasing the risk of AIDS in their workforce.

Train private company clinic providers on appropriate diagnosis and therapy of STD. Clinic providers will receive skills upgrading to ensure they can provide accurate risk reduction messages and appropriate condom information to men with STD. As company clinical care providers are less burdened with high patient volume, they may be able to provide, in addition to accurate diagnosis and therapy, risk reduction counseling and condom education. These clinical care providers will also be incorporated into a partner notification system whereby sexual partners of employees can be referred for appropriate therapy.

5.1.3 MALE STD CLIENTS

Target group risk profile:

Male STD clients are at increased risk due to the strong

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association of STD as possible cofactors contributing to HIV infection and possibly accelerated disease progression and the fact that behaviors which contribute to STD transmission also transmit HIV.

Studies indicate that urban STD patients in Lilongwe already have an HIV-1 infection approaching 60%. Male STD clients are a prime target group in particular since male STD symptomatology is more obvious and profound than that of females, usually resulting in the desire for treatment. In 1989, the last completed HIS summary, there were about 500,000 outpatient visits for STD. Based on other data about 80% of these patients were men.

Self-medication for treatment of STD is reportedly common and is usually ineffective, resulting in prolonged infectiousness and antibiotic resistance of the STD pathogens. Treatment of STD is becoming more difficult in Malawi, as in all of Africa, due to resistance of organisms to commonly used antibiotics and increasing HIV-1 infection among STD patients.

Severe time constraints by STD clinical staff often preclude even rudimentary counseling: a baseline KAP study of male STD patients (Wynendaele et al) indicated that 40% of STD patients in this sample did not receive any advice or counseling during STD treatment. Of those who received some "advice" during STD treatment 39% were told to complete their course of treatment, 10% were told about condom use, 24% were told about reducing number of sexual partners, and 7% were told to bring a sexual partner in for treatment.

Over 10% of the respondents reported having sex with "freelancers;" and 41% had sex with someone other than their spouse.

Condom use among STD patients is abysmally low -- in the same study, only 27.5% of the male STD patients reported ever using a condom and only 10% can correctly demonstrate its use. Only 61.7% of them have ever seen a condom and only 8.2% think condoms can prevent HIV infection. Approximately 40% of those who have used a condom report problems with condom breakage. If asked by a partner to use a condom fully one-quarter of them will either refuse to use one or withdraw their intention for sex.

Communication

Target-specific communication goal:

The overall goal is to provide communication programs which change individual male STD client behavior in the following ways:

- motivate those infected with STD to seek early

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treatment and to refer sexual partner(s) for early treatment

- o increase perception of risk for acquiring HIV infection as a result of STD infection

- o increase sense of self-worth to improve desire to be infection-free

- o increase skills needed to prevent further STD infection and/or HIV infection (e.g., condom use)

Male social norms will also change regarding STD:

- o reinforce adoption of risk reduction behavior among small groups of men by motivating the community (especially village leaders, party leaders, religious leaders, traditional healers) to change norms about acceptance of behaviors which contribute to sexually transmitted diseases.

Communication interventions:

It is well recognized that outpatient clinic staff have severe time constraints due to their heavy patient load. In order to take advantage of the opportunity for prevention education which occurs when a male client presents for STD treatment communication efforts will make use of printed material that can be distributed, audio (and video) cassettes for the waiting room, and the use of "para" health personnel or community volunteers. All training for these groups will be provided by the cadre of trainers based at MIE and will be coordinated through the regional and district levels. See Implementation Plan for further details.

Communication programming, described in detail below, will be designed to enhance the "treatment experience" by providing small group education and counseling to men at treatment sites. As part of these services, men will be encouraged also to "refer" sexual partner(s) for treatment and education/ counseling. These client-specific interventions are then reinforced through "buddies" (paired) or small support groups organized at the community level and by mass media campaigns targeted to men at the community level.

STD/ HIV prevention education from "health care providers". Printed materials (brochures, posters) will be developed by the project for distribution in waiting areas and during STD treatment. Because of their wide distribution, these materials will be primarily pictorial, geared to low literacy audiences. They will provide guides to symptom-recognition in males.

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instructions on how to use condoms correctly, and information on HIV disease progression related to cofactors including alcohol and STD.

Following formative research, accompanying audiocassettes and/or videotapes will be developed to explore attitudes/ perceptions related to unprotected sexual behaviors, condom use, self-worth (protection), protection of other male friends ("buddies"), and protection of sexual partner(s). Trained staff (HAs, HSAs) or volunteer/auxiliary staff (e.g.,cleaning staff) will be responsible for condom demonstrations, conducting question and answer sessions, and operating equipment in waiting rooms. Health staff will help to reinforce these objectives by distributing condoms as a part of "treatment"--enough for every sexual encounter and to share with friends and encouraging partner referral.

One-on-small group interpersonal communications for behavior change. Using the opportunity presented by large numbers of male clients waiting at clinics for long periods of time, trained staff will facilitate small group discussions to further early treatment-seeking, condom-seeking, and partner-referral behaviors and to provide referral information about community-based support groups for men.

Outreach education and community social mobilization. Selected STD treatment sites will have outreach workers trained in organizing community forums and support groups for men. Building on social mobilization efforts during area level AIDS briefings, characteristics and needs of men who have a history of STD will be studied. Using sustainable, community-based peer groups, long-term normative change will be targeted in the following areas: (1) reduction in the number of unprotected sexual acts among sexually active men; (2) overcoming barriers to assertive condom use during every sexual encounter with every partner; and (3) sharing condom supplies with friends as a mark of (male-to-male) friendship and/or as part of sex education provided to male adolescents.

Since many of these clients are also clients of bars, developing group norms will be further reinforced by changing the normative environment (i.e., bars). A "designated provider" approach will be piloted in select sites in which one member of a group of males will be encouraged to ensure adequate supplies of condoms for his friends for the evening (much like "designated driver" campaigns).

Mass communication programs to reinforce changing social norms among men. Media (e.g., videotapes, radio) will be used at both the national and community level to reinforce perceptions among men about self- and group-protection from HIV disease. They will connect themes of status and self-worth with individual

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low-risk behaviors, partner and community protection from HIV disease, and assertive condom-seeking.

Support for facilitators. The project through the cadre of trainers will provide training and technical assistance support to health and auxiliary staff, outreach workers and community volunteers participating at various intervention points in the program. Skills will be upgraded in the following areas: operation and maintenance of equipment, risk history taking, risk assessment/risk reduction counseling, community outreach and organization, group motivation and problem-solving, and follow-up/evaluation.

Condom Promotion and Distribution

Target specific condom goal and interventions:

The goal of condom efforts for this group will be to increase demand, self-efficacy skills, and, of course, condom accessibility.

Maximizing accessibility is an important component of the strategy for this group, but as important is the need to expose these men to condoms and to increase their knowledge and self-efficacy skills.

Condom knowledge and self-efficacy. Close collaboration with the communication/behavior change strategies will be important with this target group as a first step to getting the men ready to seek out condoms. Upgrading basic knowledge of STD patients on the efficacy of condoms, how and when they are used and how they are disposed of will be critical components of counseling.

Condom access. As a preliminary step in encouraging condom access, it will be imperative that counseling staff provide a good supply of condoms to the client as part of the counseling exercise. Ample supplies of free condoms will be crucially important at the STD clinics since it cannot be assumed these men will obtain condoms on their own due to lack of familiarity and possibly embarrassment.

A secure condom supply should also be provided at the places these men congregate -- bars, resthouses, etc. Initially condom supply to bars and resthouses will remain the responsibility of the AIDS Secretariat although it is expected that the CSM project will assume responsibility for these outlets in a phased roll-out quickly after project initiation.

STD Control

Target specific STD goal and interventions:

The overall goal is to improve STD case management services for symptomatic males presenting to STD and OPD clinics and improve health seeking behavior for all symptomatic males.

Improvement and expansion of appropriate STD services in outpatient clinics in public and private hospitals. Outpatient records suggest that symptomatic males are seeking care in large numbers. This project will improve the care of these men in the clinic setting. It is anticipated that as clinical care in the outpatient clinic is improved patients may be less likely to seek independent alternative therapies (e.g., traditional healers, self therapy, etc). The project will attempt to improve health seeking behavior in the population through education and the following improvements in service:

- Maximizing the services delivered at the place and time of first encounter, avoiding the necessity of requiring the patient to return for a second visit or third visit;
- Use of syndrome diagnosis and treatment when laboratory support is not immediately available and increasing access to rapid laboratory tests for diagnosis of STD;
- Introducing the use of standardized drug treatment regimens that will cover the most likely causes of a clinical presentation;
- Providing ongoing surveillance of etiologies for common clinical presentations and drug resistance patterns;
- Adding/improving counseling of STD patients which includes promotion of and access to condoms;
- Establishing a partner notification/treatment system that asks the symptomatic patient to refer his partner for treatment (passive); and using the health inspectors, devise an active contact tracing protocol when a contact of a core group is named;
- Establishing minimum level of laboratory diagnostic support appropriate to the level of care;
- Establishing mechanisms to monitor health care providers;
- Strengthening the health information system to improve STD surveillance;

Social Marketing of STD Services. The project will conduct a feasibility study of the potential for supporting a "social marketing of family health services" approach of privatizing STD services. Under one option an NGO would provide "family health services" such as STD therapy, child spacing services, and AIDS/HIV prevention counseling services with some form of cost recovery.

5.1.4. BARGIRLS/FREELANCERS AND BAR OWNERS/MANAGERS

Target group risk profile:

The risk of transmission of HIV infection is particularly acute among women who have multiple sexual partners ("clients") because they trade sex for money, e.g., bargirls, single women available at legitimate trading centers ("mahuli" or "freelancers"), and married women who sell local beer (chibuka) or who otherwise need to supplement their income. The EC estimates that there are about 18,000 bar girls and ten times that number of freelancers in Malawi (personal communication, Kumwenda) Estimated HIV seroprevalence data is 75-85% among bargirls (personal communication, Liomba). The EC-financed KABP study (Wynendaele, 1991) in which 242 bargirls were interviewed found that 70% of bargirls were less than 30 years old and 81% of them were divorced. Though not directly reported, the chance that a majority of these women are supporting children is probably quite high.

Sexually transmitted diseases including HIV among bargirls is high. Studies of bargirls in Blantyre indicated gonorrhea rates of 29%, trichomonas at 27%, positive syphilis serology in 21% and genital ulceration at 6% (unpublished data, Dallabetta). Registered bargirls are legally required under the Food Handling Act and Communicable Disease Control Act of Malawi to submit to regular medical assessments by health providers in government hospitals on a regular basis. Infected women, who are prohibited from working during the course of therapy (1 to 2 weeks), often simply change locations.

In a study by Wynendaele, over half the bargirls recognized that their livelihood was associated with high risk for acquiring HIV infection, though only 10% thought that they were personally at risk for becoming infected with HIV. Reasons stated in focus groups (Kishindo) for not protecting themselves included: negligence, belief that they are already infected or that AIDS does not really exist, the need for income obtained through sex, client refusal to use condoms, lack of condoms, lack of trust in the reliability of condoms, inconvenient to obtain condoms, and the effect of alcohol on intent to use condoms. Yet the most frequently mentioned behavior change in response to AIDS was the use of condoms, though only one group reported insistence on condom use with every client.

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Knowledge of condom use is high although none of bargirls reported using condoms with all partners. Wynendaele noted that 34% of bargirls thought condoms should be used with "transporters", and whereas 16% self-identified as members of a group with whom condoms should be used, only 1% thought they should use condoms with their husbands and only 7.5% with their boyfriends.

Nearly 80% of bargirls reported having refused a client at one time or another, 40% on the basis of "disinterest". Yet 92% of their monthly income (or K122 of 135 earned on average) is from payment for sex. They perceive their livelihood also engenders considerable freedom from control from men and earn comparatively good monthly salaries.

Most of the bar owners participating in 1990 focus groups felt that whereas most of the bargirls wanted to use condoms, most of their clients did not. None of the bar owners were currently (as of Sept.-Oct., 1990) supplying condoms to their bargirls; yet there was much support for the idea of distributing condoms through bars or allowing bargirls to sell condoms to other bargirls.

Communication

Target-specific communication goal:

Communication will focus principally on promoting better self-care and confidence among bargirls to enhance skills in preventive behaviors. With these skills bargirls will have more power as individuals and have improved status within their community; and norms among them will be encouraged to support self-protection and group-protection.

The goals among freelancers are fivefold: (1) to increase perception of risk, (2) to identify alternative forms of income supplement or security, (3) to reduce the ratio of paid to unpaid sexual partners, (4) to increase condom-seeking behavior and condom use, and (5) to increase STD treatment-seeking behavior.

Additionally, bar owners will be encouraged to establish "condom only" bars/resthouses and to actively distribute condoms to bargirl condom vendors on a pilot basis. If successful, these condom only bars will be extended. Bars as locations for educational campaigns to the men who frequent bars will also be piloted.

Communication interventions:

Communication programming will target women who because they trade sex for money are not in a strong negotiating position for

determining low-risk behavior. The program will first provide information and forums to discuss barriers/enhancers to condom use, treatment options, and lifestyle options, followed by peer education for programs among bargirls, and from bargirls to less organized "freelancers" in the community. Norms within the community of bargirls will be changed by providing self-directed support groups and low-risk environments (i.e., ready supply of condoms, clients motivated to use condoms, and "condom only" bars).

"Small" media communication program to provide prevention education to bargirls and their clients. Formative research will be conducted to assess: (1) bargirls' work, medical, and relationship/ divorce history; (2) level of discrimination experienced--by health care providers, by community members, by bar owners, etc.; (3) issues of "self-worth", i.e., status as independent income earners, status as "core transmitters" of disease; (4) other resources available to provide assistance (women's organizations, advocacy groups).

Printed materials developed during the first phase of this project will support peer education efforts and low-risk activities at bars (e.g., posters for customers, "counseling cards" to help bargirls negotiate safe sex). During the second phase these materials will be used during support group formation and outreach to freelancers.

Peer education program among bargirls to promote and support sustained behavior change. Using specific criteria (e.g., status/seniority, profit drive, communication skills, desire to lead), bargirl peer leaders will be identified and further trained, building on accomplishments with this group to date. Peer education will address self-care/protection issues (building on experience with pregnancy and child spacing) and self-efficacy. Communication programming through small, organized groups will facilitate skill-building and normative change to incorporate negotiation, condom use, and non-penetrative sex into a higher ratio of sexual encounters.

Community outreach. Individual self-efficacy and group inclusiveness will be further developed through peer education to the "community" of women who trade sex for money. Outreach through the network of bargirls at bars and resthouses around the country will be provided through expanded peer education activities. Outreach to freelancers will provide decision-making, negotiation and condom skill-building and will provide incentives (other income-generating options, establishment of condom vendors) for empowerment and condom supply/ distribution to this group. Limited organization of this group of women will extend peer education, support, and medical/treatment services to women who because of their clandestine risk-associated behavior are otherwise difficult to reach.

Establishment of "condom only" bars and "condom vendors". Expanded access to the "community" of bargirls is possible by providing communication programs to the "gatekeepers" of that community, i.e., bar owners, resthouse attendants. From research initially conducted, a small number of bar owners will be identified who are concerned about HIV/STD prevention for bargirls and their customers. Additional incentives include increased profit due to sale of condoms at their bars and their status as role models for other bar owners. First on a pilot basis, bar owners will receive training in business management, condom logistics, and marketing to support change in the normative environment (bars) to promote condoms as part of every sexual encounter with every customer. Ongoing evaluation of the experience of these bar owners in terms of customer preferences and compliance, and profit margins will inform expansion of this program to other areas. Similarly, "condom vendors" will be trained among bargirls on a pilot basis.

Support for facilitators. Training and technical assistance will be provided to bargirl peer leaders, bar owners, community leaders involved in helping to identify freelancers, and health care providers. Current curricula for bargirls will be assessed and modified to train leaders in methods of training delivery, replication, and simple evaluation. Support group leaders will be trained in methods of group interaction and facilitation as well as methods of resource identification and development. Outreach workers will be trained in methods of community survey, prevention education, and feedback. Bar owners will be trained in business management and condom supply and distribution system development. Health care workers will be trained to provide counseling and/or treatment upon request in a non-judgmental manner.

Condom Promotion and Distribution

Target-specific condom goal and interventions:

The condom goals for this target group consist of increasing accessibility of condoms and correct condom use.

Bargirls require easy access to condoms in multiple outlet points to ensure that condoms become an invariable part of commercial sex. Additionally, they require counseling and training to facilitate the negotiation of condom use with their partners.

Condoms will be made available in the bars and resthouses where these women work through the HSMP project and through the public sector in hospitals and clinics. Condom access will be improved by strengthening the condom distribution and counseling

component of the periodic check-ups which these women undergo as part of their registration requirements. Improved distribution through the public sector should also facilitate condom access by "freelance" women who present at district hospitals or clinics with STD but who otherwise might not be reachable in their villages.

STD Control

Target-specific STD goal and interventions:

The goal is to decrease the level of STD, especially genital ulcer disease, in the these women. The majority of commercial sex workers in the urban centers of Malawi are HIV-1 infected. By reducing the STD level in these women and increasing condom use, STD and HIV infection should decrease.

The overall strategy for this target group will focus on strengthening the "food handlers" clinic to diagnose, treat and follow-up the bargirls and freelancers. Activities that should be supported include:

- Improving diagnosis and therapy in the food handlers clinic including presumptive treatment at the initial visit and shifting emphasis to STD case management and away from diagnostics.
- Expanding food handler clinic services to freelancers and unregistered bargirls.
- Adding/improving counseling of bargirls/freelancers and including promotion of and access to condoms;
- Considering periodic mass therapy with a focus on genital ulcer disease in settings where STD diagnosis is impossible;
- Working with bar owners to encourage STD treatment in bargirls and consistent condom use.
- Examination of whether spermicides are effective against HIV and without irritation.

The following three target groups are important but will be addressed initially through the first four target groups and after the interventions for these target groups have begun.

5.1.5 UNMARRIED WOMEN 18 YEARS OLD AND OLDER

Target group risk profile:

Unmarried women who are sexually active with one or more partners are at significantly increased risk of HIV infection, particularly because their ability to negotiate dimensions of their relationships is compromised by their lack of power and status in Malawian society. These dimensions include ability to accept/reject sex as a condition of relationship, their ability to negotiate monogamous relationships, their ability to limit sex which may be traded for money, and their ability to communicate/negotiate such risk reduction measures as non-penetrative sex, consistent condom use, and alternate displays of intimacy.

Since there is relatively great social and economic pressure exerted on women to marry, a significant number of women may have been married (and "divorced") one or more times, thereby moving in and out of low to high risk status with circumstance. Any or all of these sexual relationships carry a potential risk of HIV infection for women who are by definition less than equal partners with men.

From "FLE Problems and Issues as Viewed by Women, Men and Teenagers in Malawi", focus group interviews revealed that although the average woman in Malawi functions primarily as a "producer", a majority of women view themselves as "merely housewives" who are dependent on men. This leaves unmarried women in precarious positions socially and economically and may serve to further undermine unmarried women's ability to negotiate safe sex with sexual partners. These interviews also confirm that "the principal objective of a divorced woman is to find another husband as soon as she can".

None of the available studies done to date in Malawi have measured HIV-related knowledge, attitudes, behaviors, or practices among this group. From "Report on KAP Baseline Survey, Project Hope, Malawi Child Survival Project, Dec. 1990-Jan. 1991" (in which only two questions addressed AIDS knowledge), 92% of 275 women from eight tea estates (who had children less than 2 years old and who were between the ages of 15-49) had heard of AIDS. In response to the question, "how can the germ that causes AIDS be transmitted?", most respondents (80%) accurately described transmission routes. Only one woman believed that AIDS was caused by "evil spirits".

Communication

Target-specific communication goal:

The overall goal of communication programming to unmarried women 18 years old and older is to provide HIV prevention education in a format and setting conducive to exploration of associated issues of personal power, relationships, and

pressures/influences to engage in risk-associated sexual behaviors.

A secondary goal will be to provide a mechanism for catalyzing women's support networks within the community to support normative change for women's roles as sexual partners. This would include support for women initiating sex and/or having decision-making power regarding type and frequency of sexual behavior, and support for women taking measures to protect themselves and other women from risk-associated sexual activities.

Communication interventions:

Formative research will be conducted to determine those values and perceptions most relevant for the design of educational and motivational materials to reduce risk among women in this target group. Natural community leaders (e.g., women who are village leaders, party leaders through the C.C.A.M., respected traditional healers or traditional birth attendants, teachers, etc.)will also be identified through this research.

Materials will be designed to support women's discussion groups as one outcome of the research in a) to support changes in self-perception and behavior change among unmarried women. These materials, for use during facilitated discussions, will highlight the contributions, increased chance for completion of education, and positive outcomes of self-control and self-esteem; they will provide points of discussion to help unmarried women in the community strategize as a group about how to protect themselves from risk of HIV infection. These discussion points will also encourage group strategies regarding economic alternatives to trading sex for money.

Volunteer peer leaders will form support groups for unmarried women. These groups will provide social outlets and mechanisms for peer support. Their major goal will be to reinforce individuals' attempts at behavior and relationship changes; secondarily, they will provide possibly new group norms among unmarried women which reduce HIV infection risk.

Programming through audiotape production will produce a series aimed at raising the status of unmarried women 18 years old and older.

Condom Promotion and Distribution

Target-specific condom goal and interventions:

The primary goal for this target group is to ensure access to condoms and condom information from community and clinic based systems.

Unmarried women can most successfully be reached through primary health care systems including community-based and clinic-based distribution systems established for child spacing. These routes are most effective since contraceptives (including condoms) are not to be dispensed to women without full medical examinations. Through such venues these women can also acquire and practice communication skills which will reduce the likelihood of unprotected sex by partners with whom they may not be in stable relationships.

STD Control

Target-specific STD goal and interventions:

The goal is to increase women's recognition of their symptoms and to educate them to seek care. Essential to this intervention is improved STD case management of symptomatic women at clinical services.

Interventions include:

- Education of women as to early recognition of STD symptoms, appropriate treatment and locations to receive care.
- Establish a passive partner notification/treatment system.

5.1.6 FEMALE STD CLIENTS

Target group risk profile:

Although health care workers report anecdotally that a small proportion of clients receiving STD treatment (mostly in outpatient settings in Malawi) are female, the numbers of potential female STD clients are probably quite large. The STD management which does occur in MOH and PHAM-operated facilities is chiefly concerned with VDRL testing of pregnant women and of bargirls. Pregnant women are generally tested for syphilis only at hospital clinics which have the needed reagents or adequate lab technician time.

There are many barriers to management of STD among female clients. Because the majority of STD in women are asymptomatic or may persist so chronically that they are considered "normal", most women are deterred from actively seeking treatment. Also, treatment-seeking behavior for STD presupposes that a woman must discuss symptoms and sexual organs with health care providers, a rather daunting challenge for women who are uneducated about their bodies or otherwise unused to communicating about such

subjects, especially to men. Most hospitals and rural health clinics lack examination equipment (e.g., speculums) and private examination rooms conducive to proper diagnosis. Most health care workers in the country have not had sufficient training to be able to recognize STD symptomatology in women, except perhaps for profound discharges. Finally, STD treatment currently provided does not include prevention education, symptom recognition, or prevention counseling of any kind due to client loads in outpatient clinics and limited staff training in these skill areas.

Therefore, by definition, those women who are currently STD clients, represent the "tip of the iceberg" of STD infection among women. They also represent an important group for immediate targeting of comprehensive HIV/STD prevention programs.

Communication

Target-specific communication goal:

The overall communication programming goal targeting female STD clients is to provide STD/HIV prevention education and counseling which enables female STD clients to more quickly recognize symptoms, seek treatment, and carry out behavior change to reduce risk of STD/HIV infection.

Communication interventions:

Printed materials will be developed to increase symptom recognition and the chance for early treatment among female STD clients.

Prevention education followed by discussion groups will be conducted through women's support groups (see target group 6), women's organizations, and in conjunction with parent education programs delivered by the Ministry of Women, Children and Community Services.

Referral of female STD clients will also be improved through aggressive counseling of male STD clients, which will include strong advice about encouraging female sexual partners to seek treatment whether or not they are having symptoms.

Prevention counseling will be provided as part of STD management for all female STD clients. Provision of counseling will be introduced on a pilot basis at 10 STD treatment sites.

Condom Promotion and Distribution

Condom goal and interventions:

The key goal for women in this target group is to ensure that condoms and condom education/counseling are provided when women present for treatment.

Condoms should be provided to these women through clinic and community-based distribution systems at the time of disease diagnosis, treatment and counseling. Given the difficulty women face in convincing their partner(s) to seek treatment, emphasis must be placed on pairing condoms with negotiating skills and correct condom use instructions to increase the likelihood that protection will be taken when these women return to the partner(s) from whom they obtained the infection.

STD Control

Target-specific STD goal and interventions:

The goal is to improve STD case management of symptomatic women and to increase women's recognition of their symptoms.

Interventions will include:

- Maximizing the services delivered at the place and time of first encounter, avoiding the necessity of requiring the patient to return for a second visit or third visit;
- Use of syndrome diagnosis and treatment when laboratory support is not immediately available and increasing access to rapid laboratory tests for diagnosis of STD;
- Introducing the use of standardized drug treatment regimens that will cover the most likely causes of a clinical presentation;
- Providing ongoing surveillance of etiologies for common clinical presentations and drug resistance patterns;
- Improving counseling of STD patients which includes promotion of and access to condoms;
- Establish a passive partner notification/treatment system
- Establishing minimum level of laboratory diagnostic support appropriate to the level of care.
- Piloting rapid diagnostic tests for the syndromes of vaginitis and cervicitis as well as syphilis.

- o Piloting the use of traditional healers/TBAs in education efforts in such areas as compliance, condom promotion, partner notification, and health.

Social Marketing of STD Services. The project will conduct a feasibility study of the potential for supporting a "social marketing of family health services" approach of privatizing STD services. Under one option an NGO would provide "family health services" such as STD therapy, child spacing services, and AIDS/HIV prevention counseling services with some form of cost recovery.

5.1.7 EMPLOYED MIDDLE-AGED MEN 30 YEARS OLD OR OLDER

Target group risk profile:

While this target group probably shares many characteristics with the employed male target group above, there are also some significant distinctions. These men are considered middle-aged; divorce is a rather common event as reported by most adult women and men participating in focus groups (Kishindo) which does not necessarily involve legal ramifications. The probability exists therefore, that a major subset of this group has most likely had one or more serial spouses and multiple sexual partners over lifetime.

According to the focus group findings cited above, "the reason why marriages do not last today...is that men and women have ceased to be 'good family men' and 'good wives' respectively. Men have become more promiscuous than before. Instead of taking care of their wives and children, they move from woman to woman." From an older male perspective "marriages are breaking up because of starvation. When a man leaves a home with nothing to eat, the woman loses her trust in the husband, and the marriage flounders." Another reason provided for unstable marriages is excessive beer drinking and hemp smoking among men.

Both men and women provide anecdotally that "both young boys and older men, including teachers, are responsible for getting young girls pregnant." While respondents advocated strong measures against the girls and boys involved in such behavior, they overlook any consequences for the men. A possibly related phenomenon described in the literature as "sugardaddies" may apply to interaction between these economically-stable and relatively powerful middle-aged men and women (inside or outside the nuclear family) who are 10 or more years younger.

Little STD data exists on this group of men. They probably represent individuals of higher socio-economic status who are

likely to seek STD care within the private sector.

Attitudinally, men in this target group who live in rural or semi-urban areas most likely share more traditional values which may be in conflict with exposure to influences of modernization through work. Because the role of the father is not one of either mentor or authority but rather that of a distant male relationship to be avoided even by his own daughters, appeals to sexual responsibility regarding significantly younger women are somewhat undermined. However, the father remains in a relatively strong male network in which the uncle and grandfather play prominent roles as advisors and protectors of children, especially female children. The Wynendaele study reported relatively low awareness of risk among truck drivers who were 30 years and older. Yet 34% of this group did identify having multiple partners as a risk factor. Almost a quarter of them reported having one or more sexual partners during trips.

Men in this target group are more likely to see condoms as products used in relationships outside of the primary relationship (71% said they should be used with bargirls as opposed to only 9.3% who thought they should be used with one's wife) and are less knowledgeable than their younger counterparts about condom use. Thus, for example, only 44.9% knew condoms were supposed to be used prior to physical contact with the woman, 25% of them were not aware that a condom should be used only once, only 17% were able to demonstrate correct condom use and 42.3% of those who have ever tried using a condom reported problems with condom breakage. They also hold the opinion that condoms encourage promiscuity and believe that it is unhealthy to touch a used condom after it has been inside a woman's body.

Over 60% of them think that condoms are difficult to obtain but half of them are reportedly willing to buy condoms (up to a average maximum price of K1.54 for three).

Communication

Target-communication goal:

The overall goal is to increase individual perception of risk as well as increased compassion for younger sexual partners (defined for this target group as women 10 years or younger). Based on the findings of future research, these programs will further influence social norms among men to create a protective environment for younger women and further dissuade sexual interaction between partners of such disparate age (and potential risk status).

Communication interventions:

In-depth research will be conducted to investigate the phenomenon of "sugardaddies" and to characterize communication channels, channels of authority, and support networks which exist for employed men over the age of 30. Other research conducted by the project (see target group 1.) might include, if feasible, ethnographic study of those initiation rites for young girls which reportedly culminate in intercourse with male elders.

Multi-channeled communication campaigns will be designed which by their broad reach have increased potential for providing a barrage of messages to this target group and especially other male peers or authority figures in the community. The campaigns will utilize Malawian proverbs and will reinforce social norms (and traditional values) which prohibit sexual activity between partners of greatly disparate ages.

Mentoring systems will be developed between young females to provide peer support which dissuades them from seeking older men as sexual partners. Strengthened networks of girls could also provide protection (from any sexual activity) and might also be developed into forums for discussing HIV-associated risks and strategically planning risk reduction measures as a group. (This would be implemented only if research conducted for target group 1 substantiated this as a possible strategy.)

Condom promotion and distribution

Target specific condom goal and interventions:

The goal for this target group will be to expand condom access and to increase efficacy skills as a prerequisite to behavior change.

Men in this age group are even less likely than their younger counterparts to obtain condom supplies from clinic or hospital sources given feelings of disenfranchisement with such systems and the greater likelihood that their jobs will be an obstacle to clinic hours. Additionally, since men in this age group tend to associate condom use with illicit sexual encounters, they are less likely to want clinic staff to see them obtaining condoms with all of the implications -- real or imagined -- it entails. Finally, these are men with greater disposable incomes for whom purchasing condoms will pose fewer problems than even their younger counterparts.

Given their severe lack of knowledge, skills, and hence confidence about using condoms, however, the project will need to ensure access through the private sector to information which can teach correct condom use and dispel inaccurate assumptions about condoms.

The main distribution point for condoms for these men will be through the social marketing program. The main distribution point for information for these men will be materials (pamphlets, brochures, etc) provided through the CSM outlets.

STD Control

Target specific STD goal and interventions:

The overall goal is to improve STD management (diagnosis, treatment, counseling, condom promotion, and partner treatment) in the employee health clinics and in the private sector.

Improvement and expansion of a appropriate STD services in employee based clinics and private sector practitioners. As mentioned above, this group probably shares many characteristics of the target group employed males, and with respect to STD case management will be reached through improvement in employee health clinics. In addition to the strategies outlined in Section 2 (Employed males) the following strategies will be used:

- Education of private practitioners through the regular meetings of the Medical Association of Private Practitioners (Subdivision of Malawi Medical Association). The private practitioners in Malawi are few. As patients are able to pay for services the majority of the patients receive adequate therapy at these clinics for STD even if the drug therapy chosen is not the most cost effective.

- Ensuring that private practitioners have access to written educational material or risk reduction and condoms.

5.2 CAPACITY BUILDING

As noted above, a significant focus of the project will be the development of further capacity of Malawians to effectively address their AIDS prevention program. The following overview of capacity building illuminates the focal areas to be addressed to increase host country capabilities as a priority under this project.

5.2.1. Communication

The project will support a systems approach to communication programming. This will include institutional strengthening of particularly HEU and AIDSEC, spearheading initiatives to help redefine department or unit "service delivery" systems within

MOH. The project will assist with allocation of resources and will provide extensive technical assistance in order to build the kind of planning and management capacity needed to develop, implement, and monitor these systems. Additionally, it will provide mechanisms for coordinated capacity-building and collaborative HIV prevention effort between various public and private sectors.

The following major efforts will provide capacity-building for HIV prevention communication programming:

- o enhancing the technical production capacity of the Health Education Unit (HEU) through PHICS: videotape production, audiotape production, development and production of printed materials and other "small" media

- o establishing a training capacity which includes: training planning, training design (for training of master trainers, peer educators, community organizers, behavior change facilitators, different types of modern and traditional health care providers, and different types of target audiences), curriculum design, trainer cadre development, training delivery system development, and evaluation

- o establishing a HIV prevention counseling capacity which includes a managed system of counselors trained in techniques of: interpersonal communication, risk history assessment, facilitating step-wise risk reduction, strategic planning for behavior change, follow-up, and individual and group support

- o establishing a community mobilization capacity which supports systematic development of the following kinds of community action through NACP or local NGOs/PVOs: grassroots youth and/or parent organizations; sustained networks of peer leaders and educators; stable, facilitated support groups; and planned outreach activities

In order to accomplish these efforts, the project will work in close collaboration with the USAID-funded PHICS (Promoting Health Interventions for Child Survival) in the following ways:

1) coordinating both planning and technical assistance with the PHICS basic health training program at Lilongwe School of Health Sciences;

2) jointly planning in-service training of health staff (on national, regional, and district levels) and HEU staff to build skills in the areas described above; and

3) providing planning and technical assistance to provide ongoing in-service training and transfer of skills in the above areas to "field workers" (e.g., HSAs, HAs, agriculture extension workers, CDAs, SWAs, homecraft workers, adult literacy workers, village health volunteers, and members of the community involved in any aspect of communication programming).

The project will coordinate with the World Bank in implementing the major components of the Population, Health, and Nutrition (PHN) Sector Credit:

1) strengthening staff management systems (especially to improve production capability, training systems, counseling systems, and planned community mobilization efforts);

2) strengthening HEU capability, especially in IEC areas above; and

3) mobilizing community workers and outreach capacity.

5.2.2 Condom Programming

Superimposed across the targeted condom promotion and distribution strategy is the need to strengthen condom distribution and supply management systems to ensure that condoms are available when and where they need to be and in adequate quantities to meet the needs of those who need to use them.

According to condom assessments provided for the Mission (Atkinson, SOMARC), condom supply requirements will increase from approximately 4.1 million in 1992 to over 10 million per year by 1996. These estimates are based on recent supply levels, presumed distribution capacity of the public sector, and CSM sales targets.[5] At such levels commodity costs alone will escalate from approximately $250,000 in 1992 to $600,000 in 1996 if USAID provides all Project condoms. Significant system strengthening will be required early in the Project to monitor the accuracy of estimated commodity requirements, and to maximize and safeguard such sizeable investments as they are made.

To accomplish this, technical assistance will be provided through the Project to the AIDS Secretariat and the Ministry of Health to:

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[5] For a complete assessment of condom demand for the Project see Technical Appendix D of this paper.

(1) improve condom supply forecasting in the near term through establishing and testing the validity of sentinel reporting sites, and over the long term through improved national level reporting systems managed by the Condom Logistics Unit of the AIDS Secretariat,

(2) improve the consistency of condom distribution systems in the public (i.e., CMS) sector by systematizing delivery schedules, improving inventory management at all levels of the system and institutionalizing logistics training capability at the regional level,

(3) strengthen private sector (e.g., Lever Brothers, Chibuku Beer, Napolo Distributors) distribution by increasing competition among distributors, enhancing sales force training, and supporting on-going incentive schemes at the wholesale and retail levels,

(4) develop a unified condom inventory management and reporting system for child spacing and AIDS prevention which will be managed co-managed by the AIDS Secretariat Condom Logistics Unit and MOH Child Spacing Program Director with input from CMS; the Regional Health Officers, the District Health Officers and SOMARC,

(5) develop and implement a strategic plan for a long term sustainable supply of condoms addressing (a) sources of supply, (b) means of financing, (c) logistics and inventory management requirements, and (4) a scheme for introducing cost recovery over the life of the project.

5.2.3 STD Control

The project will support the MOH in the development of a national STD control program. The STD control program for Malawi is to be combined with the AIDS control program. The support will include institutional strengthening of the STD control unit capacity for management and coordination, supporting the health information system at CHSU, and enhancing STD surveillance and research capacity with CHSU and the Medical School. The following major efforts will provide capacity building for STD control in Malawi.

- Working with the MOH to ensure that a national STD prevention and control plan is developed with attention to the implementation for standardized STD treatment guideline and consistent access to appropriate drugs. It is currently planned that positions for a program manager and two assistants will be filled at the AIDS secretariat. STD management responsibilities will be assigned to one of the two regional AIDS coordinators. Management structure beyond

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the regional level has not been defined. With these individuals in place, a system of system of supervision and quality control within each service area will be established.

o Upgrading laboratory facilities.

- Referral hospitals. One referral hospital per region be established. Capabilities of these hospitals labs should include the following:

  - syphilis confirmatory testing
  - N. gonorrhoeae culture facilities
  - dark field capabilities
  - H. ducreyi culture capabilities (selected sites).

The three regional hospitals have most the laboratory equipment necessary for these capabilities. The major effort in upgrading will be laboratory technician training and ensuring adequate reagents.

- District hospitals. All district hospitals should have the capabilities and supplies to perform the following tests.

  - gram stain
  - wet mount
  - VDRL (RPR) testing.

All district hospitals should have these capabilities. Upgrading will entail laboratory technician in-service training and ensuring adequate reagents.

- Central reference laboratory. A central reference STD laboratory should be established (CHSU) to perform the following functions. Collaboration with GTZ should be explored.

  - quality control monitoring of laboratory services
  - capabilities to perform N. gonorrhoeae antibiotic sensitivity testing, H. ducreyi cultures, chlamydia antigen detection, Herpes virus detection, syphilis confirmatory testing.
  - serve as site to train lab technicians in STD laboratory techniques.
  - laboratory support for surveillance studies.

The majority of the necessary equipment already exists at CHSU. One of the current laboratory technicians has a masters degree in microbiology. Upgrading will entail training of the laboratory technician in STD diagnostics, supplying the necessary equipment.

- Research lab. A laboratory to assist in support for necessary operations research should be established.

Potential research sites in Malawi would be Blantyre or Mangochi because of the expected input from the Department of Community Health in the Medical School. Mangochi would be ideal because links between CHSU and the Medical School could be established there. CHSU through the PHICS Project will have a field research site established at Mangochi. Additionally, it is planned that medical students will be sent to Mangochi for their senior year projects. This laboratory would have the same capabilities as a referral hospital with some additional capabilities described under the reference lab.

- Drug procurement through Central Medical Stores. CMS has a procurement systems that achieves a favorable price for drugs and commodities as well as a distribution system already established. Coordination of drug procurement will be between CMS and DAP.

- Improve Health Information System for STD (CHSU) such that it provides useful, timely information (through PHICS). The health information system for STD monitoring is currently inadequate.

- Develop training capacity for service sector
  - clinical (in service training and curricula update in health training centers)
  - laboratory (in service training and curricula update in health training centers).

- Establish surveillance sites. These sites will collect more information than is obtained by the passive surveillance of HIS. These sites should be chosen to represent different areas of the country and will varying laboratory backup. These sites will provide indicators for progress of the STD control program and will also serve as sites for STAPH program impact indicators.

- Develop operations research capabilities. The medical school of Malawi will be enlisted to carry out STD operations research questions of a biomedical nature. The Medical School in conjunction with Chancellor College will be enlisted in behavioral STD research questions. The medical school will have individuals with expertise in STD case management and community STD control measures, the ability to design and conduct operations research necessary for program implementation and evaluation, and the capability to provide input into STD curricula for training institutions and in service training for care professional and technical service providers. Additionally, if the Mangochi field site is fully developed, the medical school in conjunction with CHSU will the laboratory facilities and

resources to conduct epidemiologic surveillance

- o Test, establish and monitor a partner notification/treatment system.

- o Ensure adequate clinical facilities and lab support for diagnosis and treatment.
  - private exam rooms/spaces
  - adequate equipment (speculums, blood drawing equipment, gloves)
  - supplies (swabs, diagnostic reagents)

- o Development of a logistics management information system (MLIS) for condom supply and STD drugs and diagnostics.

- o Providing counselling services and materials

- o Ensuring adequate condom supplies

Details of this design, an implementation plan and budget notes are provided in Annex C: Elements of STD Control Program for Malawi.

5.2.4 Policy Development

AIDS prevention interventions will meet the highest degree of support, the least resistance and the best chance for sustainability when key leaders and resource holders are provided with a steady flow of correct, understandable and useful information about the epidemic.

The Project will support a 5-pronged process to identify policy makers and opinion leaders and to secure their support for effective, comprehensive AIDS prevention programming in Malawi. These five steps include: (1) policy maker identification, (2) policy maker assessment, (3) policy maker education, (4) AIDS issues analysis and (5) strategic planning and implementation to support policies and procedures supportive of AIDS work. These are described in more detail below.

Policy maker identification. The Project will identify key private and public sector individuals and/or institutions that shape policy maker attitudes and behaviors in regards to resource allocation, social agenda setting and social norms.

Policy maker assessment. An assessment of current policy maker knowledge, attitudes and behaviors regarding national HIV prevention activities will be made. Specifically, 50-100 qualitative research interviews will be conducted with officials and leaders in the public sector (e.g., health, planning, finance, local government, media, traditional authorities/district area representatives), private sector (e.g., agricultural and industrial business interests, private health

providers, professional associations) and others (e.g., donor community). These interviews will attempt to discern not only the opinions of such leaders regarding AIDS prevention but whether they have personal experiences with AIDS (e.g., known members of families and social networks who have/have died from AIDS, and whether they consider themselves and their families to be at risk).

Policy maker education. Based on the above, a strategy will be developed for educating policy makers on critical AIDS issues and their relevance for Malawi. Educative tools might include "partnership briefings" for disseminating the key finds from the AIDS economic impact study and other reports, additional sectoral studies of AIDS impact in Malawi, and site visits to neighboring countries to learn first hand about successful AIDS programming (e.g., the AIDS prevention program of the Farmers Union in Zimbabwe, AIDS prevention in military health programs). Special tools could also be developed to support positive and informed media programming (e.g., providing grants to support "AIDS reporters" who would develop positive, human-interest, non-technical AIDS education through print and radio). Presentations through other social organizations (e.g., Rotary clubs, church groups, medical practitioners association, marketplace stalls) could provide other informal venues for improved AIDS reporting.

Policy maker education may also include on-going modeling and forecasting efforts to update education and encourage development of a national capacity in this area.

AIDS issues analysis. A comprehensive analysis of current de facto and de jure policies which influence the effectiveness of AIDS prevention will be undertaken early in the project. This analysis will examine such critical issues as tariff rates on condoms, media restrictions, drug prescribing limitations/restrictions. The assessment will examine the policies by impact on program effectiveness and potential for change.

Strategic planning and implementation. Based on the assessment above, a strategy will be developed with the AIDS Secretariat to address removal of policy constraints or weaknesses and adoption of positive policies.

Condom supply. Discussions will be held with the Ministry of Health to develop and implement a strategic plan for a long term sustainable supply of condoms addressing (a) sources of supply, (b) means of financing, (c) logistics and inventory management requirements, and (4) a scheme for introducing cost recovery over the life of the project.

To be maximally effective the overall policy strategy should be developed and implemented in collaboration with number of

national resources. These include the AIDS Secretariat, the University of Malawi, and private associations. Part of the policy development strategy for the Project will therefore be to identify, strengthen and institutionalize in-country capability to conduct policy dialogue.

5.3 Information Needs

5.3.1 Formative and Operations Research

Initial qualitative and quantitative data and information gathering will be conducted in order to assess the ongoing programs and to develop additional effective programming strategies for all groups. This information gathering and research will be consistent with country identified priority research. Listed below are the initial baseline information needs for each of the target groups, although not all activities will start in the first year(s). During the implementation phase of the proposed project an individual with expertise in behavioral research will identify initial research goals, explore local capacity to perform this research, and develop protocols and instruments.

Youth in and out of school

- perform a curriculum evaluation to assess adequacy and impact
- assess rapidly the key factors/influences/values to formulate messages and channels; this would include determination of knowledge, attitudes, and practices of youth regarding condom use and STD treatment-seeking
- pilot several "youth group" models in those areas that district communication officers (DCO) have been hired to work in conjunction with the DACs and the DHEOs.
- identify authoritative information sources for youth

Employed males

- assess of attitudes and practices (including choice of sexual partners, motivation and condom use patterns, and STD perceptions, condom use, and treatment-seeking behaviors) and social norms among men
- assess of various mechanisms of condom community-based distribution systems/ mechanisms at different worksites
- perform a financial analysis for STD/HIV interventions

for policy dialog with employers to encourage them to expand or start services.

Male STD clients

- o assess baseline data on prevalence of STD and "predisposing" factors regarding symptom-recognition and treatment-seeking among male STD clients
- o collect data on relationship of perception of personal risk of STD to condom use, condom-seeking behavior, partner selection, sexual behavior
- o determine of spectrum of sexually transmitted disease in Malawi and testing of proposed treatment regimens
- o perform a feasibility study of social marketing of STD treatment
- o investigate the barriers to partner notification
- o investigate condom knowledge and attitudes

Bargirls/freelancers/owners

- o determine the professional and personal networks of bargirls and freelancers to improve access and peer educator development
- o identify bar owners willing to establish "condom only" bars
- o evaluate the current "safe sex" behaviors and interest/acceptability of alternative low-risk behaviors
- o perform a pilot study presumptive or periodic treatment to assess the performance of the antibiotics chosen and the level of reduction in STD
- o investigate condom knowledge and attitudes

Unmarried women 18 years or older

- o perform an analysis of single women's perceptions of risk, condom attitudes
- o evaluate the natural communication channels and networks
- o assess baseline data on prevalence of STD and "predisposing" factors regarding symptom-recognition and

treatment-seeking among females

- o investigate the types of male relationships that exist and the networking within the female community

Female STD clients

- o gather baseline data regarding prevalence of STD among these women and promoters/barriers to STD treatment-seeking
- o determine the "predisposing" factors for STD infection, perception of relative risk, and risk-associated behaviors
- o evaluate the clinical indicators of vaginitis/cervicitis
- o assess baseline data on prevalence of STD and "predisposing" factors regarding symptom-recognition and treatment-seeking among female STD clients
- o perform a KAP of condom use, source of supply, and attitudes

Employed males 30 years or older

- o explore the "predisposing factors" contributing to selection of partners ten years younger (or more)
- o assess the natural communication channels/ networks between "middle aged" men in urban and semiurban areas
- o gather rapidly information regarding attitudes and condom-using/condom-seeking behaviors among these men

Additional needs

- o classify villages in terms of mobility, level of commercial activity and migrant labor participation (semi-urban) to classify risk
- o assess current logistics management system for condoms, STD drugs and STD diagnostic supplies
- o pilot test of potential STD drugs for use in syndrome treatment and to asses drug utilization patterns

5.3.2 Biomedical and Behavioral Research

The research activities listed in this group are generally more extensive and more costly. Insights gained from them would

benefit many countries in the region or worldwide and, therefore, would not necessarily be performed in Malawi. This research will be done in collaboration with country based researchers at the Malawi Medical School, Chancellor College or Bunda College. Possible topics for research include:

- o the development of sexual identities, initiation to sex, and the regulation of sexual behaviors;
- o the interaction of alcohol, commercially available sex, and high-risk sexual behavior in male behavior;
- o investigation of which approaches to behavior changes are most effective in reducing the transmission of STD/HIV to each target subgroup;
- o testing of simple, inexpensive, and field-appropriate STD diagnostic laboratory tests and evaluate their performance characteristics and cost-effectiveness. This work will be undertaken in collaboration with the STD Diagnostic Network.
- o evaluation the effect of STD interventions including counseling on future episodes of STD and on the transmission of HIV.
- o determination of whether female-controlled chemical and mechanical barrier methods are safe, acceptable, and effective in reducing the acquisition of sexually transmitted infections including HIV, in a randomized controlled trial.
- o evaluation the impact of HIV infection on the presentation, natural history, diagnosis, and response to therapy of specific STD.
- o controlled trials using clinics as the unit of randomization to test the impact of comprehensive prevention programming in promoting client access, client return, compliance with treatment and contact tracing.

Malawian institutions and research scientists will also be informed of the opportunities to carry out research investigations into behavior related to HIV/AIDS through the Projects Behavioral Research Program conducted in collaboration with developed country institutions.

6.0 KEY CONSTRAINTS

A number of constraints can be identified which hinder present and future AIDS prevention programming in Malawi.

6.1 Personnel

Key among these constraints are issues relating to personnel:

- Human resources available to public sector health and social services are scarce,
- transfers of staff from positions for which they have been trained to new posts for which they have no expertise are frequent, and
- low salaries combined with limited career potential discourage professionalism and motivation.

Even when positions are financed by external donors, inefficiencies in the public service system and housing shortages (a standard benefit to compensate for low wages) can cause formidable delays in personnel hiring. Finally, new staff positions (e.g., 4500 additional health surveillance assistants expected to be trained and fielded in the next few years under the PHICS program) are often so overloaded with community-based responsibilities that they are unable to adequately address any single health concern.

The shortages of staffing not only result in delays in approval of AIDS education materials and project implementation but in an inability to provide monitoring and follow-up of new initiatives, a lack of time for preventive health care or health education, and the absence of quality assurance in programming.

In the absence of serious attention to these related issues, project implementation and sustainability will be seriously compromised. The project attempts to address these constraints through three related strategies: (1) institutionalizing training-of-trainer capacity within the AIDS secretariat and Ministry of Health to ensure regular training for new recruits, (2) developing community-based, volunteer programming to augment public sector staffing, and (3) supporting the delivery of AIDS prevention programming through the private sector and PHAM.

6.2 Condom distribution and supply

A second associated set of constraints relates to the current and long term availability of condoms. At present:

- the AIDS Secretariat has no plan for ensuring a long term supply of condoms,
- condom distribution through the child spacing programs and AIDS prevention programs are not jointly monitored, reports of distribution stop at the district hospital

level, and distribution to non-clinic sites in inadequate,

- o storage facilities are inadequate for projected future supply requirements
- o distribution of donated condoms is hampered by shortages of funding to cover the costs of MOH (CMS) delivery charges
- o customs duties on private sector condoms make them prohibitively expensive for most Malawians

The above constraints can only be addressed through a prudent, multi-year strategy with clearly defined objectives and a reasonable course of action including policy analysis and dialogue at various governmental and non-governmental levels.

6.3 STD prevention and treatment

Personnel, drug and laboratory resource shortages combine to limit the effectiveness of STD treatment and control efforts currently undertaken in Malawi. Policies which confine drug dispensing to clinical officers and medical assistant (while many health clinics are managed by nurses) and limit the types of drugs available in primary health care settings diminish further the reach of STD control efforts.

As Malawi struggles to address the severe limitations in STD treatment and prevention, serious attention must be paid to committing sufficient resources to effective drug therapy, seeking means improved partner notification and treatment, expanding the role of community health workers and individuals in the informal sector (traditional healers and TBAs) and the private sector (including non-governmental organizations) in STD treatment and prevention, and identifying innovative methods of STD treatment (including selective mass treatment of high risk individuals and social marketing of STD services) and finding ways of controlling STD drug supply.

7.0 PROJECT IMPLEMENTATION

Project implementation will be guided by two overall principles:

(1) Effective implementation will require that responsibilities be clearly delineated for and assigned to the most appropriate level -- national, regional or district/community.

(2) Effective implementation will also require collaboration and partnership among public, semi-

private (i.e., parastatal) and private sectors.

As outlined on the following Project Organizational Chart, distinct responsibilities will be assigned at the national, regional and district/community levels. In general, these three levels correspond with the responsibilities of (1) policy setting and oversight (national level), (2) systems building, coordination and management (regional level), and (3) service delivery/program implementation (district/community level).

7.1 Policy Coordination/Goal Setting (National Level Activities)

The AIDS Secretariat remains the focal point of leadership of the Project. It will be responsible for:

- setting and monitoring national goals and policies,
- articulating and coordinating the national AIDS program vision,
- developing protocols, models and training curricula in communications, counselling, STD treatment and prevention and condom promotion to be adapted at the regional level,
- identifying, assessing and disseminating innovations emerging from regional level management and district/community level implementation, and
- evaluating programming for impact, reprogramming, and re-evaluation

At the national level the AIDS Secretariat will collaborate with a number of other ministries including:

Ministry of Labor to facilitate policy and coordination with the private sector

Ministry of Education to develop a small cadre of "master trainers" and a national AIDS training team in coordination with the Malawi Institute of Education (MIE)

Ministry of Agriculture and Ministry of Women, Youth and Community Services to coordinate participation of their district and community level workers

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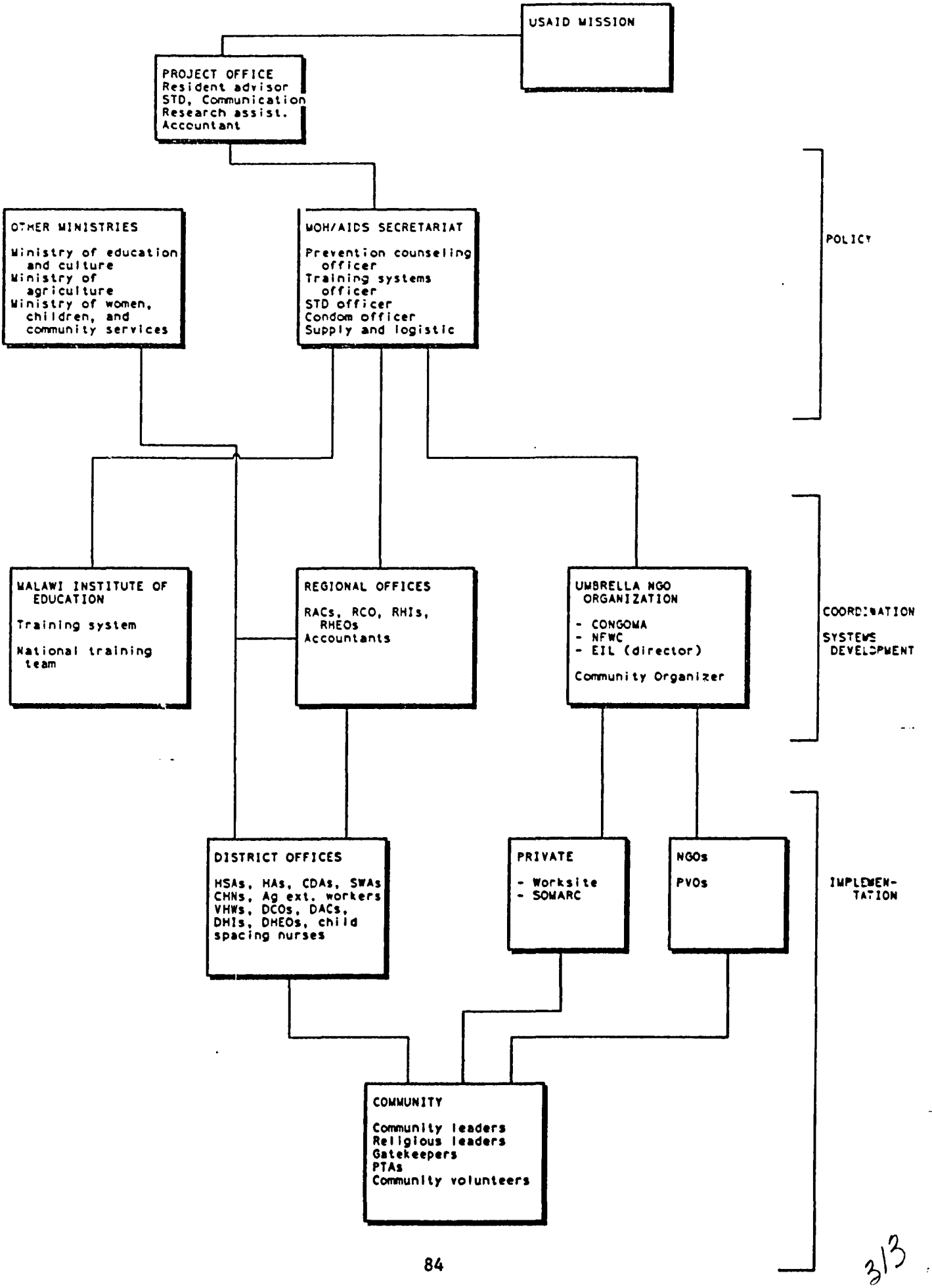

USAID MISSION
PROJECT OFFICE
Resident advisor
STD, Communication
Research assist.
Accountant
OTHER MINISTRIES
Ministry of education and culture
Ministry of agriculture
Ministry of women, children, and community services
MOH/AIDS SECRETARIAT
Prevention counseling officer
Training systems officer
STD officer
Condom officer
Supply and logistic
POLICY
MALAWI INSTITUTE OF EDUCATION
Training system
National training team
REGIONAL OFFICES
RACs, RCO, RHIs, RHEOs
Accountants
UMBRELLA NGO ORGANIZATION
- CONGOMA
- NFWC
- EIL (director)
Community Organizer
COORDINATION
SYSTEMS DEVELOPMENT
DISTRICT OFFICES
HSAs, HAs, CDAs, SWAs
CHNs, Ag ext. workers
VHWs, DCOs, DACs,
DHIs, DHEOs, child spacing nurses
PRIVATE
- Worksite
- SOMARC
NGOs
PVOs
IMPLEMEN-TATION
COMMUNITY
Community leaders
Religious leaders
Gatekeepers
PTAs
Community volunteers

3/3

The AIDS Secretariat will also provide the major official link between the MOH and other major programs (e.g., Health Education Unit and Child Spacing Program) and parastatals (e.g., the Malawi Institute of Education, MIE) and the private sector (e.g., Employers Confederation of Malawi). Other major programs of the Ministry of Health which will require close collaboration at the national level include:

Community Health Services Unit (CHSU) to manage STD data and the central reference laboratory

Drug Action Program (DAP) for printing, distribution, and training of STD treatment guidelines and protocols; and STD drug accounting at sentinel sites

Health Education Unit (HEU) which has primary production responsibility for materials development and distribution for materials produced by the Ministry of Health, is undergoing significant capacity building via efforts of PHICS and the World Bank. Materials development and production will be focused on the private sector (e.g., Graphic-Lintas) with technical assistance and monitoring from the project office. As production capability increases, the role of HEU in the project may be increased. HEU will be responsible for collaborating with community based organizations to expand and replicate the village band and drama program. To do this, it is proposed that two full time positions be created: village band director and drama group leader.

Child Spacing Program particularly with respect to condom distribution and reporting, and staff training and time allocation

AIDS Secretariat will ensure collaborative partnerships between a number of parastatals most of whom will operate at and directly collaborate with the regional or district levels. These organizations can also serve as technical resources in the design of protocols and prototypes for diffusion at the regional and district levels. These include:

Department of Information (DOI) which can provide AIDS education through mobile cinema vans and video production/editing

Department of Youth (DOY) through which nascent youth groups, parent organizations, and community leaders interested in starting family health-oriented NGOs may be identified

Central Medical Stores (CMS) which is the prime procurement and distribution agency for drugs and supplies in the country

Malawi Institute of Education (MIE) technical assistance to

the AIDS Secretariat Training System Officer, and to develop a national training team, including training-of-trainers, certification exams, apprenticeship programs, and periodic "update" training

MIE will also assist to alleviate HEU workload by pre-testing and producing publications, designing training plans for regionally-held training, and continuing evaluation/revision of training curricula, counseling curricula, community organization curricula, and printed materials.

Chancellor College/Center for Social Research to design and assist with implementation of formative and operations research. Through the Behavior Grants mechanism, longer-term basic behavioral research will be conducted in conjunction with a U.S.-based university.

Medical School of Malawi particularly the Department of Community Health in conducting biomedical and operational research related to sexually transmitted diseases.

Malawi Broadcasting Corporation (MBC) which will produce and air radio (soap opera) programs and personal interviews for radio broadcast focusing on the impact of HIV on youth. MBC's national network of relay stations will be utilized to distribute print materials and media (audiocassettes, audiocassette players, radios) to urban and semi-urban youth centers.

To facilitate achievement of the above responsibilities, a few key new management positions will be created at AIDS Secretariat: Prevention Counseling Officer - to integrate prevention in the spectrum of AIDS counselling services, and Training Systems Officer - to establish a national training system (training planning, curriculum development, cadre development and feedback systems) in coordination with MIE. Additional training will be provided to current critical staff (e.g., the STD Officer, and Condom Officer).

7.2 Program Management/System Strengthening (Regional Level Activities)

The regional level will be the main focus of project management and coordination. AIDS program management teams at the regional level will be responsible for developing annual workplans with district level personnel, modifying materials (protocols, materials, training) developed at the national level, conducting training, maintaining the service delivery systems, serving as technical resources persons to the district staff, and providing financial support to implement their plans.

At this level, staff will be responsible for coordinating and managing (1) condom distribution, inventory, resupply, (2)

STD clinical services (appropriate therapy, condom availability, training materials, partner notification), (3) bargirl therapy, (4) STD drug tracking system, (5) training systems, (6) prevention counseling system, and the (7) community organization network.

Funds will be deposited into special AIDS prevention regional accounts to facilitate, evaluate and monitor service delivery across all districts. Additionally, the regional offices will coordinate regional responses across all ministries, in parallel with lead responsibility for AIDS prevention at the national AIDS Secretariat level.

The following positions will be needed in each region to assist regional offices in the roles described above:

- Regional AIDS Coordinator (RAC): job description to be modified to include only supervision of AIDS/HIV activities, with particular responsibility for training logistics, prevention education/area level briefings and follow-up/monitoring of peer education programs and peer educator replications.

- Regional Communications Officer (RCO): development and oversight of district activities regarding community organization, counseling and training.

- Supply and Logistics Manager: based at the CMS or regional depot to coordinate supplies of condoms and STD drugs.

- Accountant: monitoring of project related funds for personnel, supplies and services.

With the exception of the RAC, each of the above positions will be new, non-established posts recruited from outside of the MOH. These officers will coordinate with the regional health officer, the regional health education officer, the regional health inspector and the regional education officer.

On a parallel and coordinated track, an indigenous NGO (e.g., the National Family Welfare Council, the Council of Non-Governmental Organizations in Malawi) will be selected and strengthened with an AIDS Prevention Division which will include an AIDS Division Director, Community Organization Officer and Private Sector Coordinator to ensure maximum participation by these two segments of Malawian society in the implementation of the ACP. This selected NGO will be responsible for (1) managing an umbrella grants program for non-governmental, community-based organizations, and (2) for coordinating the participation of the private sector.

This NGO will be strengthened in its role through on-site technical assistance of a U.S.PVO for the first two years (and intermittently TA thereafter). The USPVO will assist in the development of in-house capacity of the umbrella institution to identify, nurture and strengthen community based organizations (CBO) interested in implementing AIDS prevention programming in their communities as well as to assist in grant monitoring and management.

The use of Peace Corps Volunteers (PCV) will be explored in these regional offices to help in the development of training systems and the organization and management of AIDS activities. The PCV counterparts would be the RAC and the RCO.

7.3 Program Implementation (District/Community Level)

To maximize acceptability by and relevance to the target audiences, the Project will ensure that those closest to the community being targeted -- the district level health and various community support staff -- will take the lead role in designing and delivering AIDS prevention to the community.

Activities and services of the project described above will be implemented at the district level. Special AIDS prevention district officers will organize and monitor community-level activities undertaken by community-based work teams including distributing communication program materials and condoms to community-based distributors. They will be responsible for the day-to-day supervision of the work teams carrying out implementation, for monitoring the quality of service delivery, and reporting STD drug and condom supply distribution systems designed for their district.

The community-based work teams will include health assistants, health surveillance assistants, agricultural extension agents, community development assistants, community health nurses, social welfare assistants, and volunteer health workers.

Community-based workers will be enlisted to participate in outreach efforts, including identification of village and community leaders, youth group leaders, support group leaders, peer educators among men, and village health volunteers.

Each core District AIDS Management Team will consist of a:

- District AIDS Coordinator (DAC): a currently existing appointed position which should be elevated to full time status for implementation and supervision of AIDS/HIV activities, especially peer education amongst bargirls, and clinic-based STD prevention education activities.

- o District Health Inspector (DHI): who will continue to have responsibility for "food handlers" clinics with expansion of job description to include monitoring of partner notification forms. These staff will also have prime responsibility for identifying bargirl peer leaders and bar owners willing to establish pilot "condom only" bars.

- o Child Spacing Nurses whose job description will be expanded to include gynecologic evaluation of women with vaginal discharge in child spacing clinics. These staff will initiate HIV prevention counseling among couples and youth as appropriate.

On a pilot basis, the Project will also support the establishment of an additional member of the district management team, a District Community Organizer (DCO) who will be responsible for organizing outreach through these community-based work teams, and providing technical support to community groups (e.g., audiotape distribution, equipment maintenance, community volunteer leader identification and coordination). The use of Peace Corps Volunteers (PCV) will be explored on these district management teams. activities. The PCV counterparts would be the RAC and the RCO.

Community volunteers for youth groups and peer support projects will not be paid. Instead they will be compensated with periodic meetings where problems and experiences will be discussed and skills will be updated. It is envisioned that these working group and planning meetings will be 1 to 2 days in length with per diem or lunch allowances provided.

The District AIDS Management Teams will also be responsible for coordinating input from cooperating ministries primarily:

Ministry of Agriculture for distribution of videos and materials through existing mobile vans and clinic sites and agricultural extension workers who will add AIDS prevention to their community outreach activities

Ministry of Women, Children and Community Services who will provide community development assistants (CDAs), social welfare assistants (SWAs) and home craft workers for community outreach

Activities being conducted by the District AIDS Management Team will be complimented by umbrella grant activities supported through the NGO/private sector consortium in collaboration with community based and private organizations.

Umbrella grants program. Acknowledging both the nascent level of CBO development in Malawi as well as the potential contribution of this sector for sustainable AIDS prevention, this

component will focus as much on institutional strengthening as it does on prevention programming. The grant process will include an initial "general support" grant to develop/strengthen programmatic and financial management capability of the CBOs; only when these systems are satisfactorily in place will the funding be given for program implementation. The counterpart USPVO will also assist the umbrella NGO in the design, management and evaluation of the small grants program for supporting AIDS community initiatives and will collaborate in the provision of ongoing training, technical assistance and support to the CBOs as they implement their programs.

Private sector. As more fully described in the strategy for employed males, private industrial and agricultural businesses will be encouraged to fully integrate AIDS prevention and STD prevention/treatment into the package of health services provided to their workers. The services to be delivered through the private sector include STD treatment and prevention, AIDS prevention counselling (including the establishment of on-site peer and eventually couple counselling programs), and condom distribution. A number of such activities with the private sector have been initiated by the AIDS Secretariat directly and indirectly through such organizations as EC, Project HOPE and Banja la Mtsogolo. These programs and others (e.g., the feasibility of introducing a social marketing of family health services) should be moved to this NGO coordinating institution as the focal point of private sector participation in the national fight against AIDS. A full-time Private Sector Coordinator will be hired at the coordinating NGO to initiate and manage these activities in the workplace. This Private Sector Coordinator will also have responsibility for building private sector interest in expanding AIDS prevention and STD prevention/treatment through the workplace and other policy dialogue issues (e.g., expanding STD services to partners of workers). This person will also have responsibility for coordinating with the SOMARC condom distribution program assistance will be provided by AIDSCAP.

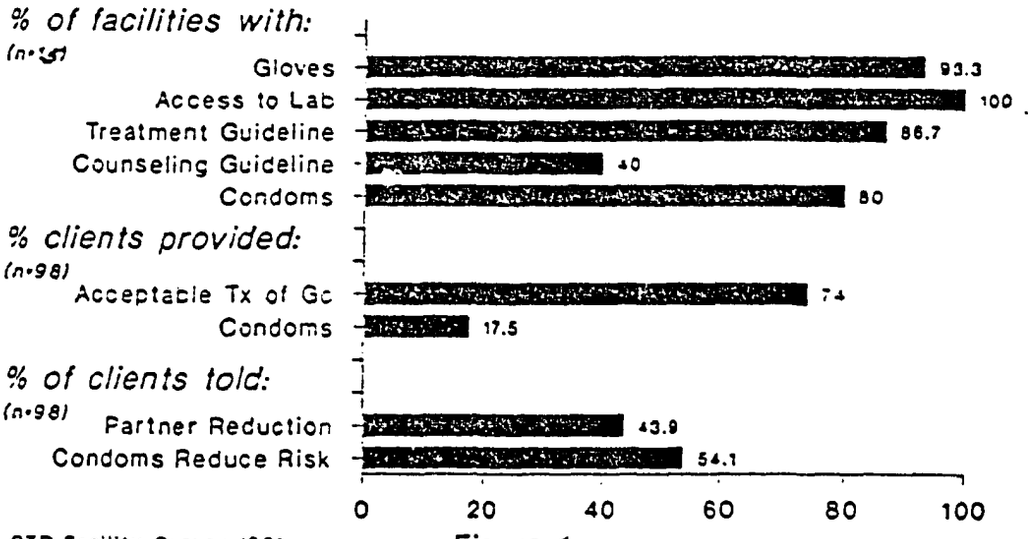
Parent and Teachers Association (PTA)

In conjunction with programs developed by the Ministry of Women, Children, and Community Services, The Project will identify and work with community leaders and fledgling PTAs with potential for growth as community-based organizations.

Religious Organizations

The Project will identify and collaborate with those individual churches and/or congregations willing to provide comprehensive prevention education and counseling through organizing community-based youth centers.

STD Case Management in Public Health Facilities Jamaica, 1991



STD Facility Survey 1991

Figure 1

Components of STD Case Management

Nat'l Program	Facility	Provider
Policy/Guidelines Service Availability Training	Screening/Referral	Take History Perform Exam
Laboratories & Quality Control	Equipment Access to Lab	Order/Read Test
Affordable, Available Condoms & Medicines	Treatment Guide Condoms	Make Diagnosis Prescribe Tx Educate & Counsel
Surveillance/HIS		Keep Records

HIV Indicators Project

Figure 2

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The observation-based method was found to provide valid data useful for program managers. CDC is currently working on a clinic record form that can serve both as an intervention to improve health worker performance and as a source of routine data on STD treatment practices.

OBJECTIVES AND RELATED RECOMMENDATIONS

Objective 1: **To assess whether the preliminary indicator would provide a valid and reliable measure of STD service quality if monitored by national STD programs.**

Recommendations:

1. Limit the current indicator to the public health service system.

1b. Investigate alternative indicator(s) and methods for assessing the quality of STD case management in the private sector. Conduct focus groups early in the process of adapting the indicator protocol to each country setting to obtain descriptive information about the range of STD service providers.

1c. Develop and field test a population-based indicator of <u>access</u> to STD services.

1d. Change the unit of assessment in the current indicator from "facilities" to "STD patients". Select the sample of facilities to be assessed based on their volume of STD patients.

1e. Do not use a composite score of STD clinical management as the indicator numerator at this time.

1f. If a single indicator is used, "Percent of STD patients diagnosed with syphilis or gonorrhea who are treated appropriately" is recommended.

1g. The use of a single indicator should be supplemented by a country profile that includes indicators of the STD service system at the national program, facility and provider levels of the STD service system.

Objective 2: To test the feasibility of a facility-based observational method as a strategy for collecting the data needed to support the preliminary indicator.

Recommendations:

2a. The facility-based assessment approach is an acceptable method for collecting data to support the STD service quality indicator.

2b. The baseline facility-based assessment should be conducted only when minimum program requirements (e.g., availability of STD policy, services and surveillance system at the national program level) have been met. Follow-up assessments should be conducted only after significant inputs have been directed to improving service quality.

2c. The facility-based assessment is an intensive, non-routine activity; where possible it should be supplemented with routine reports of service quality obtained through supervision and/or use of special recording forms in the facility.

Objective 3: To investigate the extent to which the indicator activity could contribute to national level STD control programs.

Recommendations:

3a. In future applications of the facility-based assessment protocol, allow additional lead time so that country programs may add items needed to monitor and evaluate their country-specific program activities.

3b. In the continued development of the STD service quality indicator, ensure that the protocol will provide adequate data to program managers while allowing specific indicators to be abstracted from the data set for reporting purposes.

APPENDIX C:

STD MANAGEMENT: PATIENT OBSERVATION

Date: day _____ month _____ year _____

Observer Initials: _____

Facility: _____

Patient Number: _____

Sex of patient: Male |_| Female |_|

Age of patient: _____

1) HISTORY

a) Provider type/initials: _____ 1a

Does the provider ask about:

b) Reason for visit.....Y N 1b

c) Symptoms (if no, skip to 1e).....Y N 1c

If yes, circle the symptoms reported by the patient:

d) Discharge 1d1 Burning 1d2 Ulcer or Sore 1d3

Rash 1d4 Lower Abdominal Pain 1d5 Other 1d6 _____

e) History of STD.....Y N 1e

f) Health of sex partner(s).....Y N 1f

g) Use of medications during recent past.....Y N 1g

h) Known allergy to any medications.....Y N 1h

i) For women, possibility of being pregnant or history of a delayed menstrual period.....NA (male) Y N 1i

2) EXAMINATION

a) Provider type/initials: _____ 2a

Does the provider:

b) Conduct a physical examination (If no, skip to question 4).....Y N 2b

c) Inspect for or ask about rashes.....Y N 2c

d) Inspect external genitalia.....Y N 2d

e) Perform bimanual exam.....NA (male) Y N 2e

f) Perform speculum exam .....NA (male) Y N 2f

g) Wear gloves .....NA (did not touch) Y N 2g

3) CLINICAL FINDINGS

a) Lesion (sore/ulcer/vesicle).....Y N 3a

b) Discharge (urethral/cervical/vaginal).....Y N 3b

c) Rash.....Y N 3c

d) Other _____ 3d

4) LABORATORY TESTS

Are specimens ordered or collected for:

a) Syphilis serology.....Y N 4a
b) HIV screening test.....Y N 4b
c) Gram stain .....Y N 4c
d) Culture for gonorrhea .....Y N 4d
e) Wet mount .....Y N 4e

5) DIAGNOSIS/TREATMENT

a) DIAGNOSING provider type/initials:_____ 5a
b) Was a diagnosis made (if no, skip to 5f).....Y N 5b

DIAGNOSIS	TREATMENT (type/amount)
5c) _____	5g) _____
5d) _____	5h) _____
5e) _____	5i) _____
5f) _____	5j) _____

i) Does the provider record information in a medical record..... Y N 5m
j) Does the provider explain how to take medications....NA (no meds) Y N 5n

6) COUNSELLING/EDUCATION/PARTNER NOTIFICATION

a) How was counselling/education done?

Individual 6a1 Group 6a2 Both 6a3 None 6a4

Did the provider:

b) Discuss with the patient the STD.....Y N 6b
c) Offer partner notification services via provider referral.....Y N 6c
d) Counsel the patient to send his partners to the clinic for examination/treatment.....Y N 6d
e) Advise the patient to abstain from sex for a specified period of time.....Y N 6e
f) Discuss with the patient partner reduction to reduce the risk of STD and HIV.....Y N 6f
g) Discuss with the patient condom use to prevent STD and HIV.....Y N 6g
h) Ask if the patient has any problems with condom use.....Y N 6h
i) Offer condoms to the patient.....Y N 6i
j) Use educational supports.....Y N 6j
k) Conduct a contact interview (If no, skip to 6m).....Y N 6k
l) Conduct the contact interview where it cannot not be overheard.....Y N 6l
m) Ask at the end of the visit if the patient has questions.....Y N 6m

7) COMMENTS

_____

_____

_____

Facility: _____

Observer: _____ Date: __/__/__
D M Y

STD MANAGEMENT: CLINICAL FACILITY REVIEW

Title of the most senior clinical provider _____

1.A. Indicate which days of the week the clinic is open.

M T W Th F Sat Sun

1.B. Indicate which days of the week the clinic offers STD service.

M T W Th F Sat Sun Other

1.C. In the past 30 days, were any patients ever turned away from this clinic? If "no", skip to question 1E. Y N 1c

1.D. In the past 30 days were STD patients ever turned away? Y N DK 1d

1.E. How many of the providers here today diagnose STD patients? _____ 1e

1.F. Did any of these providers (from question 1E) attend an update training or seminar on HIV/STD during the past 12 months? _____ 1f

2. The following therapies apply to adult males or non-pregnant females. Write the drug used, the route of administration, the dosage and frequency, whether this information is from a written document or from a verbal (spoken) source only and whether or not there is any drug is available in the facility at present,

CONDITION	DRUG	ROUTE	DOSE & FREQ.	SOURCE	AVAILABLE
Gonorrhea 1st line	2A1	PO IM 2B1	2C1	Written/ Verbal 2D1	Y N 2E1
Gonorrhea Rx Failure	2A2	PO IM 2B2	2C2	W V 2D2	Y N 2E2
Primary Syphilis 1st line	2A3	PO IM 2B3	2C3	W V 2D3	Y N 2E3
Chancroid 1st line	2A4	PO IM 2B4	2C4	W V 2D4	Y N 2E4
NGU or NSU 1st line	2A5	PO IM 2B5	2C5	W V 2D5	Y N 2E5
P.I.D. 1st line	2A6	PO IM 2B6	2C6	W V 2D6	Y N 2E6

3.A. Ask "Does the clinic have a written policy or guidelines for STD treatment?" If no, skip to question 4. Y N 3A

3.B. Ask "May I see a copy, please?" Is a copy provided to the observer? If "no", skip to question 4. Y N 3B

3.C. Indicate the source of the policy/guidelines. _____ 3C

3.D. What year were the policy/guidelines written? _____ 3D

4.A. Can laboratory tests for any STD be ordered from this clinic? If "no", skip to question 5. Y N 4A

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Complete the following table by indicating the number of tests performed in the clinic during the past 7 days, where the following tests were performed and whether results are available during the client's visit:

TEST	No. Performed in clinic in last 7 days?	Performed at another site?	Result available during visit?
Wet Prep	4B1a	4B2a Y N	4B3a Y N
Gram Stain	4B1b	4B2b Y N	4B3b Y N
Syph. Serology—QUAL.	4B1c	4B2c Y N	4B3c Y N
Syph. Serology—QUAN.	4B1d	4B2d Y N	4B3d Y N
HIV Serology	4B1e	4B2e Y N	4B3e Y N

If RPR test is not performed at this clinic, do not answer 4C.

4.C. If RPR tests are done at this clinic, is quality control testing done at least weekly for RPR? Y N 4C

5.A. Can patients obtain condoms at this clinic? Y N 5A
If "no", skip to question 5D.

5.B. How many condoms are there at this clinic? <10 10-100 >100 5B

5.C. Cost to client for 10 condoms: $\_\_\_\_\_$ 5C

5.D. Do you have written guidelines regarding counselling of STD patients in HIV/STD prevention? Y N 5D
If "no", go to question 6.

5.E. Ask "May I see a copy, please?"
Is a copy provided to the observer? Y N 5E

6.A. Ask "Is there a record that indicates the number of STD patients seen during the previous week?" Y N 6A
If "no", skip to question 7.

6.B. How many STD patients were seen here in the past week? _____ 6B

7.A. How many disposable gloves are present and available to the clinic staff? none <25 25-100 100-1000 >1000 7A

7.B. Does the clinic have a vaginal speculum? Y N 7B

7.C. Is fresh water available in the clinic? Y N 7C

7.D. Is private space (ie. where talk cannot be overheard) available for patient counselling in clinic? Y N 7D

If blood is not drawn at this clinic, skip questions 8A and 8B.
If blood is drawn at this clinic, observe blood collection for 5 patients or indicate number_____:

8.A. Is a sterile needle and syringe used for each observed? Y N 8A

8.B. Are all needles immediately disposed in a designated "sharps" for all observed? Y N 8B

COMMENTS

_____

_____

_____

_____

APPENDIX H:

Facility: _____ Date: _____

PATIENT CONSENT FORM

The Ministry of Health is working on a project to identify simple methods to improve National AIDS and STD Programs.

If it is okay with you, Mr./Ms. _____ from the Ministry of Health/USAID will sit in the room as we talk and as I examine you. You may refuse and this refusal will not affect the service you receive here today or in the future.

The reason for Mr./Ms. _____'s presence is to observe my work as a health care provider. No information about you will be collected other than your gender and symptoms. Your name will not appear on the survey sheet. Your information will be grouped with other information in any discussion of the survey, so no one will be able to learn about your individual case. Is it okay with you if Mr./Ms. _____ sites in with us?

IF YES:

Thank you. Now let's do our best to take care of your problem.

IF NO:

That is just fine.

(Please indicate below patient's sex and age.)

SEX: M F AGE: _____

Employees Confederation of Malawi (ECOM)

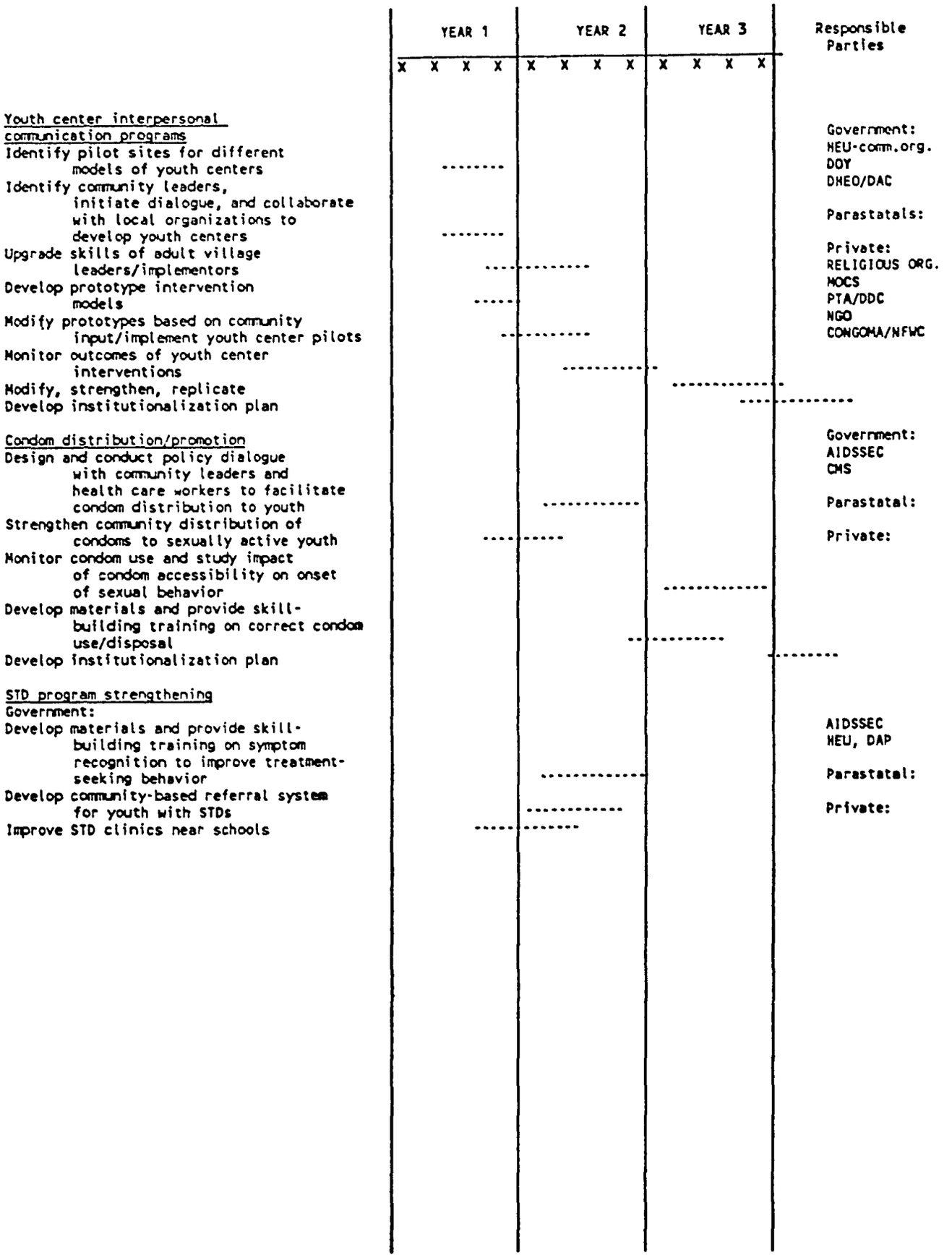
The Project will collaborate with ECOM to provide worksite-based AIDS prevention education/individual and couple counseling. ECOM will also help identify first phase worksites to provide male-to-male counseling and support programs.

7.4 Technical Assistance

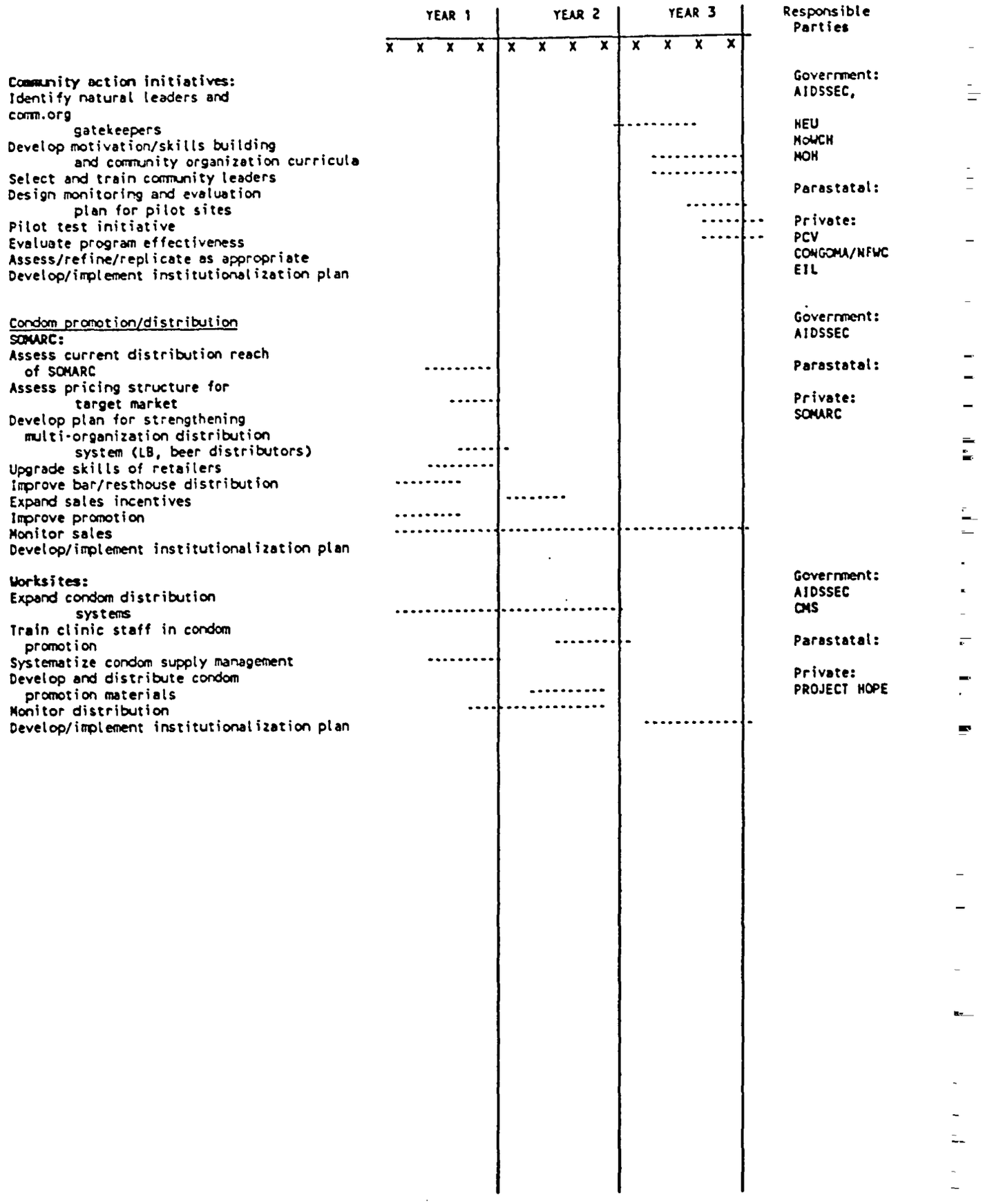
Technical assistance will be provided to the public and private sectors by the Project through a buy-in to an AID/W cooperative agreement and other US-based organizations. [To be complete with USAID/Malawi].

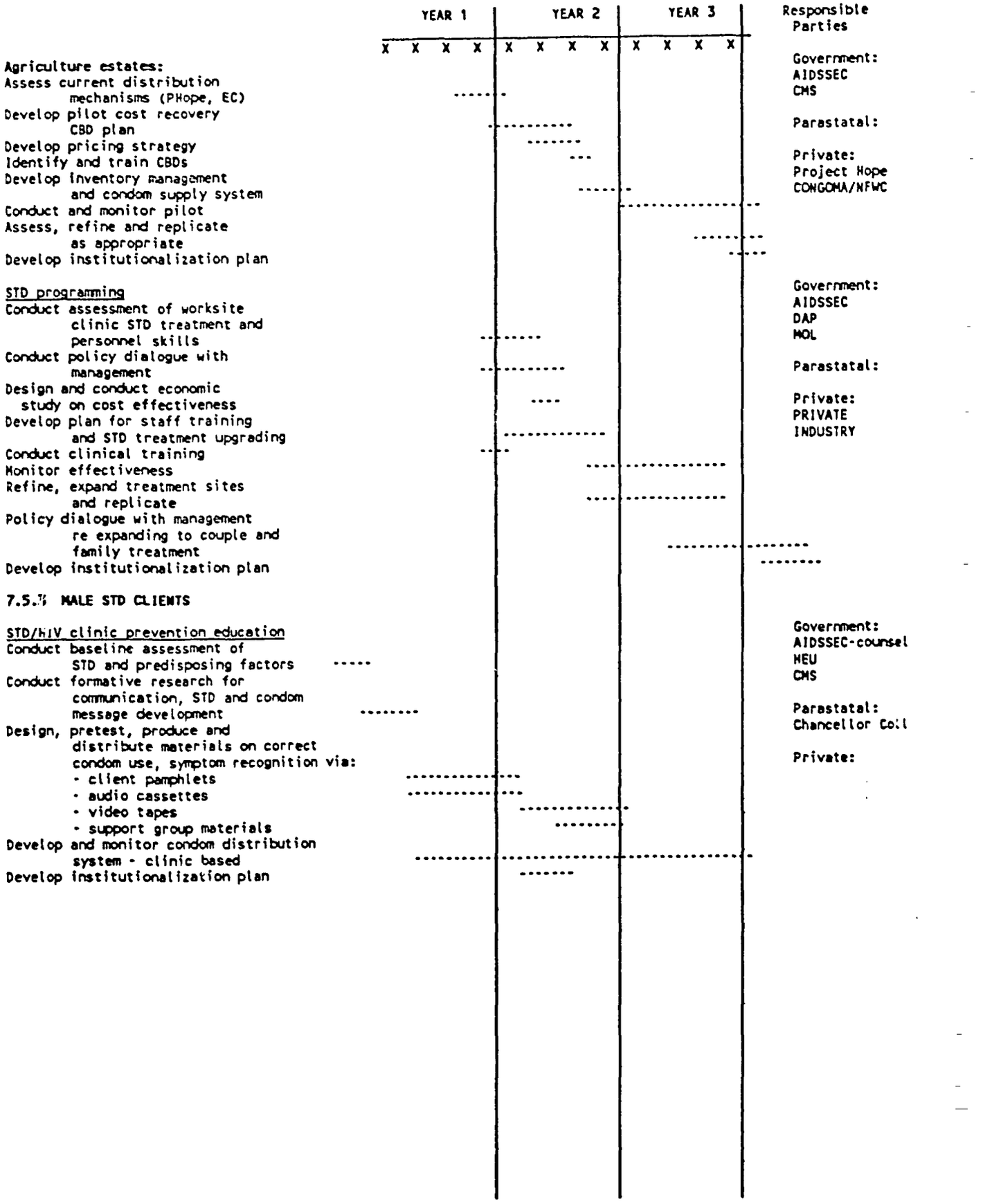
7.5 Detailed implementation plan and timeline for years 1993 - 1995

	YEAR 1				YEAR 2				YEAR 3				Responsible Parties
	X	X	X	X	X	X	X	X	X	X	X	X	
7.5.1 YOUTH													
AIDS education in schools													Government:
Monitor, assess impact in St 1-4	----	----	----	----									MOE
Modify, reprint materials as needed			----	----	----	----							HEU (MOH)
Assist in integrating St 5-8 and Fm 1-4	----	----	----	----									Parastatal:
Monitor, assess impact	----	----	----	----									MIE
Modify, reprint materials as needed					----	----	----	----					
Modify curriculum for other groups (e.g., Ag, Community Serv, GABLE)						----	----	----	----				Private: UNICEF
Communication for attitude/ perception exploration													
Radio:													Government:
Conduct formative research for message development			----	----									MOI HEU, DAC
Develop radio drama scripts			----	----		----	----						
Pretest, produce (incl. audiotapes)				----	----	----			----	----			Parastatal:
Air radio drama and disseminate audio tapes to youth centers						----	----	----		----	----	----	MIE, UCM
Evaluate radio drama							----	----					Private:
Conduct follow-up radio interviews/ discussion groups							----	----	----	----	----	----	
Procure radios					----	----	----	----					
Village drama groups/bands:													Government:
Evaluate effectiveness of drama and band interventions:	----	----	----	----									HEU, DHEO, DAC AIDSSEC
Develop drama stories and musical scores									----	----	----	----	Parastatal:
Train groups										----	----	----	UCM
Conduct dramas/bands concerts in communities (with follow-up discussion groups)											----	----	Private:
Evaluate/modify													
Develop institutionalization strategy													
Other print/electronic materials:													
Continue video production	----	----	----	----									Government:
Develop and disseminate to youth groups/community centers									----	----	----		HEU, MOAg, DCY, MOI, AIDSSEC-coun
Develop individual and small group counseling program materials						----	----	----	----	----			Parastatal: MBC Private:


YEAR 1
YEAR 2
YEAR 3
Responsible Parties
X X X X X X X X X X X X
Youth center interpersonal communication programs
Identify pilot sites for different models of youth centers
Identify community leaders, initiate dialogue, and collaborate with local organizations to develop youth centers
Upgrade skills of adult village leaders/implementors
Develop prototype intervention models
Modify prototypes based on community input/implement youth center pilots
Monitor outcomes of youth center interventions
Modify, strengthen, replicate
Develop institutionalization plan
Condom distribution/promotion
Design and conduct policy dialogue with community leaders and health care workers to facilitate condom distribution to youth
Strengthen community distribution of condoms to sexually active youth
Monitor condom use and study impact of condom accessibility on onset of sexual behavior
Develop materials and provide skill-building training on correct condom use/disposal
Develop institutionalization plan
STD program strengthening
Government:
Develop materials and provide skill-building training on symptom recognition to improve treatment-seeking behavior
Develop community-based referral system for youth with STDs
Improve STD clinics near schools
Government:
HEU-comm.org.
DOY
DHEO/DAC
Parastatals:
Private:
RELIGIOUS ORG.
MOCS
PTA/DDC
NGO
CONGOMA/NFWC
Government:
AIDSSEC
CMS
Parastatal:
Private:
AIDSSEC
HEU, DAP
Parastatal:
Private:

	YEAR 1				YEAR 2				YEAR 3				Responsible Parties
	X	X	X	X	X	X	X	X	X	X	X	X	
7.5.2 EMPLOYED MALES													
Baseline research/assessments													Government: AIDSSEC/ HEU
Develop assessment plan for PHope, EC and Banja workplace activities			-----										Parastatal: UCM
Conduct assessments			-------										
Establish monitoring and evaluation plan				----									Private: BANJA, PHOPE
Media to reframe attitudes													
Collect baseline and formative information for messages	----------												Government: HEU
Design, pretest, produce and distribute materials:			-----										Parastatal: CHANCELLOR COLL.
- discussion guides				---	----------								Private: NGO GRAPHIC LINTOS
- booklets/pamphlets					---------								
- posters					---------								
- condom instructions					---------	---							
Small group male-to-male counseling													Government: MOL/HEU
Strengthen administrative & organizational development skills of Banja			-------	----------	----------	---							Parastatal:
Identify and train cadre of NGO trainers					-------								Private: BANJA, PHOPE ECOM NGO's
Systematize training program (e.g., developing training plans, refining curricula, apprenticing new trainers)				-------	--								
Initiate training programs							---	---------					
Monitor training programs									----------				
Upgrade trainer skills based on													
- trainer feedback													
- participant/workplace evaluation												-------	
Modify and replicate training programs													
Develop/implement institutionalization plan													
Couple counseling program													
Government:													
Develop training plan													AIDSSEC-coun. HEU MOH
Design curricula													
Identify and train counselors													
Develop monitoring and evaluation tools													Parastatal:
Pilot counseling program													Private: BANJA, PHOPE NGO
Evaluate program													
Refine and replicate as appropriate													
Assess model for expanded applications (family, peer counseling)													
Develop/implement institutionalization plan													
Explore options for couple counseling in CS clinics							-----	---------					


YEAR 1
YEAR 2
YEAR 3
Responsible Parties
Community action initiatives:
Identify natural leaders and comm.org gatekeepers
Develop motivation/skills building and community organization curricula
Select and train community leaders
Design monitoring and evaluation plan for pilot sites
Pilot test initiative
Evaluate program effectiveness
Assess/refine/replicate as appropriate
Develop/implement institutionalization plan
Government:
AIDSSEC,
HEU
MoWCH
MOH
Parastatal:
Private:
PCV
CONGOMA/NFWC
EIL
Condom promotion/distribution
SOMARC:
Assess current distribution reach of SOMARC
Assess pricing structure for target market
Develop plan for strengthening multi-organization distribution system (LB, beer distributors)
Upgrade skills of retailers
Improve bar/resthouse distribution
Expand sales incentives
Improve promotion
Monitor sales
Develop/implement institutionalization plan
Government:
AIDSSEC
Parastatal:
Private:
SOMARC
Worksites:
Expand condom distribution systems
Train clinic staff in condom promotion
Systematize condom supply management
Develop and distribute condom promotion materials
Monitor distribution
Develop/implement institutionalization plan
Government:
AIDSSEC
CMS
Parastatal:
Private:
PROJECT HOPE


YEAR 1
YEAR 2
YEAR 3
Responsible Parties
Agriculture estates:
Assess current distribution mechanisms (PHope, EC)
Develop pilot cost recovery CBD plan
Develop pricing strategy
Identify and train CBDs
Develop inventory management and condom supply system
Conduct and monitor pilot
Assess, refine and replicate as appropriate
Develop institutionalization plan
Government:
AIDSSEC
CMS
Parastatal:
Private:
Project Hope
CONGOMA/NFWC
STD programming
Conduct assessment of worksite clinic STD treatment and personnel skills
Conduct policy dialogue with management
Design and conduct economic study on cost effectiveness
Develop plan for staff training and STD treatment upgrading
Conduct clinical training
Monitor effectiveness
Refine, expand treatment sites and replicate
Policy dialogue with management re expanding to couple and family treatment
Develop institutionalization plan
Government:
AIDSSEC
DAP
MOL
Parastatal:
Private:
PRIVATE INDUSTRY
7.5.3 MALE STD CLIENTS
STD/HIV clinic prevention education
Conduct baseline assessment of STD and predisposing factors
Conduct formative research for communication, STD and condom message development
Design, pretest, produce and distribute materials on correct condom use, symptom recognition via:
- client pamphlets
- audio cassettes
- video tapes
- support group materials
Develop and monitor condom distribution system - clinic based
Develop institutionalization plan
Government:
AIDSSEC-counsel
HEU
CMS
Parastatal:
Chancellor Coll
Private:

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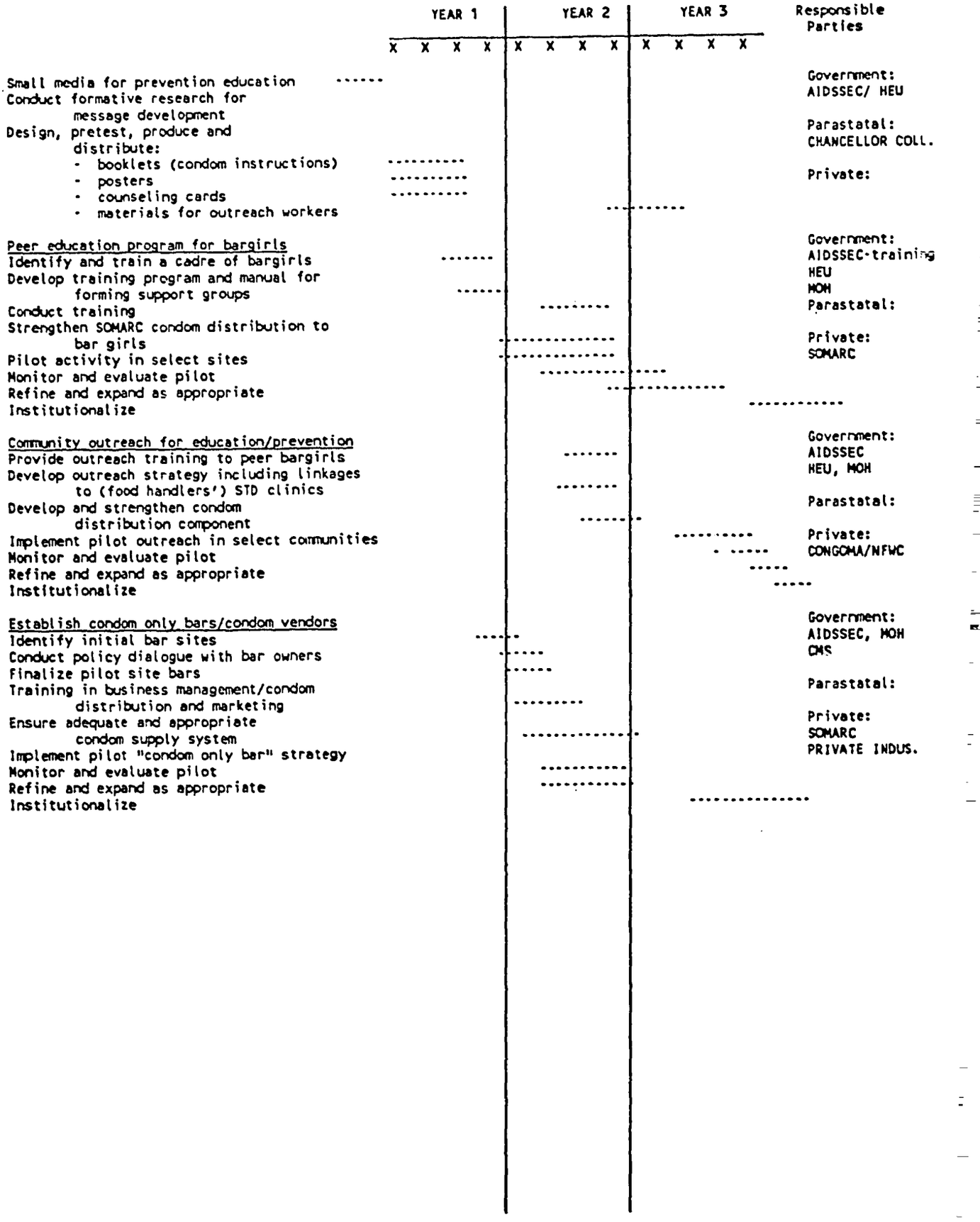
	YEAR 1				YEAR 2				YEAR 3				Responsible Parties
	X	X	X	X	X	X	X	X	X	X	X	X	
<u>Small group communication</u>													Government:
Identify and train small group facilitators							.....	.					AIDSSEC-train HEU
Conduct discussion groups and follow-on support groups										.....			"PARA"-HEALTH PERSONNEL
Conduct intervention-linked research on sexual attitudes and behaviors and condom use										.....			Parastatal:
Monitor and assess										.....			Private:
Refine, expand to other treatment sites											.....	.	VILLAGE HEALTH VOLUNTEERS
Develop and monitor condom distribution system -										.....		.	CONGOMA/NFWC
Develop institutionalization plan											....		
<u>Community outreach/education</u>													Government:
Identify and train community comm.org. volunteers outreach workers							.....	.					AIDSSEC- HEU, MOAg
Develop community based peer groups							.....	.					
Develop and pilot "buddy" support system							..	.....					Parastatal:
Develop and monitor condom distribution system - community level										.....			Private:
Monitor and assess											.....	...	PCV
Refine and expand									.....				CONGOMA/NFWC
Develop institutionalization plan									.....				
<u>Mass communication for normative change</u>													Government:
Formative research on current male norms	.....												AIDSSEC MOI, HEU
Assessment/design of appropriate messages and channels						.....							Parastatal:
Assess materials distribution systems							.....	.					CHANCELLOR
COLLEGE													
Design, pretest, produce and deliver:													MBC
- video tapes							....	.....					
- radio programs													Private:
Monitor, refine, evaluate										.....			

	YEAR 1				YEAR 2				YEAR 3				Responsible Parties
	X	X	X	X	X	X	X	X	X	X	X	X	
<u>Strengthen and expand clinic-based STD services: public sector</u>													Government: AIDSSEC, CHSU CMS, DAP
Pilot studies:													
1) Drug choice	---												Parastatal: MEDICAL SCHOOL CHANCELLOR COLL. MIE
2) Drug utilization, partner notification, condom utilization	----------												
Assess pilot systems	----------												
Refine, expand and replicate				----	----------								
Complete diagnostic and treatment guidelines.	-----												Private:
Train TOT on guidelines	------												
Begin CMS procurement for STD drugs		-----											
Establish lab diagnostics support					----------				----------				
Train lab technicians			----------		----------				----				
Establish sentinel surveillance sites		------											
Develop monitoring and evaluation system of clinic based services		------											
Develop management logistics system		----------			----------				----				
Clinical service site upgrade				----	----------				----				
Improve HIS					---------								
Improve STD services for women in child spacing sites							----------						
Develop institutionalization plan										----------		---	
<u>Explore options for STD services in the private sector</u>													<u>Private:</u> NGO CONGOMA/NFWC
Conduct feasibility study for supporting social marketing of "family health services"		-------											
Pilot alternative mechanisms					---------								
Evaluate and replicate model as appropriate									----------				
Develop institutionalization plan										----------			
7.5.4 BARGIRLS/FREELANCERS/BAR OWNERS-MANAGERS													
<u>Baseline research</u>													Government: AIDSEC, HEU
Conduct rapid research on networks, channels, potential peer leaders, motivated bar owners and current safe sex behaviors	-----												Parastatal: CHANCELLOR COLL MEDICAL SCHOOL
Conduct pilot study of presumptive or periodic mass treatment					---------								Private:


YEAR 1
YEAR 2
YEAR 3
Responsible Parties
Small media for prevention education
Conduct formative research for message development
Design, pretest, produce and distribute:
- booklets (condom instructions)
- posters
- counseling cards
- materials for outreach workers
Government: AIDSSEC/ HEU
Parastatal: CHANCELLOR COLL.
Private:
Peer education program for bargirls
Identify and train a cadre of bargirls
Develop training program and manual for forming support groups
Conduct training
Strengthen SOMARC condom distribution to bar girls
Pilot activity in select sites
Monitor and evaluate pilot
Refine and expand as appropriate
Institutionalize
Government: AIDSSEC-training HEU MOH
Parastatal:
Private: SOMARC
Community outreach for education/prevention
Provide outreach training to peer bargirls
Develop outreach strategy including linkages to (food handlers') STD clinics
Develop and strengthen condom distribution component
Implement pilot outreach in select communities
Monitor and evaluate pilot
Refine and expand as appropriate
Institutionalize
Government: AIDSSEC HEU, MOH
Parastatal:
Private: CONGOMA/NFWC
Establish condom only bars/condom vendors
Identify initial bar sites
Conduct policy dialogue with bar owners
Finalize pilot site bars
Training in business management/condom distribution and marketing
Ensure adequate and appropriate condom supply system
Implement pilot "condom only bar" strategy
Monitor and evaluate pilot
Refine and expand as appropriate
Institutionalize
Government: AIDSSEC, MOH CMS
Parastatal:
Private: SOMARC PRIVATE INDUS.

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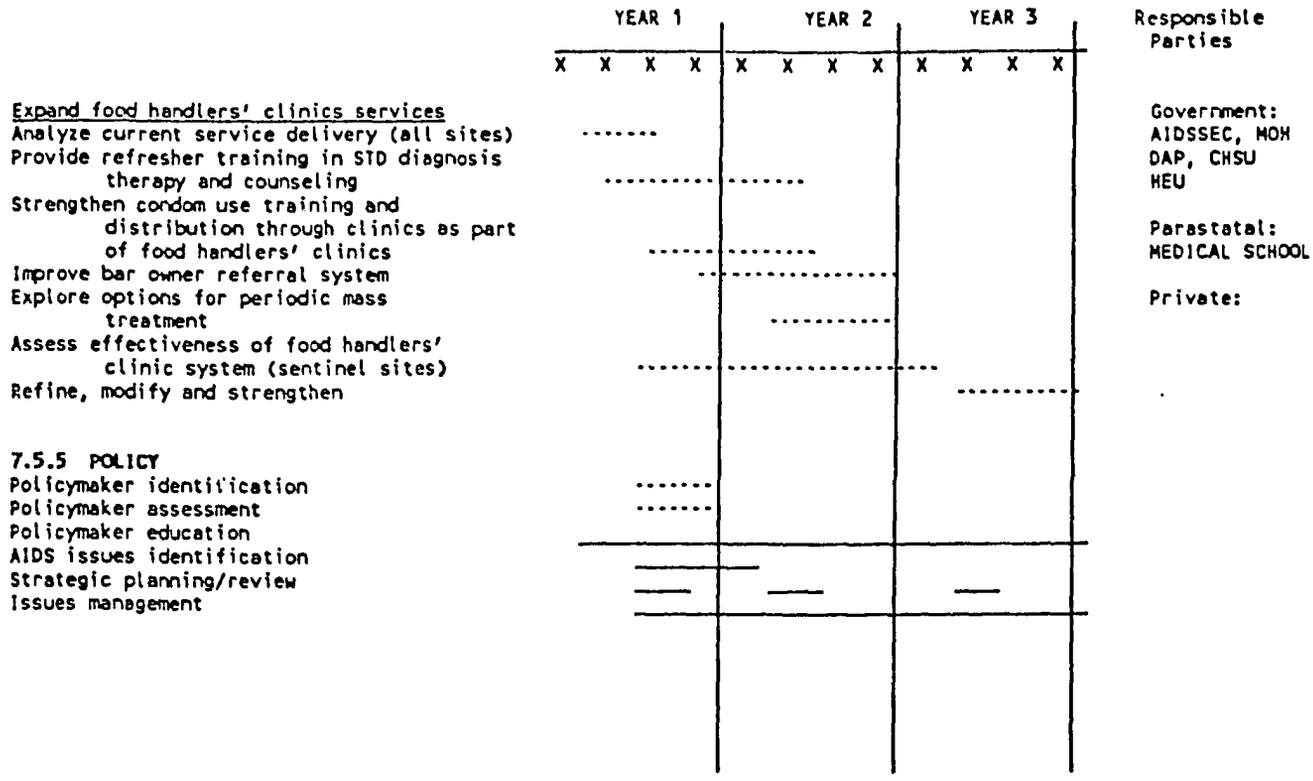

7.6 Illustrative plan for years 1996 - 2000

The implementation plan for these year will include modification of currently implemented projects based on the information from the ongoing evaluations and will include the following:

- continuing assessment, modification and reprinting of school curricula
- expansion of community based youth centers using model that was successful in pilots
- expanding services to employed males to include spouses, couple counselling
- designing programs to reach the other three target groups, unmarried females, females with STD, and employed men over 30 years of age. The female target groups can be integrated into the expanded child spacing services accomplished under STAPH.
- expansion of mass media campaigns and interpersonal communication strategies.
- Expansion of "family health" social marketing, if successful.
- Continuing identification and involvement of NGO's in aspects of program implementation.
- Expansion of condom social marketing.

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8.0 EVALUATION STRATEGY

While each individual sub-project within each country program will be monitored and evaluated, the summary outcome and impact of all of the components will be monitored and evaluated by the Project at all levels.

The evaluation plan for country programs will use as an evaluation "core" measures similar to those being developed by the WHO/GPA/USAID AIDS Prevention Program Indicators (PPI) process (Annex I). The PPIs are in the process of being refined by WHO/GPA/USAID as country-level, HIV/AIDS prevention indicators of program impact. The purpose of developing this set of indicators is to provide a standardized protocol for monitoring and evaluating HIV/AIDS prevention and control programs that will allow cross-national comparisons. The basic constructs within the PPIs which will be measured within the Project include the following:

(1) HIV and syphilis seroprevalence shifts assessed over the medium term (5 years)

(2) survey-based (as well as qualitatively measured) reported behavior change (eg. partner-type specific condom use, number and types of partners) assessed over the short (2 years) and medium term;

(3) survey-based knowledge of HIV prevention in the general population assessed over the short and medium term.

(4) survey based self-report of a history of STDs in males assessed over the medium term.

(5) a facility-based assessment of STD case management (biomedical and condom/communication aspects) at the onset of activities in the STD program, and re-evaluated in the final year; and

(6) condom distribution and sales figures aggregated from participating organizations and institutions on an on-going basis, with an additional assessment of condom outlets in the initial (and final) years of the program activity.

These PPIs are not intended to provide national AIDS Control Programs or the Project with all the information necessary to monitor the implementation of prevention programs, nor to measure the impact of all the information necessary to monitor the implementation of prevention programs, not to measure the impact of all prevention and control activities. National AIDS Control Program strategic plans will include other monitoring and evaluation protocols, and Project country program strategic plans will also include additional indicators depending on the specific components (subprojects) of country programs.

AIDS case reports are routinely gathered by the AIDS Secretariat. However, counts of AIDS cases are less useful for program monitoring

and evaluation, because of the long incubation period of HIV infection, roughly 7 to 10 years. Any impact of prevention programs on the number of AIDS cases would only be apparent many years after the implementation of prevention activities. Following recommendations developed under AIDSTECH, the AIDS Secretariat will conduct an annual count of AIDS cases to provide the needed routine reports for government and WHO. However, a more detailed analysis of data on AIDS cases will only be conducted on a one month national sample of AIDS cases identified during July of each year. This methodology is recommended because of the prohibitively large amount of data which are generated on an annual basis.

In collaboration with the Ministry of Health, the project will identify four or five sentinel sites which will be more thoroughly evaluated than the complete program area (see below under HIV sentinel surveillance for additional details). In addition to the PPIs, special more detailed evaluation studies will be done at these sites, as discussed in more detail in connection with the various major program components.

Many of the aspects of HIV prevention are difficult to measure or fully comprehend in a quantitative manner. Thus, there will be qualitative data collection activities conducted to complement quantitative assessments, both at baseline and throughout the life of the project. The content of these qualitative efforts will be designed to complement the quantitative measures at both the country program and sub-project level. For example, more subtle aspects of the quality of STD services, such as the extent to which services are accessible, confidential and private, and the staff well trained, are best evaluated through participant observations. After a few days of observation, well-trained observers can produce an accurate assessment.

8.1 Priority Prevention Indicators

8.1.1 HIV and Syphilis Seroprevalence

The most rigorous approach to monitoring the incidence rate of new infections is to follow the age-specific level of HIV and syphilis infection in young pregnant women, 15 to 24. Most adolescent girls aged 13 or 14 are uninfected, but levels rise quite steeply between 15 and 25. Thus after five years, a control program that prevents infection in young men and women should show a measurable impact on seroprevalence, especially in the under-20 age group. Depending on the effectiveness of the program, an impact on HIV infection levels might be visible even earlier than five years.

The project will take an active role in helping the MOH establish a sentinel surveillance system for pregnant women, as a follow-up to AIDSTECH's pilot survey in this area. Five sentinel sites will be set up, one in a large urban area (Blantyre or Lilongwe) and four at district hospitals. One of the sites will be Mangochi because of the planned collaboration with the CHSU and medical school research and training activities there. At least one additional site will be chosen from each region. The two district hospitals chosen for

testing in the AIDSTECH pilot sentinel surveillance survey, Mchinji and Mulanje, will also be considered as possible sentinel surveillance sites under the new project.

Syphilis testing (and treatment) will be done routinely during antenatal clinics at these sites, and samples will be saved for unlinked anonymous testing for HIV on a sample of women at one or two months once a year. Women under 24 years of age will be over-sampled for HIV testing to provide enough data for detailed analysis of the under-20 and the 20-to-24 year old age groups. These seroprevalence rates will be coupled with attempts to define the representativeness of these samples to the larger adult population, eg. asking on survey instruments about antenatal attendance for the most recent birth in the household. HIV testing will be done by the CHSU. Data analysis will be done on a collaborative basis between CHSU and the AIDS Secretariat.

In addition to HIV sentinel surveillance among pregnant women, blood donor data will continue to be used as a very rough indicator of HIV infection levels in areas not covered by sentinel surveillance sites. Following recommendations developed under AIDSTECH, the AIDS secretariat will do an annual analysis of data from donors who are tested in February and March of each year. Only a two-month sample of blood donors is recommended because of the prohibitively large amount of data which are generated on an annual basis.

8.1.2 Reported Behavior Change

Using two-stage cluster sampling techniques, a population based survey of 15-34 year old men and women will be conducted in the five sentinel sites and in other sites to be selected. This population survey will be conducted in years 1, 4 and 6 of the program. This survey will include the following WHO/USAID Priority Prevention Indicators:

(1) condom use during the most recent act of sexual intercourse - stratified by gender and age of respondent, and type of partner

(2) number of sexual partners in the past 3 months, appropriately stratified

(3) knowledge of preventive practices

(4) self-reported STD history among men

The surveys will be carried out by the Center for Social Research, of the University of Malawi, or a similar private sector research group, preferably based in Malawi.

8.1.3 STD Case Management

STD control and prevention programs will incorporate measures of

appropriate levels of diagnosis and treatment, in accordance with national standards. Adequacy of case management includes condom distribution and advice on partner notification, among other management guidelines. An example of a pilot test of a method used in Jamaica for assessing the quality of STD case management is found in Annex 2. While a brief baseline assessment will be performed, a more thorough evaluation will not be done until some progress has been made in upgrading STD services. A follow-up evaluation will be conducted in the last year of the project in the contest of routine facility supervision The three PPIs captured with this methodology are:

(1) proportion of clients (male and female) presenting with a specific syndrome (GUD or discharge) who are assessed and treated according to national guidelines;

(2) proportion of clients presenting for treatment of any syndrome who received condoms and instruction in their use;

(3) proportion of clients presenting for treatment of any syndrome who received counselling to promote partner notification and treatment.

8.1.4 Condom Distribution and Availability

Five indicators will be used to measure condom distribution and availability:

(1) reported condom sales for condom social marketing (CSM) and cost-recovery community based distribution (CBD) by month and as percentages of sales forecasted for the period;
(2) reported numbers of points of purchase (e.g., bars, bottle shops, etc.) and as percentages of total possible outlets targeted in the distribution strategies for CMS and CBD,
(3) reported free distribution through clinics and other outlets where free distribution is taking place (e.g., worksites, police barracks) and as a percentage of estimated distribution,
(4) reported number points of free distribution and as a percentage of total possible outlets targeted in the free distribution strategy, and
(5) consistency of supply in CMS, CBD and free distribution outlets as measured by the number of distribution sites which report an uninterrupted supply of condoms over the past quarter (numerator) divided by the total number of distribution sites surveyed (denominator).

Data for indicators (1) and (3) will be collected from sales and distribution data provided by program managers on a monthly basis; data for indicators (2) and (4) will be collected semi-annually; and data for indicator (5) will be collected as a result of sampling outlets for each distribution system.

8.1.5 Additional Country Level Indicators

Additional indicators that might be measured at baseline and assessed again at the end of the intervention (outcome indicators), and to be used during monitoring of project activities (process indicators) include:

(1) reported delays in onset of sexual activity among youth (<20 years);

(2) sources of HIV/AIDS information in the past 3 months, and the most useful of these sources;

(3) percentage of population who specifically mention condoms use as a way to protect themselves from HIV infection;

(4) percentage of population surveyed who believe that a majority of their friends and peers use condoms (or other risk reduction behaviors);

(5) awareness of and perceived accessibility of condoms, STD services, etc.;

(6) personal acquaintance with HIV carriers or persons with AIDS;

(7) perceived risk of HIV/AIDS in the population and reasons for expressed level of risk;

(8) changes in policies assessed to be ineffective or impediments to AIDS prevention and control initiatives;

(9) number of facilities or organizations "upgraded", including number of staff/educators/clinicians trained;

(10) amount (days/weeks) of technical assistance (by technical area) that is provided to a country program;

(11) number of contacts/meetings with NACP, MOH, other donors and policy makers; and

(12) number of appropriate newspaper articles published about AIDS/HIV infection.

8.2 Target Specific Indicators

Each component of the intervention strategies will contain an evaluation plan incorporating those PPIs and other program indicators that are relevant to the component, along with process and outcome indicators specific to each component. The will be developed with input from at staff member from the evaluation unit in the regional office. Target group component evaluations will often provide interim estimates of progress to objectives for the country program as a whole, in addition to their primary purpose of assessing the success of a particular component. Component evaluations will involve all involved groups to facilitate the utilization of the results and to

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strengthen implementing the agencies' capacity and inclination relative to evaluation.

8.2.1 Youth in and out of School

An evaluation of the impacts of programs to prevent HIV infections in youth are relatively easy compared to older adults, because young people start off with a "clean slate." Two major types of data can be used to estimate the impact of prevention programs: (1) HIV sentinel surveillance data; and (2) data on the number of unwanted teenage pregnancies. At sentinel sites, data will be gathered on an annual basis on the number and age distribution of teen-age pregnancies and their HIV seroprevalence. In order to estimate the project specific impacts of prevention programs, a case control of study of unwanted and/or syphilis infected teen-age pregnancies will be conducted.

Another indicator which may be used is the ratio of female to male seroprevalence among entrants to Malawi University. Students entering Malawi University are customarily tested for syphilis. Recently, the MOH tested the 1991 blood samples for HIV in an unlinked, anonymous fashion. This revealed that among new university entrants, three times as many young women were infected as young men. An effective intervention program should lower this ratio by lowering the percent of young women who become infected.

AIDSTECH is pilot testing an anonymous, self-administered survey of in-school youth which includes questions on alcohol use, smoking, and sexual behaviors. If the pilot test is successful, this survey will be repeated annually as a means of gathering data on high-risk behaviors. The survey includes questions on the high-risk behaviors of out-of-school friends of respondents. If needed additional KAP surveys may be performed on out-of-school youth. Appropriate process indicators for youth programs will be established based on the final determination of program activities when implementation begins.

8.2.2 Employed Males

Evaluation of this component will be facilitated by the fact that many large Malawi corporations provide health care for their employees, and include treatment of STD as part of the health care package. Two approaches will be used to measure program impact on men's high risk behaviors: sentinel surveillance of STD rates among men at selected workplace health clinics (based on new employee or yearly syphilis testing that is performed by some employers), and a case control study of men with STD.

8.2.3 Male STD Clients

The PPI process methodology for monitoring the quality of clinical STD services will be used to help evaluate this intervention. Public and PHAM hospitals as well as private practitioners will be included in the sampling frame for the quality of care evaluation.

Additional indicators that may be used include the rates of STD consultation in sentinel clinics, as well as the proportion of STD due to genital ulcer disease compared to other STD, and changes in reported behaviors among STD clients.

8.2.4. Bargirls/Freelancers/Bar Owners

While bar managers' cooperation will be evaluated through the use of process indicators, the major evaluation effort will be on the level of STD in bargirls. One to three sentinel sites will be established which have the laboratory capability to do relatively thorough testing for STD, specifically the ability to culture chancroid and gonorrhea, and to do syphilis testing. Using these laboratory facilities, medical staff will periodically do thorough STD exams on bargirls, testing for syphilis, chancroid and gonorrhea. The sentinel sites will be established in collaboration with the Medical School and the CHSU facilities in Mangochi and in one or two additional sites in collaboration with government or PHAM hospitals in other districts.

Special attention will be paid to chancroid in the context of a district-level pilot study of the feasibility of eliminating chancroid as a common disease in Malawi. A more detailed protocol will be developed for the pilot test and will include additional chancroid-specific evaluation activities.

Additional indicators will be condom use among bargirls and freelancers and condom promotion, attitudes, and support for the girls from the bar owners. A set of indicators will be developed at baseline, based on the formative research, and monitored during the intervention.

8.3 Special Studies

While HIV surveillance data may show a decrease in HIV incidence in a given community, it may not be clear which program is responsible for the decrease. Demonstrating an impact of specific prevention programs on the incidence of new HIV infections is difficult, however a number of proxy indicators may be used as outcome measures for case-control studies, especially teen-age pregnancies and STD cases. Early in the project, it may be useful to conduct one or more case control studies to better examine in detail the risk factors associated with syphilis infection and/or teenage pregnancy (or septic abortion) in young women. From a practical point of view, syphilis infection is associated with the same high-risk behaviors that lead to HIV infection, but is much easier to study because of the lack of ethical difficulties in routine syphilis testing. An innovative type of case control study could be done, using a combination of qualitative and quantitative interview techniques to get in-depth data on the most important risk behaviors in Malawi.

While case control studies are usually thought of as identifying "risk" factors, they may also be used to estimate protective factors.

Later in the project, when process indicators show that program implementation is progressing well, case control studies of syphilis infection and/or teen-age pregnancies among young women and new STD cases among men of all ages can be used to estimate the effectiveness of specific interventions. The general approach is to ask questions which measure a subject's exposure to the interventions of interest, and look for an inverse relationship between exposure to the intervention and the outcome (i.e. a relative risk of less than one). For example, if a youth intervention were effective, one would expect to find that among "control" non-pregnant teenagers, there was a higher level of exposure to program interventions than among "cases" (pregnant, syphilis infected teenagers).

9.0 COST ESTIMATES AND FINANCIAL PLAN

9.1 Administration of Funds

Funds will be obligated by means of a PIO/T to AID/Washington requesting an amendment to the Cooperative Agreement with FHI for implementation of the AIDSCAP Project. This Cooperative Agreement is for a multi-year, multi-country project, to which the AIDS component of the STAPH Project is an add-on.

When an OYB transfer of funds is deemed to be more advantageous to an add-on the following procedure is recommended: Transmit a cable to AFR/DP, Glenn Cauvin indicating transfer from mission OYB to RD/H/AIDS. AIDSCAP Project #936-5972. Provide budget plan code, allotment symbol, and amount of money being transferred. It is also recommended that the mission send a scope of work to RD/H/AIDS. AIDS Division staff will track funds and assure that stated activities are implemented.

9.2 Project Financial Support

As a priority country, Malawi will be eligible for:

a. Centrally-funded activities

- Strategic Planning.
- Monitoring and Evaluation - including some TA by headquarters staff for assessment visits and program design.
- Behavior Research Grants and Fellows Program.
- PVO Grants Program

b. Mission-funded activities

- TA through OYB transfer or add-on.
- Resident Advisor, other professional and clerical staff, and associated office costs.

9.3 Project Budget

STAFH Project : AIDS Project Budget

STAFF		YEAR 1		YEAR 2		YEAR 3	
CENTRAL	Base	Units		Units		Units	
Prev Counseling Officer	6,000	1	6,000	1	6,000	1	6,600
Training System Officer	6,000	1	6,000	1	6,000	1	6,600
Condom Logistic Supply Officer	5,000	1	5,000	1	5,000	1	5,500
REGIONAL							
Regional Com Officer (3)	5,000	3	15,000	3	15,000	3	16,500
Operating Costs for RCO	5,000	3	15,000	3	15,000	3	16,500
Oper Expen for Implementation	100,000	1	100,000	1	100,000	1	110,000
DISTRICT							
District Community Organizers	5,000	3	15,000	3	15,000	5	27,500
Operating costs for DCO	7,000	3	21,000	3	21,000	5	38,500
Motorbikes	2,000	3	6,000	0	0	2	4,400
UMBRELLA NGO							
AIDS Division Director	7,000	1	7,000	1	7,000	1	7,700
Community Organization Officer	6,000	1	6,000	1	6,000	1	6,600
Private Sector Coordinator	6,000	2	12,000	2	12,000	2	13,200
Admin Asst/Secretary	4,000	1	4,000	1	4,000	1	4,400
Driver	3,000	1	3,000	1	3,000	1	3,300
Vehicle	25,000	1	25,000		0		0
NGO/PVO subagree.: large NGOs	150,000	2	300,000	3	450,000	4	660,000
NGO subagreements: local NGOs	20,000	3	60,000	10	200,000	12	264,000
NGO Training	2,900	3	8,700	30	87,000	36	114,840
Office recurrent costs	3,000	12	36,000	12	36,000	12	39,600
TARGET GROUPS							
(incl. IEC, training mats&per diems lab supplies, transportation)							
In/out of school youth			150,000		230,000		300,000
Employed males			100,000		260,000		230,000
Male STD patients			300,000		400,000		250,000
Bargirls			100,000		130,000		130,000
Social marketing:fam health clinics			30,000		520,000		325,000
EQUIPMENT & SUPPLIES							
STD drugs			500,000		250,000		100,000
Condoms			246,000		379,200		462,000
SUBTOTAL			2,076,700		3,157,200		3,142,740

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TECHNICAL ASSISTANCE									
IN-COUNTRY TA									
Resident Advisor	250,000	1	250,000	1	250,000	1	275,000		
STD Specialist	250,000	1	250,000	0	0	0	0		
Communication Advisor	50,000	1	50,000	1	50,000	1	55,000		
Accountant	6,000	1	6,000	1	6,000	1	6,600		
Admin Asst	6,000	1	6,000	1	6,000	1	6,600		
Secretaries	4,000	2	8,000	2	8,000	2	8,800		
Research assistants	5,000	4	20,000	2	10,000	2	11,000		
NGO IN-COUNTRY TA									
Manager/Org Dev/NGO Specialist	250,000	1	250,000	1	250,000	0.50	137,500		
Secretary/Admin Asst	6,000	1	6,000	1	6,000		0		
Office costs/equip/mat	3,000	12	36,000	12	36,000				
Community organizer	50,000	1	50,000	1	50,000				
SHORT-TERM TA									
Condom logistics	250,000	0.33	82,500	0.13	31,250	0.08	22,917		
STD	250,000	0	0	0.17	41,667	0.17	45,833		
Communication	250,000	0.25	62,500	0.17	41,667	0.17	45,833		
Evaluation	250,000	0.25	62,500	0.17	41,667	0.08	22,917		
Other	250,000	0.33	83,333	0.25	62,500	0.33	91,667		
OTHER TA COSTS									
Conferences			10,000		15,000		15,000		
1 Vehicle	25,000	2.00	50,000	1.00	25,000	1.00	27,500		
Office equipment			50,000		15,000		10,000		
Office recurrent	12,000	12	144,000	12	144,000	12	158,400		
Evaluation Research			10,000		5,000		5,000		
Social marketing:condoms/orals			430,000		464,000		612,000		
TA SUBTOTAL			1,916,833		1,558,750		1,557,567		
AIDS PROGRAM TOTAL			3,993,533		4,715,950		4,700,307		

10. REFERENCES

References reviewed and cited:

A report on population programme review and strategy development for Malawi. October 7-8, 1991.

A proposal for donor support for the National Family Welfare Council of Malawi [NFWCM]. Government of Malawi. April 1991.

A selected bibliography of health information in Malawi, 1980-1991. Ministry of Health, Research Unit, Lilongwe, 1992.

Allen S, Linden C, Serufiliria A, et al. Human immunodeficiency virus infection in Urban Rwanda: Demographic and behavioral correlates in a representative sample of childbearing women. JAMA 1991; 226: 1657-1663.

Atkinson B, FPLM. Logistics systems and contraceptive supply status review. Malawi Child Spacing and AIDS Control Programs. January 9 - February 9, 1992.

Auvert B, Moore M, Betrand WE, et al. Dynamics of HIV infection and AIDS in central African cities. Int J Epi 1990; 19: 417-428.

Bacchetti P, Moss AR. Incubation period of AIDS in San Francisco. Nature 1989; 338: 251-253.

Brown J, Somarc/The Futures Group. Trip Report, Malawi, November 11-21, 1991.

Cameron DW, Simonsen JN, D'Costa LJ et al. Female to male transmission of Human Immunodeficiency Virus Type 1: Risk factors for seroconversion in men. Lancet 1989; ii: 403-407.

Courtright P, Biggs Jarrell B. Village Health Volunteers: Maximizing a resource, an IEF/ADRA Hosted Seminar. Report, July 1991.

Chin J, Lwanga SK. Estimation and projection of adult AIDS cases: a simple epidemiological model. Bull World Health Org 1991; 69: 399-406.

Dallabetta GA, Miotti PG, Chiphangwi JD, et al. High socioeconomic status is a risk factor for HIV-1 infection but not for sexually transmitted disease in women in Malawi: implications for STD control. J Infect Dis 1992. In press.

Forsythe S. The economic impact of HIV and AIDS in Malawi. Draft report March 6, 1992.

Girl's Attainment in Basic Literacy and Education (GABLE) 612-0237, Project Paper, September 1991.

Kashindo P. Condom use: Rapid assessment study. Draft Report.

Kristensen JK. The prevalence of symptomatic sexually transmitted diseases and human immunodeficiency virus infection in outpatients in Lilongwe, Malawi. Genitournin Med 1990; 66: 244-246.

Laga M, Nzila N, Manoka AT, et al. Non-ulcerative sexually transmitted diseases as risk factors of HIV infection. In: Programs and abstracts of the Sixth International conference on AIDS; June 20-24, 1990; San Francisco, CA. Abstract Th.C.97.

Liomba G, Dallabetta GA, Chiphangwi J, Miotti PM, Saah AJ. Prevalence of sexually transmitted diseases (STD) and symptomatology in urban, pregnant women in Malawi. 7th African Union Against Venereal Diseases and Treponematoses (AUVDT) Regional Conference, Lusaka, Zambia, March 17-20, 1991.

Mackie WE. Malawi AIDS education for schools project: A paper presented to the annual conference of the Confederation of African Medical Associations and Societies(CAMAS). March 1992.

Makhumula P, Wynendaele B. The prevention of sexual transmission of the HIV/AIDS for targeted groups in Malawi through information, education and communication (IEC) activities: base-line data for selected districts in Malawi. Presentation at the VIIth International Conference on AIDS, Florence June 16-21, 1991.

Malawi health social marketing project. 1991-92 Marketing Plan for PROTECTOR Condoms.

Malawi country report, National AIDS control Programme. January-December 1990.

Malawi AIDS Control programme, Annual Report, January-December 1991.

Malawi national AIDS control programme. Reprogramming Document 1992-1993. October 1991.

Malawi AIDS control programme. Second annual review report April 22-26, 1991.

Malawi AIDS control programme. Review report. March 30, 1990.

Mertens TE, Hayes RJ, Smith PG. Epidemiological methods to study the interaction between HIV infection and other sexually transmitted diseases. AIDS 1990; 4: 57-65.

Miotti PG, Dallabetta GA, Ndovi E, et al. HIV-1 and pregnant women: associated factors, prevalence, estimate of incidence and role in fetal wastage in Central Africa. AIDS 1990; 4: 733-736.

Mitchell. A short summary of constraints facing child spacing efforts in Malawi.

Mkawa EF. The effect of AIDS education on knowledge, attitudes towards AIDS and sexual practices of prostitutes in Malawi. Thesis submitted to the Faculty of the College of Nursing of Howard

University. October 1991.

Msapato KM, Kumwenda KM, Chirwa BZ, Chalira AM, Mzembe CP. Study of knowledge and aspects of attitudes of school teenagers in Mzimba district about HIV infection/AIDS. Health Research Unit, Ministry of Health, Malawi, October 1990.

Msukwa LAH. Primary health care in Malawi, a search for relevance. September 1987.

Nagelkerke, NJD, Plummer FA, Holton D, et al. Transition dynamics of HIV disease in a cohort of African prostitutes: a Markov model approach. AIDS 1990; 4: 743-747.

Nagle WJ. An overview of nongovernmental organizations (NGOs) in Malawi with special emphasis on the World Bank and NGOs. Draft Report, April 3, 1990.

News and Comment. AIDS Vaccine Meeting: International Trials Soon. Science, 1991.

Over M, Piot P. Health Sector Priorities Review: HIV infection and sexually transmitted diseases. Forthcoming in Dean T Jamison and W. Henry Mosley (editors), Disease Control Priorities in Developing Countries. New York: Oxford University Press for the World Bank.

Palloni A, Lee YJ. Families, women and HIV/AIDS in Africa. CDE Working paper 90-32. Center for demography and ecology, University of Wisconsin-Madison. 1990.

Pepin J, Plummer FA, Brunham RC, et al. Editorial review: The interaction of HIV infection and other sexually transmitted diseases: an opportunity for intervention. AIDS 1989; 3: 3-9.

Plummer FA, Nagelkerke NJD, Moses S, et al. The importance of core groups in the epidemiology and control of HIV-1 infection. AIDS 1991; 5 (suppl): S169-S176.

Plummer FA, Simonsen JN, Cameron DW, et al. Cofactors in male-female sexual transmission of Human Immunodeficiency Virus Type 1. J Infect Dis 1991; 163: 233-239.

Preble EA. Impact of HIV/AIDS on African children. Soc Sci Med 1990; 31(6):671-680.

Potts M, Anderson R, Boily MC. Slowing the spread of human immunodeficiency virus in developing countries. Lancer 1991;338 :608-613.

Poverty in Malawi, Situation analysis. Malawi Government, University of Malawi and United Nations. December 1990.

Promoting Health Interventions for Child Survival (PHICS) 612-0231, Project Paper, June 1989.

Recommendations of the workshop for principal secretaries on population review strategy development. October 7-8, 1991.

Redfield RR, Burk DL, Ketter N, et al. A phase 1 evaluation of the safety and immunogenicity of vaccination with recombinant gp160 in patients with HIV infection. New Engl J Med 1991; 324: 1677-1684.

Republic of Malawi Population, Health, and Nutrition Sector Credit, Program Manual, Population and Human Resources Division, Southern Africa Department, World Bank Report, February 7, 1991.

Research International, East Africa. Baseline K.A.P. Study for Malawi. RI/1320. July 1991.

Resource Mobilization Meeting for the Medium Term Plan for AIDS Prevention and Control in Malawi. Lilongwe, Malawi, Report, 29-30 June, 1989.

Ronald A, Aral SO. Assessment and prioritization of actions to prevent and control reproductive tract infection in the third world. In press.

Rosner L. Preliminary institutional assessment of Malawian NGOs. Conducted for: Services for health, agriculture, rural and enterprise development (SHARED) 612-0232. EIL, December 14, 1990.

Sokal DC. Preliminary needs assessment in the area of HIV surveillance, STD surveillance and control, monitoring and evaluation and operation research. October 20, 1991.

Staff appraisal report, Republic of Malawi Population, Health and Nutrition sector credit. Population and Human Resources Division, Southern Africa Department, World Bank Report. February 19, 1991.

Strengthening of the IEC and social mobilization unit of the Ministry of Health. Health Education Unit, Lilongwe, Malawi, June 1990.

Study on employment-based preventive health care on Malawian estates and industries. Banja La Mtsogolo. May 1991.

Sultana A, Kavinya A, Kandonda K. FLE problems and issues as viewed by women, men and teenagers in Malawi. 1990.

Summary of current, planned and proposed USAID/Malawi support to AIDS control in Malawi. Draft report.

Summary of current, planned and proposed USAID/Malawi support to the Health and population sector in Malawi (as of October 1991).

Support to AIDS and Family Health. Project 612-0238. Project identification document. 1992.

The role of NGOs in promoting primary health care activities in Malawi. Report of workshop. Mzuzu, July-August, 1991.

The situation of children and women in Malawi. Government of Malawi and UNICEF. Lilongwe, Malawi. September 4, 1991.

Thompson C. Report on KAP baseline survey, Project Hope, Malawi child survival project. Draft Report, December 30, 1990 - January 4, 1991.

Thompson C. Summary update September 1991 - February 1992. Project Hope, March 9, 1992.

Training Programme for Peer group Leaders: Training Intervention Team for Targeted Groups. European Community, Lilongwe, Malawi, October 8, 1991.

USAID support for phase three of the Malawi AIDS control program, 1992-1993. Draft report.

Wawer MJ, Serwadda D, Musgrave SD, Konde-Lule JK, Musagara M, Sewankambo N. Dynamics of spread of HIV-1 infection in a rural district of Uganda. BMJ 1991; 303: 1303-1306.

Workplace Preventive Health Care: A Management Brief. (A manager's primer on child spacing, sexually transmitted disease and AIDS in the workplace). Banja La Mtsogolo. May 1991.

World Vision Malawi, KAP Survey workshop. Lilongwe. January 1991.

Wynendaele B, Makhumula-Nkhoma PP, M'Manga WR, Bomba WG. A KABP study to establish baseline data in targeted groups of selected districts of Malawi, for future HIV prevention campaigns. Draft Survey Report. December 1991.

Appendix A: Technical notes related to HIV/AIDS projections for Malawi

Future projections of HIV infection

Based on the above-described surveillance data, the AIDS Secretariat, with technical assistance from USAID has developed national projections of the future level of HIV infections. The projections were Using Lotus spreadsheet software to use to estimate AIDS cases from HIV seroprevalence. The spreadsheet is similar to WHO/GPA's EpiModel (Chin & Lwanga, 1991). As additional software became available, we used DemProj3 and the AIDS Impact Model (AIM). DemProj is a demographic projection program that has been used for many years in over 50 countries. In collaboration with The Futures Group, we modified DemProj so that it included HIV infection, and AIDS cases and deaths. AIM was created by Family Health International and The Futures Group for use as a modeling and presentation tool with policy makers and others who need to better understand the likely impacts of the AIDS epidemic. AIM takes the demographic and morbidity / mortality data from DemProj and does additional calculations to estimate secondary impacts of the epidemic. It uses simple estimation methods which are described in detail in the user's manual.

AIM estimates the number of future AIDS orphans, by defining orphans as the number of children under 15 whose mother died of AIDS. To estimate future TB cases, we used national surveillance data as our baseline. Thus the future estimates are assumed to have the same degree of under-reporting as present TB surveillance. We estimated the median incubation period of HIV to be 10 years (Moss, 1989).

To estimate 1990 levels of HIV infection in urban areas we used published data. To estimate levels of HIV infection in rural areas, we made a conservative estimate based on surveillance data from blood donor testing and unpublished data (personal communication, AIDS Secretariat). We also used blood donor data to help prepare an age-adjusted national estimate of the overall adult seroprevalence level. We used a novel approach to make future projections of AIDS cases. Previous authors have assumed a constantly increasing prevalence of HIV infection (Preble, 1991), or a gradually decreasing incidence of HIV infection following an arbitrary mathematical curve (EpiModel, WHO). We created two scenarios using a high and low estimate of the endemic incidence rate of new HIV infections, 1% and 2% annual incidence rates. We were unaware of the other projections when we made our estimates of future HIV infections.

There are two major uncertainties in these projections - (1) the level of HIV infection in rural areas, and (2) the estimated incubation period of HIV infection. A field study is being planned to gather seroprevalence data on women attending prenatal clinics in rural areas. There has been much discussion, and suggestions by several researchers (Nagelkerke, 1990; Konde-Lule, Uganda personnel communication) that the incubation period is shorter in African populations than in populations in developed countries. Until there is more and better data from African studies, WHO has recommended using an incubation period of 10 years for all populations. In the

meantime, it has been proposed that alternate projections should be prepared based on a median survival of 7 years. As additional data becomes available in these two areas, these projections should be revised.

Appendix B: Modeling in AIDS Prevention

EpiModel

Description. WHO's EpiModel is now considered as the "standard" model for short and medium term projections. EpiModel is a forward projection model which presents information about the three clinical stages of HIV infection. In addition, there are optional components for estimating (1) AIDS orphans and pediatric AIDS cases,and (2) incidence and prevalence parameters. The three clinical stages are:

(1) HIV infection
(2) AIDS
(3) death

Requirements - Short Term Projections. EpiModel requires only three pieces of data from the user. Despite this simplicity, sensitivity analysis has shown that when used as recommended for short term projections, it is quite reliable (Chin, 1991). The data needed are:

(1) the year that epidemic spread of HIV began in the group being modeled
(2) a reference year to be examined
(3) the number of adults currently infected in the group being modeled

In addition to these data from the field, the user must set three internal model parameters. First, the user must decide whether to include infections that will occur after the "reference year," or whether to just project the absolute minimum number of AIDS cases and deaths which would result from the existing infections. The second and third parameters involve a visual estimation of what phase the epidemic is in, compared to a theoretical S-shaped epidemic curve. The only other parameters that the model contains are progression rates from HIV to AIDS and AIDS to death. The default values in the model are for a median progression rate of 10 years from HIV infection to AIDS, and one year from AIDS to death. These may be changed by the user.

Longer Term Projections. While the above approach is reasonable for short-term projections, experience has shown that it is extremely important to make medium to long-term projections so that policy makers can appreciate the gravity of the epidemic. Following a request from FHI(AIDSTECH)/USAID in 1990, WHO added incidence and prevalence parameters to EpiModel in order to facilitate its use for longer term projections (20 to 25 years).

To make rational, epidemiologically based long-term projections, FHI/AIDSTECH has suggested an approach based on specifying the annual incidence rate of new infections for future years. The annual incidence rate can be estimated from the experience of neighboring countries with similar patterns of the epidemic. With a given incidence rate and a 10-year median incubation period, prevalence will plateau at about 10 times the annual incidence rate (prevalence-

incidence X duration).

Appropriate Uses. In the basic mode, EpiModel can be used to prepare short term projections (5 years). In the advanced mode, when one includes incidence and prevalence, EpiModel can be used to create scenarios for longer term projections. However, making long-term projections is much more difficult and may require considerable judgement. Making long-term projections should be a collaborative project among two or more epidemiologists in order to arrive at a consensus on what are responsible and credible scenarios.

SimulAIDS

Description. SimulAIDS is a stochastic simulation model. It was developed in 1987-88 by Bertran Auvert (INSERM, Paris) in collaboration with the University of Kinshasa's and Tulane University's Schools of Public Health. Additional development, in particular the addition of a co-circulating STD, was done in collaboration with FHI/AIDSTECH.

Stochastic models work by assigning probabilities to the occurrence of discrete events over time. At the beginning of a simulation, SimulAIDS creates a population with behavioral characteristics specified by the initial variables. Then, it moves through time steps (for example 10 days), and at each time step, it performs two basic processes. First, it calculates the probability of various events for each individual in the population, and second, it chooses random numbers and uses the random numbers to decide whether various events actually occur or not.

For example, when a man reaches the age for marriage (e.g. 25), the model would randomly choose a partner from among eligible young women. If either one of the partners were infected with HIV, the model would calculate a probability of transmission from one to the other at each subsequent time step, and use a random number to decide whether the infection was actually transmitted. If neither were infected, then the inherent danger for this partnership would come from the man's extra-marital contacts. For each such contact, SimulAIDS would calculate the probability of transmission (including STD as a factor that are known to increase efficiency of infection) and again use a random number to decide whether transmission actually occurred or not.

Data Requirements. SimulAIDS needs demographic, behavioral and biologic inputs. The demographic inputs include the usual data on the age/sex structure of the population, and birth and death rates. SimulAIDS includes three categories of sexual relationships: long-term (e.g. 15 years +/- 7); short term (e.g. 300 days +/-100); and casual (one time contacts). Behavioral data needed include an estimate of the proportion of married and single men who participate in these three types of sexual relationships, and the frequency of sexual contacts in each one. For long and short term partnerships, the user should specify the average duration and the variability of the

duration of the partnerships. SimulAID can also simulate preventive behaviors such as condom use and STD treatments. Biologic data needed include the probability of transmission of HIV per contact in the presence or absence of genital inflammation caused by a "classical STD." In addition, an estimate of the variability of HIV transmission by stage of infection is desirable. Estimates of the infectiousness and duration of a co-circulating STD are also needed.

Appropriate uses. Since SimulAIDS includes the ability to model behaviors, condom use and STD treatments (and changes in those behaviors), it can be used to estimate the potential benefits of various intervention strategies. As a stochastic model, in which events such as condom use and STD treatment are considered, it is particularly suited to perform cost estimations. It may also be useful for modeling STD control programs. It is currently being modified to include options for selective mass treatment (or selective periodic treatment) of STD, and should be useful for trying out various strategies of selective mass treatment for the control of STD, such as chancroid. SimulAIDS is a research tool that was designed to model a single, relatively homogenous urban population, and caution must be exercised in applying it to any more complex environment. As a stochastic model, each run is unique. Thus, it should be run a number of times with the same initial parameters in order to estimate the variability of the results obtained.

Appendix C: STD Control Program for Malawi

IMPLEMENTATION:

- Appoint STD officer and two assistants; define management structure. (Recruitment in progress)

Bridging Activities:

April-July '92:

1) Initial pilot study (clinical trial) to determine:
   - the most efficacious drugs for Malawi,
   - sensitivity and specificity of the WHO syndromic diagnosis for men and women,
   - the spectrum of pathogens in symptomatic STD patients (chlamydia infection, syphilis),
   - risk factor information,
   - perception of symptoms
   - health care seeking behavior.

Funds requested for this activity from USAID Mission. The Project will be responsible for protocol development. It is essential that this activity be completed as quickly as possible such that the diagnostic and treatment guidelines be completed for inclusion in the Drug Action Program (WHO) prescriber's training course to start in September 1992. The pilot will be conducted with Dr. Lule of the Malawi medical school and TA from the Project office.

September '92 - February '93

2) Pilot on a larger scale (central and district hospitals and clinic based services) STD diagnostic treatment guidelines which would include evaluation of the following:
   - drug utilization for cost projections,
   - clinic utilization patterns with improved therapy,
   - partner notification forms,
   - piloting of various type of clinic based information and counselling systems,
   - condom utilization
   - effectiveness of therapy
   - referral patterns

The pilot study is necessary to evaluate drug utilization patterns in order to estimate what additional drugs will need to be purchased for STD control and to test various methods of controlling STD drug use. The trial sites can also be utilized to pilot partner notification forms, clinical based counselling formats, condoms utilization patterns and quality of service delivery. Funds exist for this pilot from EC and from CIDA. Additional funds may be necessary when final protocol is written. The Project will take the lead in protocol development.

YEAR 1:

- Publish diagnosis and treatment guidelines.

- Train clinical care givers in new guidelines. TOT model through DAP.

- Train STD officer in STD control and public health issues.

- Procure equipment and supplies for reference and referral labs.

- Train STD lab technicians (one for each referral center, for CHSU central reference lab).

- Working with CMS and drug committee begin procurement of necessary drug supplies (after analysis of second pilot study).

- Establish monitoring system on
    - clinical service delivery
    - pharmacy accounting
    - lab quality assurance
    - condom availability
    - drug information system

- Establish sentinel surveillance sites. Develop sentinel forms, train staff. Sites ideally should be representative of all parts of the country and (some) should be affiliated with institutions with good lab facilities. Collect baseline data.

- Modify HIS report forms (involves retraining of clinical staff and possibly modification of the HIS database).

- Conduct feasibility study of social marketing of STD drugs.

- Upgrade some clinical treatment sites (walls, curtains)

YEAR 2:

- Expand STD service delivery to women in child spacing clinics.

- Continue monitoring STD case management and drug supplies.

- Continue lab upgrade.

- Expand training of clinical and lab staff on diagnosis and treatment.

- Pilot study of social marketing of STD drugs.

- Begin establishing research lab.

BUDGET:

- Pilots (including drugs) (bridging activity)

1) drug trial	$ 35,000
2) larger pilot	$ 50,000 (additional funds)

- Drug supply

Listed below are estimates for the entire annual STD drug need. The costs estimated for drugs were made using the prices listed in the Central Medical Stores catalog for drugs commonly available in Malawi and the least expensive, yet effective, drug regimens available for the syndromes.

STD clinic patients:
assumptions made for estimates:
- 0.5 % adult (5 and over) men with an STD (based on HIS data) - 9,000,000 x 5% x 82.5% (% of population over 5)/(2)(.65 average report return) - 287,000 cases in men
- equal number of STD in women - 287,000
  60 % of men with genital ulcer disease (GUD) ($ 4) [Erythromycin and penicillin]
  40 % of men with urethritis ($ 1.5) [Ampicillin/augmentin/probenacid + doxycycline]

  7% of women with genital ulcer disease ($ 4)
  93% of women with vaginal discharge ($1.75) [same as urethritis + metronidazole]

GUD in men	$ 689,000
Urethritis in men	$ 172,000
GUD in women	$ 80,000
Vag. Dis in women	$ 467,092

Bar Girls (periodic mass treatment for GUD)

- 18,000 registered bar girls
- 30% of 180,000 unregistered bar girls and free lancers will come in for therapy

Estimate for periodic mass therapy to control GUD in bar girls. 72,000 bar girls, treatment 4 times per year at $5.00 treatment. $ 360,000

The actual additional drug need is difficult to estimate. One of the purposes of the larger pilot project is to assess what happens to drug utilization when drugs for STD are provided in the health center and hospital settings. Additionally, different mechanisms for control drug use will be explored including the following: prepackaging of doses, limiting drugs to specific signatures, drugs dispensed only in STD clinic, etc.

Changes in drug utilization may not increase dramatic for the following reasons:

- repeat visits for failure of therapy decrease
- STD decreases as a result of the HIV/STD prevention project

Drug utilization may increase for the following reasons:

- increase number of patients seeking care in the clinical setting as a result of better clinical services or because of partner notification.
- antibiotics are available and are used for other clinical reasons by clinical care providers.

- Laboratory support:

Most of the laboratories described have most of the basic equipment necessary (incubators, autoclaves for media making, microscopes). The central reference laboratory will need some equipment (heating block, steers replicator block, mixers) and the research laboratory, if constructed in Mangochi, will need to be fully equipped.

- Training of lab technicians:

The laboratory technicians at the referral center can be sent for training in the central reference laboratory. Many of the lab techniques for STD diagnosis are known by most all lab assistants and technicians. The technician in the central reference laboratory should receive training in a regional center, either Nairobi or Zambia. Additional training for district level technicians and for private company technicians can be done on the regional level.

- Establish sentinel sites:

Sentinel sites are necessary for more in depth information gathering than is possible through the passive surveillance system of HIS. These sites are also necessary to follow STD and anonymous HIV infection trends to assess project impact. Sites ideally should be representative of all parts of the country and (some) should be affiliated with institutions with good lab facilities. Funds will be necessary for special forms, blood tubes, diagnostic reagents for syphilis serology and periodic HIV data and transport for monitoring.

- Clinical site upgrade:

Privacy in examination for STD is essential. Examination sites for women can be a combined with the service sites (rooms) for child spacing. Ideally, rooms would be available for men also. However, room dividers or curtains may be a possible alternative in those service sites that only have one room.

- Improve HIS:

In order to improve the passive surveillance of STD in the country, the current HIS form will need to be improved. Depending on the decision by CHSU and the Epidemiology Unit supported by PHICS, the change can be simple such that no alteration in the current database would be necessary. Any additional information, e.g. gender specific diagnosis or other syndromes would require alteration in the current database and reformatting of the current report forms. Either change would require training of the clinical staff. This may be

accomplished through the DAP program.

- Improved STD services for women:
STD services for women require the same equipment and facilities necessary for child spacing services. Additionally, child spacing nurses in their training learn to perform a pelvic examination for STD assessment. Having nurses perform simple vaginal wet mount for the diagnosis of trichomoniasis should be piloted.

- Management logistics information system
The development of a MLIS system if necessary to ensure an adequate supply of condoms and STD drugs and diagnostics at the clinic sites. In is envisioned that thiı will occur in three phases:
Phase I - site visits to assess regional warehouse capabilities, field stock assessments, interviews.
Phase II - development of system for Malawi and implementation on a pilot basis.
Phase III - evaluation of function of pilot MLIS system. Modify.
Phase IV - expand MLIS system.

Appendix D: Assessment of demand for condoms for HIV/AIDS/STD prevention

A review the demand for condoms for AIDS prevention efforts during the period 1992-2000 was conducted from pertinent documents including the FPLM Brice Atkinson report "Logistics Systems and Contraceptive Supply Status Review," SOMARC's "Malawi Health Social Marketing Project 1991-92 Marketing Plan for **Protector** Condoms," "A Note on the Calculation of Contraceptive Prevalence Rates for Condoms in Malawi" by Alan Johnston, and condom supply and distribution records and reports from the AIDS Secretariat and Ministry of Health.

The most important observation from reviewing the above documents and discussing condom supply and distribution issues broadly is that there is scant credible, consistent Malawi-specific information from which to characterize recent past efforts and upon which to base future projections. Information on actual condom use is also inconsistent at best and difficult to interpret. This assessment, therefore relies on best estimates, judgments and observations from other African experience where appropriate and possible.

Condoms received, distributed, and sold in Malawi, 1985 - 1991

The attached Table I Receipt of Condoms by Donor Agency and Year, 1989-91 indicates that a total of 14,263,200 condoms have been provided to the AIDS program since its inception. Of this total, approximately 11.5 million, or roughly 80%, have been provided by USAID; the remainder have been supplied by WHO/GPA. The table does not include condoms imported for child spacing activities (including the SOMARC project which is anticipated to play a greater role in HIV prevention than pregnancy prevention).

Receipts of Condoms by Donor Agency and Year (March 1989 - October 1991)

Donor Agency	Date	Quantity
USAID	March 1989	1,002,000
USAID	March 1990	1,002,000
WHO/GPA	November 1990	2,779,000
USAID	November 1990	1,254,000
USAID	December 1990	1,566,000
USAID	January 1991	732,000
USAID	February 1991	1,566,000
USAID	May 1991	732,000
USAID	July 1991	1,566,000
USAID	September 1991	504,000
USAID	October 1991	1,560,000
	TOTAL	**14,263,200**

Source of Supply

USAID supplied	11,484,000
WHO/GPA supplied	2,779,200
TOTAL	**14,263,200**

According to Central Medical Stores (CMS) which is responsible for most distribution to the public sector, approximately 6 million condoms have been disbursed for AIDS prevention to date. Approximately 5 million condoms (4,982,000) were distributed in 1991 alone. Sales of **Protector** condoms (launched in August 1991) totalled approximately 160,000 through the end of the year. Private sector condom sales are difficult to estimate; SOMARC suggests that approximately 50,000 condoms may be sold annually through the private sector network.

Public sector distribution of AIDS condoms is somewhat problematic. CMS charges the AIDS Secretariat 10% of the cost of the commodity as a handling/delivery fee for condom distribution. An advance of $25,000 to the CMS for condom distribution has been exhausted for some months; funds for 1992 condom distribution have not been approved by MOH. Atkinson's report suggests that each of the 24 district hospitals had condoms at the time of his January 1992 visit. (In fact, quantities on hand amounted to 1.6 million, or one-third of the total distribution of AIDS condoms in 1991.) Distribution of condoms from the district hospitals (where CMS delivers them) to the clinic level is difficult to quantify, however, since such records are not maintained at AIDS Secretariat.

Condom distribution through child spacing clinics can provide some insights here. An assessment based on 1991 child spacing reports notes a total of 10,320 registered condom acceptors and revisitors; adjusted for non-reporting clinics the total users were estimated to be 15,877. Perhaps more interesting, however, is that during the same period the MOH identifies approximately 36,000 "non-registered" condom acceptors/revisitors (55,500 if adjusted for under reporting) requested condoms from health clinics. These non-registered clients are generally accepted to be men who are using condoms for STD including HIV infection prevention.

Trends in condom attitudes and use

Attitudes towards condom use are quite positive among Malawians: most of those at highest risk of contracting the infection -- e.g., truck drivers, bar girls and STD patients -- know what a condom is and have seen one. As pointed out clearly in the technical analysis for the project paper for the STAPH project, condom use is reportedly increasing. "Ever use" among STD patients equals 27.5%; among truck drivers equals 49.5% and among bar girls equals 61%. Two out of three teenagers know condoms prevent HIV and think they are an acceptable method (Msapato). Fully 15% of young men in the SOMARC condom study reported always using condoms and 36% of the young men reported using them when they think their partner might have an STD. Anecdotal reports from the Regional Health Officer of the southern region suggest that demand is rising significantly and is limited primarily by the availability of transportation and adequacy of condom inventories. The SOMARC KAP study also reported that 28% of the men cited unavailability as the reason they did not use a condom the last time they had sex.

Evidence from baseline KAP studies (SOMARC, EEC) and focus groups

(Couchant) suggest that correct and consistent use of condoms is still an elusive goal. Only 10% of the men with STDs who reportedly had tried condoms in the EC baseline study could in fact demonstrate correct condom use.

Projection of condom users: 1992-2000

Estimating the number of condom users anticipated during the project period is difficult in the absence of sound data. While approximately two-thirds of the child spacing clinics attempt some level of reporting, figures forwarded are partial and incomplete. The AIDS Secretariat tracks distribution it conducts to high risk groups although this distribution is irregular at best and thus problematic when used to estimate demand. Finally, it should be noted that outlet distribution figures overestimate actual use. Upgrading the AIDS Secretariat condom reporting system to include all public and private distribution -- including health center distribution through child spacing clinics -- will be critical to improving condom supply estimation.

Estimating condom requirements for AIDS prevention programs is also compounded by less well-defined standards. For example, there is little consensus in AIDS prevention regarding the number of condoms which would protect a commercial sex worker or her clients for one year. The standard estimate (between 100-150 condoms per couple year of protection) used in family planning is probably not relevant.

Demand side projections, however, can be daunting. For example, using the estimate of 18,000 registered bar girls in Malawi and discounting by nearly 50% the average number of sex acts she reportedly has in one week (18 according to the EC baseline study, discounted to 10 per week) and multiplying that figure by 50 weeks per year arrives at a staggering 9 million sexual encounters per year. Using the standard family planning coital frequency of 100 times per year under represents the theoretical calculation of these sexual acts by 80%. If one considers the number of unregistered bar girls and "freelancers" (estimated to be 180,000) and their estimated sex frequency (3 times per week) the total number of sexual encounters per year would be 27 million, or 36 million acts for this risk group. How many of these sexual acts will be protected by condoms?

Working from the supply side, Atkinson estimates fairly constant increase in condom demand from 2 million in 1991 through 6 million in 1994. SOMARC sales estimates over this same period increase from 1.1 million to 2.6 million. Given the level of HIV prevalence in Malawi and the number of males working in the formal sector, these sales estimates are conservative. Sales estimation models used by Population Services International, for example, would estimate reaching 0.5% of the population with condoms by year 3 which translates into 4.5 million condoms in the case of Malawi.

Building on Atkinson's estimates and SOMARC CSM distribution targets, the following projections can be offered. The projections are made through year 5 of the project only since forecasting beyond

this period is far less reliable and therefore less useful.

Condom Supply Projections: 1992-1996
(000s)

	1992	1993	1994	1995	1996
Public sector	3,000	5,000	6,000	7,000	8,050
SOMARC	1,100	1,320	1,700	2,200	2,640
TOTAL	4,100	6,320	7,700	9,200	10,710

The above estimates assume the following caveats:

(1) Distribution of condoms through the public sector is implemented relatively smoothly (i.e., there are adequate transportation and inventory management systems to minimize the number and duration of stock-outs).

(2) Condom promotion remains at least as vigorous (and hopefully more so).

(3) There is no shortage of condom supplies.

APPENDIX E: Proposed "Bridging" Activities for Fiscal Years 1992-1993

1. Continuation of AIDSTECH and AIDSCOM activities:

a. Surveillance and modeling of the AIDS epidemic

Policy dialogue: AIDSTECH has exhausted the USAID buy-in and will be using desperately-scarce core funds to complete the final phases of planned surveillance and modeling activities. Estimated funds necessary to complete this modeling and surveillance activities would be $ 7,000.

b. Baseline information for evaluation of the AIDSCOM school intervention

An important component of an evaluation of the AIDSCOM curriculum will be a study of long term trends in the reported behaviors of students. It would be desirable to delay the proposed behavioral survey of in-school youth until October for two reasons. First, the AIDS secretariat surveillance unit is currently busy implementing the seroprevalence survey of rural and semi-urban pregnant women, and second, it would be most useful to ask the students about high risk behaviors just after their return from the long summer vacation when adolescents typically indulge in their riskiest behaviors. The estimated field costs for this pilot survey of 1,000 students are about $20,000.

c. Continuation and finalization of AIDSCOM pilot projects

AIDSCOM has started some pilot projects that will probably not be completed by the end of the AIDSCOM project. These include audio tape health dramas for hospital and clinic waiting rooms and the comic book series. The audio tape in the clinic would be a way to impart information without added burden on the clinical staff and should be evaluated. The comic book series uses characters based on Malawi folklore currently directed at semi-literate youth and may provide a medium for initiating interpersonal communication. Estimated cost for both projects would be $ 20,000.00.

2. Data collection & baseline research for future activities

a. Refinement of proposed STD treatment guidelines

Malawi had designed diagnostic protocols for STD treatment based on the WHO guidelines. These protocols have been on hold because the treatment recommendations can not be made with a pilot study on the efficacy of several of the proposed drugs. The implementation of these diagnostic strategies require an investigation of appropriate drugs for use at first line therapy such that the diagnostic and treatment protocols can be tested on a wider basis and finally implemented nationwide. We would propose to test recommended treatment protocols at 2-3 sites to determine the performance characteristics of the diagnostic guidelines and the efficacy of proposed drugs. It is estimated that about 300-400 male patients with each syndrome (genital ulcer disease or urethritis) will be tested at

each site. We would propose that the testing be coordinated between the AIDS Secretariat and the Medical School, Department of Community Health. The estimated total cost of this study is $35,000 including $15,000 to 20,000 in technical assistance (including travel costs) and $15,000 to $20,000 in local costs (reagents, drugs, personnel, supplies, etc).

b. Definition of high risk behaviors in Malawi

1. Case control study of men with STDs seen in employee health clinics

A qualitative case control study could be planned for men seen in employee health clinics in conjunction with the Department of Sociology at Chancellor College. In these clinics men with STD would be compared to other employees in the industry without STD with respect to high risk behavior. Estimated sample size 500. Estimated cost: $ 10,000.

ii. Rapid assessment for communication programming

A number of small, independent field studies should be undertaken prior to the final design of communication program interventions in order to assess:

- the optimal content of messages,
- maximum reach (channels) to target groups,
- the best (i.e., most trusted, most capable, most available) sources of prevention education and counseling

Through the detailed information gathered via such rapid assessments, even pilot phases of intervention programs can be as refined and well-designed as possible. The following areas of research are needed in order to design communication programming for two major HIV/STD prevention target groups:

a) Targeting youth in and out of school

-rapid assessment of effectiveness of AIDS curricula delivery to (primary) in-school youth
-rapid assessment to understand the sociocultural context for HIV prevention education/counseling among out-of-school youth, including individual and focus group interviews
-rapid assessment of "para-health" and "para-educational" members of the community and their relationship/ strength of interaction concerning sexuality, sexually transmitted diseases, etc. (e.g., traditional healers, elders or alangizi)
-rapid assessment of staff delivery potential for field workers from the Ministry of Health, Ministry of Agriculture, and Ministry of Women, Children and Community Services (HSAs, community health nurses, agriculture extension workers, CDAs, SWAs, etc.)
-rapid formative research to design communication program messages materials
- rapid assessments of condom knowledge, attitudes, and

practices including sources of condoms, barriers to condom access, problems with condoms, where they learn about condoms

Budget required: $40,000

b) Targeting employed males (between the ages of 18-29)

-rapid assessment of key risk-associated perceptions and behaviors and their interaction among men removed from their "normal" social environment due to employment. This might include norms and influences promoting extramarital sexual relationships, and the interaction of money, alcohol, and commercially available sex in different settings
-rapid formative research to determine optimal training design to provide prevention education/ peer support in various workplace settings
-rapid formative assessment to determine KAP, preferred sources of condoms, problems gaining access to condoms, misconceptions (and strength of those misconceptions), with whom they use condoms and how many condoms they use in a given period.

Budget required: $40,000

Total budget required: $80,000

3. Condom distribution assessment

Conduct an assessment of condom distribution for child spacing and AIDS prevention and control within the public sector over the past 3 years through an examination of distribution data and reports from central medical stores to district hospitals to health clinic level. Travel to district hospitals and selective travel to satellite clinics to review records and develop historical use and trend lines for registered child spacing, non-registered child spacing and AIDS prevention should be undertaken; incidence and duration of stock outages should be identified. Assessment of delivery costs over the same period for AIDS and child spacing condoms should be conducted.

Budget required: $20,000

APPENDIX F: Acronyms

ADRA	Adventist Development Relief Agency
AID	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AIDSEC	AIDS Secretariat
AIDSTECH	AIDS Technical Support Project
CBD	Community Based Distribution
CCAM	Malawi Young Pioneers
CDA	Community Development Assistants
CDA	Community Development Assistants
CHN	Community Health Nurses
CHSU	Community Health Sciences Unit
CIDA	Canadian International Development Agency
CMS	Central Medical Stores
CSM	Condom Social Marketing
DAC	District AIDS Coordinator
DAP	Drug Action Program
DCO	District Community Organizers
DDC	Council of NGO's of Malawi
DHEO	District Health Education Officer
DHI	District Health Inspector
DOI	Department of Information
DOY	Department of Youth
EC	European Community
ECOM	Employees Confederation of Malawi
FHI	Family Health International
GDP	Gross Domestic Product
GTZ	German Technical Assistance
HA	Health Assistants
HEU	Health Education Unit
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
HSMP	Health Social Marketing Project
IEC	Information Education and Communication
IEF	International Eye Foundation
JICA	Japanese International Cooperative Agency
KABP	Knowdedge, Attitudes, Behaviors, Practices
KAP	Knowledge, Attitudes, Practices
MBC	Malawi Broadcasting Corporation
MIE	Malawi Institute of Education
MOAg	Ministry of Agriculture
MOCS	Malawi Organization of Christian Services
MOE	Ministry of Education
MOH	Ministry of Health
MoWACS	Ministry of Women, Children and Community Services
MTP	Medium Term Plan
NACP	National AIDS Control Program
NFWC	National Family Welfare Council
NGO	Non-Governmental Organization
ODA	British Overseas Development Agency
OPD	Out Patient Department

PCV	Peace Corps Volunteer
PHAM	Private Hospital Association of Malawi
PHICS	Promoting Health Interventions for Child Survival
PHope	Project HOPE
PPI	Priority Prevention Indicators
PVO	Private Voluntary Organization
RAC	Regional AIDS Coordinator
RCO	Regional Community Organizers
RHEO	Regional Health Education Officer
RHI	Regional Health Inspectors
RNI	Rate of Natural Increase
SCF	Save the Children Federation
SOMARC	Social Marketing for Change
STAPH	Support to AIDS and Family Health
STD	Sexually Transmitted Disease
SWA	Social Welfare Assistants
TB	Tuberculosis
TBA	Traditional Birth Attendants
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Assistance
UNICEF	United Nations Children's Fund
UOM	University of Malawi
VHV	Village Health Volunteers
VHW	Village Health Workers
WHO/GPA	World Health Organization/Global Program on AIDS

ANNEX 1: USAID/GPA priority indicators

Proposed USAID/Cooperating Agency modifications to
Global Program on AIDS (GPA)
PRIORITY PREVENTION INDICATORS (PPI)
24 February 1992

General Comments All PPIs must be reported by gender if not specifically stated in the indicator, and age sub-groupings (5 year intervals) should also be reported. The periodicity of indicator collection must be carefully considered, with the intervals between formal measurement points reflecting competing cost issues, practical implementation issues, and the likelihood of measureable change. Do the survey-based indicators have to collected in a population-based sample?--could alternatives such as clinic or worksite populations be substituted?

An "#" indicates candidates for removal from list of PPIs.

****

PPI 1 : KNOWLEDGE OF PREVENTIVE PRACTICES (of marginal usefulness at this stage of the epidemic, with knowledge rates generally quite high already)

$$\frac{\text{No. of people citing at least two acceptable ways of protecting themselves from HIV-infection}}{\text{population aged 15-34 surveyed}}$$

PPI 2.1: CONDOMS PRODUCED OR IMPORTED (collectable, but not felt to be close enough to the end user of condoms to be a truly useful measure of program success - condom distribution data would be much more relevant)

$$\frac{\text{Total No. of condoms produced or imported during the preceding 12 months}}{\text{Number of males aged 15-34 in country}}$$

#PPI 2.2: CONDOM AVAILABILITY (Seen as an "extra" variable, but not a PPI; some concern about "affordability" rather than "accessability" being the defining construct)

$$\frac{\text{No. of people who can acquire a condom at an affordable price*}}{\text{population aged 15-34}}$$

*affordable price = no more than y% of the mean per capita income

#PPI 3.1: REPORTED NON REGULAR SEXUAL PARTNERS (data could actually provide the proportion of the surveyed population in all categories of sexual activity, including sexual abstinence, which may be more useful than this particular indicator)

$$\frac{\text{No. of people aged 15-34 who report having had at least one sex partner other than their regular sex partner(s) in the last 3 months}}{\text{Total No. of people aged 15-34 reporting sexual activity in the last 3 months}}$$

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PPI 3.2: NUMBER OF NON REGULAR SEXUAL PARTNERS (the interpretation of "mean number" of partners may be difficult, while the proportion at each level, incl "none" may be more amenable to measured change, and reflect the underlying dynamic processes better; if this is retained, perhaps the denominator should be those reporting non-regular partner sexual activity)

Number of non-regular sexual partners reported by people aged 15-34 in the last 3 months
Total No. of people aged 15-34 reporting sexual activity in the last 3 months

PPI 3.3: CONDOM USE IN RELATIONSHIPS OF RISK

No. of people aged 15-34 reporting the use of a condom during the most recent act of sexual intercourse with a non-regular partner
Total No. of people aged 15-34 who reporting sex with a non-regular partner in the past 3 months

PPI 4.1: STD CASE MANAGEMENT - CURATIVE (disease conditions should be specific for this indicator, but whether all must be collected is debatable)

a. No. of males with a symptomatic STD (one defined syndrome, either GUD or urethritis) who are assessed and prescribed treatment according to national standards
Total No. of males with the defined STD syndrome seeking treatment

b. No. of females with genital ulcer disease who are assessed and prescribed treatment according to national standards
Total No. of females with genital ulcer disease seeking treatment

PPI 4.2: STD CASE MANAGEMENT - PREVENTION (should these be two separate indicators?)

a. No. of individuals with symptomatic STDs seeking treatment who received a condom
Total No. individuals with symptomatic STDs seeking treatment

b. No. of individuals with symptomatic STDs seeking treatment who received advice on partner notification
Total No. individuals with symptomatic STDs seeking treatment

PPI 4.3: STD PREVALENCE, WOMEN

No. of pregnant women aged 15-24 with positive syphilis serology (VDRL or RPR)
Total No. of pregnant women aged 15-24 attending antenatal clinics whose blood has been screened

#PPI 4.4: STD INCIDENCE (Not really), MEN (questionable - requires OR into the validity of the time period as well as medical history/laboratory confirmation of self-reported disease experience)

$$\frac{\text{No. of men aged 15-34 with reported urethritis in the last 3 months}}{\text{Total No. of sexually active men aged 15-34 surveyed}}$$

PPI 5: HIV PREVALENCE, WOMEN (issue of confirmatory testing must be resolved)

$$\frac{\text{No. of pregnant women aged 15-24 seropositive for HIV}}{\text{Total No. of pregnant women aged 15-24 attending antenatal clinics whose blood has been screened}}$$

ANNEX 2: Jamaica field test of HIV prevention program indicators: STD serivice quality

JAMAICA FIELD TEST OF HIV PREVENTION PROGRAM INDICATORS: STD SERVICE QUALITY

Technical Report

January, 1992

DRAFT

EXECUTIVE SUMMARY

One strategy for the prevention of sexually-transmitted HIV is the effective treatment of STDs. The implementation and evaluation of programs designed to improve STD case management are particularly challenging because many countries, particularly in Africa, currently have little or no functional infrastructure to develop and implement STD policy or programs. Equally challenging is the development of indicators and supporting methodologies suitable for both national program management and cross-national comparisons.

Since January, 1991, CDC has participated in a collaborative working group convened by USAID and charged with the development of a limited set of HIV prevention indicators and supporting methodologies. The initial protocol included four interrelated components: a community survey, a facility-based assessment of STD services, a condom audit, and a facility-based serosurvey. CDC has lead responsibility for developing tools and indicators related to STD service quality.

This report presents the results of a field test of an indicator of STD service quality that was conducted in Jamaica in September and October, 1991. The preliminary indicator to be evaluated was:

> *The percent of health care facilities that practice correct clinical management of STD.*

The assessment exercise included an inventory of facility records, equipment and medicines in 15 public health facilities, and observations of providers as they delivered STD services to 115 patients. In addition, exit interviews and focus groups were conducted with STD patients in an effort to describe the range of STD service providers outside the public health system.

The results documented both the strengths of the Jamaican STD service system and areas for improvement (see Figure 1 for selected results). Key components of quality STD care were identified at three levels: the national program level, the facility level, and the health worker level (Figure 2).

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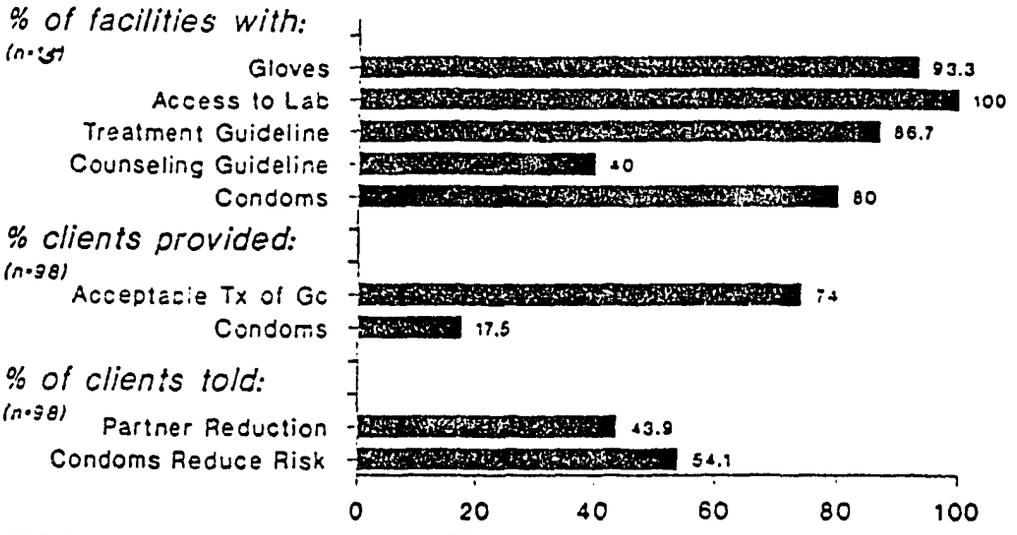
STD Case Management in Public Health Facilities Jamaica, 1991



STD Facility Survey 1991

Figure 1

Components of STD Case Management

Nat'l Program	Facility	Provider
Policy/Guidelines Service Availability Training	Screening/Referral	Take History Perform Exam
Laboratories & Quality Control	Equipment Access to Lab	Order/Read Test
	Treatment Guide	Make Diagnosis Prescribe Tx
Affordable, Available Condoms & Medicines	Condoms	Educate & Counsel
Surveillance/HIS		Keep Records

HIV Indicators Project

Figure 2

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The observation-based method was found to provide valid data useful for program managers. CDC is currently working on a clinic record form that can serve both as an intervention to improve health worker performance and as a source of routine data on STD treatment practices.

OBJECTIVES AND RELATED RECOMMENDATIONS

Objective 1: **To assess whether the preliminary indicator would provide a valid and reliable measure of STD service quality if monitored by national STD programs.**

Recommendations:

1. Limit the current indicator to the public health service system.

1b. Investigate alternative indicator(s) and methods for assessing the quality of STD case management in the private sector. Conduct focus groups early in the process of adapting the indicator protocol to each country setting to obtain descriptive information about the range of STD service providers.

1c. Develop and field test a population-based indicator of <u>access</u> to STD services.

1d. Change the unit of assessment in the current indicator from "facilities" to "STD patients". Select the sample of facilities to be assessed based on their volume of STD patients.

1e. Do not use a composite score of STD clinical management as the indicator numerator at this time.

1f. If a single indicator is used, "Percent of STD patients diagnosed with syphilis or gonorrhea who are treated appropriately" is recommended.

1g. The use of a single indicator should be supplemented by a country profile that includes indicators of the STD service system at the national program, facility and provider levels of the STD service system.

Objective 2: To test the feasibility of a facility-based observational method as a strategy for collecting the data needed to support the preliminary indicator.

Recommendations:

2a. The facility-based assessment approach is an acceptable method for collecting data to support the STD service quality indicator.

2b. The baseline facility-based assessment should be conducted only when minimum program requirements (e.g., availability of STD policy, services and surveillance system at the national program level) have been met. Follow-up assessments should be conducted only after significant inputs have been directed to improving service quality.

2c. The facility-based assessment is an intensive, non-routine activity; where possible it should be supplemented with routine reports of service quality obtained through supervision and/or use of special recording forms in the facility.

Objective 3: To investigate the extent to which the indicator activity could contribute to national level STD control programs.

Recommendations:

3a. In future applications of the facility-based assessment protocol, allow additional lead time so that country programs may add items needed to monitor and evaluate their country-specific program activities.

3b. In the continued development of the STD service quality indicator, ensure that the protocol will provide adequate data to program managers while allowing specific indicators to be abstracted from the data set for reporting purposes.

APPENDIX C:

STD MANAGEMENT: PATIENT OBSERVATION

Date: day _____ month _____ year _____

Observer Initials: _____

Facility: _____

Patient Number: _____

Sex of patient: Male |_| Female |_|

Age of patient: _____

1) HISTORY

a) Provider type/initials: _____ 1a

Does the provider ask about:

b) Reason for visit.....Y N 1b

c) Symptoms (if no, skip to 1e).....Y N 1c

If yes, circle the symptoms reported by the patient:

d) Discharge 1d1 Burning 1d2 Ulcer or Sore 1d3

Rash 1d4 Lower Abdominal Pain 1d5 Other 1d6 _____

e) History of STD.....Y N 1e

f) Health of sex partner(s).....Y N 1f

g) Use of medications during recent past.....Y N 1g

h) Known allergy to any medications.....Y N 1h

i) For women, possibility of being pregnant or history of a delayed menstrual period.....NA (male) Y N 1i

2) EXAMINATION

a) Provider type/initials: _____ 2a

Does the provider:

b) Conduct a physical examination (If no, skip to question 4).....Y N 2b

c) Inspect for or ask about rashes.....Y N 2c

d) Inspect external genitalia.....Y N 2d

e) Perform bimanual exam.....NA (male) Y N 2e

f) Perform speculum exam .....NA (male) Y N 2f

g) Wear gloves .....NA (did not touch) Y N 2g

3) CLINICAL FINDINGS

a) Lesion (sore/ulcer/vesicle).....Y N 3a

b) Discharge (urethral/cervical/vaginal).....Y N 3b

c) Rash.....Y N 3c

d) Other _____ 3d

4) LABORATORY TESTS

Are specimens ordered or collected for:

a) Syphilis serology.....Y N 4a
b) HIV screening test.....Y N 4b
c) Gram stain .....Y N 4c
d) Culture for gonorrhea .....Y N 4d
e) Wet mount .....Y N 4e

5) DIAGNOSIS/TREATMENT

a) DIAGNOSING provider type/initials:_____ 5a
b) Was a diagnosis made (if no, skip to 5f).....Y N 5b

DIAGNOSIS	TREATMENT (type/amount)
5c) _____	5g) _____
d) _____	5h) _____
5e) _____	5i) _____
5f) _____	5j) _____

i) Does the provider record information in a medical record..... Y N 5m
j) Does the provider explain how to take medications....NA (no meds) Y N 5n

6) COUNSELLING/EDUCATION/PARTNER NOTIFICATION

a) How was counselling/education done?

Individual 6a1 Group 6a2 Both 6a3 None 6a4

Did the provider:

b) Discuss with the patient the STD.....Y N 6b
c) Offer partner notification services via provider referral.....Y N 6c
d) Counsel the patient to send his partners to the clinic for examination/treatment.....Y N 6d
e) Advise the patient to abstain from sex for a specified period of time.....Y N 6e
f) Discuss with the patient partner reduction to reduce the risk of STD and HIV.....Y N 6f
g) Discuss with the patient condom use to prevent STD and HIV.....Y N 6g
h) Ask if the patient has any problems with condom use.....Y N 6h
i) Offer condoms to the patient.....Y N 6i
j) Use educational supports.....Y N 6j
k) Conduct a contact interview (If no, skip to 6m).....Y N 6k
l) Conduct the contact interview where it cannot not be overheard.....Y N 6l
m) Ask at the end of the visit if the patient has questions.....Y N 6m

7) COMMENTS

_____

_____

_____

Facility: _____

Observer: _____ Date: __/__/__
D M Y

STD MANAGEMENT: CLINICAL FACILITY REVIEW

Title of the most senior clinical provider _____

1.A. Indicate which days of the week the clinic is open.

M T W Th F Sat Sun

1.B. Indicate which days of the week the clinic offers STD service.

M T W Th F Sat Sun Other

1.C. In the past 30 days, were any patients ever turned away from this clinic? If "no", skip to question 1E. Y N 1c

1.D. In the past 30 days were STD patients ever turned away? Y N DK 1d

1.E. How many of the providers here today diagnose STD patients? _____ 1e

1.F. Did any of these providers (from question 1E) attend an update training or seminar on HIV/STD during the past 12 months? _____ 1f

2. The following therapies apply to adult males or non-pregnant females. Write the drug used, the route of administration, the dosage and frequency, whether this information is from a written document or from a verbal (spoken) source only and whether or not there is any drug is available in the facility at present,

CONDITION	DRUG	ROUTE	DOSE & FREQ.	SOURCE	AVAILABLE
Gonorrhea 1st line	2A1	PO IM 2B1	2C1	Written/ Verbal 2D1	Y N 2E1
Gonorrhea Rx Failure	2A2	PO IM 2B2	2C2	W V 2D2	Y N 2E2
Primary Syphilis 1st line	2A3	PO IM 2B3	2C3	W V 2D3	Y N 2E3
Chancroid 1st line	2A4	PO IM 2B4	2C4	W V 2D4	Y N 2E4
NGU or NSU 1st line	2A5	PO IM 2B5	2C5	W V 2D5	Y N 2E5
P.I.D. 1st line	2A6	PO IM 2B6	2C6	W V 2D6	Y N 2E6

3.A. Ask "Does the clinic have a written policy or guidelines for STD treatment?" If no, skip to question 4. Y N 3A

3.B. Ask "May I see a copy, please?" Is a copy provided to the observer? If "no", skip to question 4. Y N 3B

3.C. Indicate the source of the policy/guidelines. _____ 3C

3.D. What year were the policy/guidelines written? _____ 3D

4.A. Can laboratory tests for any STD be ordered from this clinic? If "no", skip to question 5. Y N 4A

Complete the following table by indicating the number of tests performed in the clinic during the past 7 days, where the following tests were performed and whether results are available during the client's visit:

TEST	No. Performed in clinic in last 7 days?	Performed at another site?	Result available during visit?
Wet Prep	4B1a	4B2a Y N	4B3a Y N
Gram Stain	4B1b	4B2b Y N	4B3b Y N
Syph. Serology—QUAL.	4B1c	4B2c Y N	4B3c Y N
Syph. Serology—QUAN.	4B1d	4B2d Y N	4B3d Y N
HIV Serology	4B1e	4B2e Y N	4B3e Y N

If RPR test is not performed at this clinic, do not answer 4C.

4.C. If RPR tests are done at this clinic, is quality control testing done at least weekly for RPR? Y N 4C

5.A. Can patients obtain condoms at this clinic? Y N 5A
If "no", skip to question 5D.

5.B. How many condoms are there at this clinic? <10 10-100 >100 5B

5.C. Cost to client for 10 condoms: $\_\_\_\_\_$ 5C

5.D. Do yqu have written guidelines regarding counselling of STD patients in HIV/STD prevention? Y N 5D
If "no", go to question 6.

5.E. Ask "May I see a copy, please?"
Is a copy provided to the observer? Y N 5E

6.A. Ask "Is there a record that indicates the number of STD patients seen during the previous week?" Y N 6A
If "no", skip to question 7.

6.B. How many STD patients were seen here in the past week? _____ 6B

7.A. How many disposable gloves are present and available to the clinic staff? none <25 25-100 100-1000 >1000 7A

7.B. Does the clinic have a vaginal speculum? Y N 7B

7.C. Is fresh water available in the clinic? Y N 7C

7.D. Is private space (ie. where talk cannot be overheard) available for patient counselling in clinic? Y N 7D

If blood is not drawn at this clinic, skip questions 8A and 8B.
If blood is drawn at this clinic, observe blood collection for 5 patients or indicate number_____:

8.A. Is a sterile needle and syringe used for each observed? Y N 8A

8.B. Are all needles immediately disposed in a designated "sharps" for all observed? Y N 8B

COMMENTS

_____

_____

_____

_____

APPENDIX H:

Facility: _____ Date: _____

PATIENT CONSENT FORM

The Ministry of Health is working on a project to identify simple methods to improve National AIDS and STD Programs.

If it is okay with you, Mr./Ms. _____ from the Ministry of Health/USAID will sit in the room as we talk and as I examine you. You may refuse and this refusal will not affect the service you receive here today or in the future.

The reason for Mr./Ms. _____'s presence is to observe my work as a health care provider. No information about you will be collected other than your gender and symptoms. Your name will not appear on the survey sheet. Your information will be grouped with other information in any discussion of the survey, so no one will be able to learn about your individual case. Is it okay with you if Mr./Ms. _____ sites in with us?

IF YES:

Thank you. Now let's do our best to take care of your problem.

IF NO:

That is just fine.

(Please indicate below patient's sex and age.)

SEX: M F AGE: _____

Volume II

ANNEX B

THE ECONOMIC IMPACT OF HIV AND AIDS IN MALAWI

TO: USAID/MALAWI

FROM: STEVEN FORSYTHE, AIDSTECH/FAMILY HEALTH INTERNATIONAL

DATE: MARCH 6, 1992

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I. EXECUTIVE SUMMARY

This two week assessment of the potential economic impact that AIDS may inflict upon the economy and the governmental expenditures of Malawi was undertaken in February, 1992 for USAID/Malawi to use as a resource in the design of their new population and AIDS prevention programme.

The following conclusions have been made from this analysis:

Direct Costs

1) The annual incidence of HIV from 1992 until the year 2000 is expected to be from 1 to 2 percent. As a result, the prevalence of HIV among the adult population will reach 11 to 18 percent and there will be between 500,000 and 600,000 cumulative AIDS deaths.

2) The lifetime (from the time of clinically diagnosed AIDS to death, estimated to be approximately 1 year) health care costs of treating persons with AIDS is conservatively estimated to be K515. Assuming that 65 percent of persons with AIDS receive some form of treatment, the direct costs of treating people with AIDS will be K16.5 million in 1992, or approximately 20 percent of the Ministry of Health's (MOH) curative recurrent budget.

3) In order to maintain the present level of care, K100 to K144 million would have to be spent on the care of patients with AIDS in the year 2000, or 27 to 38 percent of the MOH's curative recurrent budget for that year.

4) The hospitals in Malawi and the MOH are likely to be incapable of incurring these costs. Similarly, it is expected that international donor support will be unable to supply sufficient funds to meet the overwhelming demand. Thus the MOH and international donors will need to continue and expand an aggressive AIDS prevention programme and improve the capabilities of

less expensive "home-based", or hospice facilities.

Indirect Costs

5) The average Malawian will be employed for 25.3 years between the ages of 10 and 65. The average adult HIV infected Malawian will work for only 9.7 years during the same time period. This is a loss of 15.6 productive years due to AIDS. When the loss of children to AIDS is included in the analysis, the total productive life years lost reaches 18.7 years. In other words, AIDS results in the loss of three-quarters of a victim's productive lifetime of 25.3 years.

6) Using a 5 percent discount rate, the years lost due to AIDS is 6.6 for all infected Malawians.

7) Based on the location of industries and the income of their workforce, it is estimated that an employed person infected with HIV currently earns K1,400, which is 50 percent higher than the average income of all workers in Malawi.

8) The average discounted lifetime income lost due to each case of AIDS is estimated to be K10,500, which is 20 times higher than Malawi's per capita GNP. When incorporating estimates of new AIDS cases, the total discounted lifetime income is likely to be K330 million to K360 million in 1992, or 7 percent of Malawi's total GNP. This is likely to rise to K704 million to K1,012 million by the year 2000, or 14 to 21 percent of the projected GNP for Malawi.

Sectoral Impacts

9) The prevalence of HIV in the modern sector is likely to be substantially higher than other sectors of the economy, due to a concentration of wage earners in urban areas, where HIV prevalence has been estimated to be 2.5 times higher than in the rural areas. While it is estimated that between 11.0 and 12.6 percent of the current population over 15 are HIV-positive, it is estimated that 16 to 18 percent of the population within the modern sector are infected.

10) Even though only 6 percent of the Malawian population is engaged in the modern sector, this sector accounts for 28 percent of Malawi's national income, and is estimated to account for 19 percent of all new AIDS cases. Therefore the impact that AIDS has on this relatively small sector is likely to disproportionately affect the entire Malawian economy.

11) Certain industries within the modern sector are likely to be more impacted relative to others. For example, the concentration of businesses in areas most impacted by HIV indicates that prevalence rates may be over 25 percent for 1) finance/insurance/real estate and 2) transportation/communications.

12) Data from blood banks and pregnant women indicate that those infected with HIV may disproportionately come from the higher socioeconomic classes.

13) Other factors, such as mobility, will impact the prevalence of HIV among individual sectors of the economy, although the extent of this impact could not be quantified. It is expected that transportation, fishing, and farming businesses with a large migrant workforce may incur higher prevalence rates.

14) The ability of industries to cope with AIDS will vary greatly. Industries with a highly educated labour force will be particularly hard hit.

15) Over the longer term, it is likely that an increasing HIV prevalence in rural areas will shift the burden from the modern sector to the agricultural sector. The impact of AIDS on the agricultural sector could potentially result in a substantial decline in exports and a deterioration of nutritional intake.

AIDS Prevention

16) The direct and indirect costs of each new AIDS case is estimated to be K11,015 (K10,500

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indirect, K515 direct). In light of this substantial burden, investment in AIDS prevention, headed by the Malawi National AIDS Control Programme, is likely to be extremely cost-beneficial. Even small reductions in transmission risks (increased condom use or decreased prevalence of STDs) will provide long terms benefits which justify the immediate investment in AIDS prevention.

II. INTRODUCTION

It has been estimated that approximately 20 percent of Malawians in urban areas and 8 percent in rural areas were HIV-positive in 1990 (Sokal, 1991). This equates to a national HIV prevalence of 9.6 percent in 1990. In 1992, this national prevalence rate is expected to rise to between 11.0 and 12.6 percent.

Currently, one of every nine adult Malawians carries the AIDS virus. If the incidence of HIV continues at 1 to 2 percent per year, between 500,000 and 600,000 AIDS deaths will have occurred by the year 2000, and as many as one in five adults will be HIV-positive.

While this human crisis is overwhelming, it represents only a partial picture of the full impact that AIDS will have on Malawi. Because AIDS generally afflicts people in the most productive years of their lives, this disease cannot be defined solely in terms of lives lost.

In the short term, the economic impact of AIDS will be observed in increasing health care costs and overcrowding at already overburdened hospitals. Over the long run, the impact of AIDS will be felt through losses in the labour force and possibly even decreases in Malawi's Gross National Product. Policymakers in Malawi must now not only face the human tragedy of AIDS, but also begin to face the stark economic realities of this disease.

III. RESULTS

A. Current Levels of HIV and AIDS

An epidemiological assessment was performed to estimate and project the prevalence of HIV and new AIDS cases in Malawi, using surveillance data from antenatal clinics and blood banks. Using the assumption that the rural prevalence rate is 40 percent of that in urban areas, estimates were made of the current HIV prevalence in Malawi (prevalence of HIV among individuals 15 and above). This analysis indicated that approximately 9.6 percent of individuals in rural and urban areas of Malawi were infected in 1990.

B. HIV/AIDS Projections

In order to make projections of HIV and AIDS cases, it was necessary to use the epidemiological model Demproj. The following additional assumptions were made in developing these projections.

HIV Annual Incidence (1990-2000) (Best Case)	= 1.0%
HIV Annual Incidence (1990-2000) (Worst Case)	= 2.0%
Median time from infection to AIDS (adults)	=10.0 years
Median time from infection to AIDS (children)	= 2.0 years
Time from AIDS to death	= 1.0 year

From these models, it was possible to make the projections presented in Table 1 from 1990 to 2000. The projections assume that there is minimum behavior change in preventing the spread of HIV.

TABLE 1
Estimated HIV and New AIDS Projections

Year	People With HIV	New AIDS Cases
1992	521,000 - 591,000	32,000 - 35,000
1993	559,000 - 670,000	38,000 - 43,000
1994	579,000 - 743,000	45,000 - 53,000
1995	590,000 - 810,000	53,000 - 64,000
1996	598,000 - 873,000	59,000 - 74,000
1997	611,000 - 931,000	64,000 - 82,000
1998	624,000 - 985,000	68,000 - 90,000
1999	632,000 -1,033,000	71,000 - 98,000
2000	642,000 -1,076,000	73,000 -105,000

Source: Sokal, 1991.

In the best case scenario, HIV prevalence would stabilize at 11 percent and the cumulative number of AIDS deaths would "only" reach 500,000 by the year 2000. In the worst case scenario, HIV prevalence rates would continue to rise to 18 percent by the year 2000, and there would be a total of 630,000 AIDS deaths.

C. Economic Impact of AIDS - Methodological Issues

After performing this epidemiological assessment, it was then necessary to identify how the spread of the disease would affect the Malawian economy. The best method of performing such an analysis would be to perform HIV screening at workplaces, or collect occupational data from those infected with the virus. However, since only secondary data was available, it was necessary to make assumptions concerning HIV prevalence within individuals sectors of the economy. (Note: The author strongly recommends that a future effort be made to collect primary data so that a more comprehensive analysis of the impact of AIDS on the Malawian economy can be performed.)

This economic analysis has involved identifying: 1) the direct cost of treating persons with AIDS, 2) the indirect cost of AIDS, measured in losses within the Malawian labour force,

and 3) the possible impact of AIDS on specific Malawian industries.

It is important to note that this analysis will provide an extremely narrow estimation of the costs of AIDS, since there are other economic costs which are not quantified here (e.g., loss of training, education, consumption, exports, etc.). In addition, there is a whole array of noneconomic costs not identified here (the increased societal burden from AIDS orphans, the psychological and personal loss suffered by family members and friends, etc.). Therefore, even though many of these costs cannot be quantified, it should be noted that the measure of the value of human life presented here does not define the full cost of AIDS.

D. Direct Costs of AIDS

1. Methodology

Specific estimates of the costs of treating patients with AIDS is planned as a part of a more detailed analysis to be performed with Malawi's National AIDS Control Programme within the next year. However, for the purpose of this rapid assessment, estimates from a 1989 consultancy in Malawi by Dr. Roberto Tapia (Tapia, 1989) have been used to estimate these costs.

The Tapia assessment involved reviewing 28 medical records and identifying lifetime laboratory, drug, procedures, and overhead costs (it is expected that the lifetime cost estimates are roughly equivalent to annual cost estimates, since most patients with AIDS do not survive past 1 year). The records were collected from Kamuzu and Queen Elizabeth Central Hospitals and Dezda and Ncheu District Hospitals.

This assessment was only intended to estimate inpatient hospital costs. Subsequent analyses will address outpatient costs, costs incurred by households, and costs incurred prior to

a clinical diagnosis of AIDS.

2. AIDS Treatment in Malawi

The resource constraints at Malawian hospitals are severe, as illustrated by a MOH review of hospitals (Ministry of Health, 1988). This review indicated that occupancy rates are well over 100% at most hospitals (157% in Central Hospitals, 166% in District Hospitals, and 93% at PHAM hospitals) .

Current estimates indicate that 20 to 40 percent of all inpatients are HIV-positive (Malawi National AIDS Control Programme, 1992). Tapia estimated in 1989 that each central hospital admits 40 to 50 AIDS patients per month, while district hospitals have an average admission rate of 20 patients per month.

Based on discussions with health professionals in Malawi's hospitals, Tapia estimated that 60 to 70 percent of HIV-positive individuals have contact with the health services and 25 to 30 percent have more than one admission. That study also revealed that most AIDS patients are not identified as being seropositive at the time of their admission, with most patients being diagnosed as having TB, malaria, or diarrheal disease (Appendix A provides information concerning symptoms incurred by a sample of Malawi's AIDS patients). Once the patient is diagnosed as having AIDS, he is discharged as soon as possible, with the conclusion that not much more can be done. This situation makes AIDS patients look for other types of services, such as traditional healers or even private services. The costs of alternative treatment such as traditional healers was not included in this analysis.

3. Cost of AIDS Care in Malawi

Based on this limited review of 28 medical records, an average length of stay of 18.4 days

was determined. The cost for inpatient services of an AIDS case (including drugs, laboratory procedures, personnel, overhead, etc.) was determined to be K257.6 per admission. Tapia estimated that on average an AIDS patient has 2 admissions, and therefore the total inpatient lifetime cost was K515.20.

4. Comparative Analysis of Cost of AIDS Treatment

There have been a significant number of studies done throughout the world to estimate the cost of treating patients with AIDS. While the methodologies used to collect these cost estimates vary between studies, the comparison in table 2 does provide some idea as to the magnitude of costs within the developed and the developing world.

TABLE 2
Comparison of Direct Costs of AIDS
(U.S. Dollars)

Country	Year	Lifetime Cost	GDP (1989)	Cost/GDP
Africa:				
Malawi	1989	$210	$ 170	1.2
Tanzania	1988	$367	$ 110	3.3
Zimbabwe		$650	$ 550	1.2
Kenya	1992	$828	$ 300	2.8
Zaire	1988	$860	$ 280	3.1
LAC:				
Jamaica	1987	$1,807	$ 1,620	1.1
Mexico	1990	$3,300	$ 2,370	1.4
Barbados	1990	$4,545	$ 6,100	0.7
P. Rico	1989	$16,378	$ 5,600	2.9
Developed Countries:				
Britain	1986	$10,000	$12,550	0.8
Australia	1987	$22,000	$16,780	1.3
France	1987	$23,377	$17,010	1.4
Greece	1991	$26,000	$ 3,990	6.5
Switz.	1988	$46,035	$26,510	1.7
U.S.A.	1987	$68,000	$20,730	3.3

This table indicates that in Africa, the lifetime cost of treating persons with AIDS is roughly estimated to be between US$200 and US$900. This amounts to 1.2 to 3.3 times the per

capita GDP for each country.

Figure 1 presents a comparison (using a log scale) of direct treatment costs of AIDS patients and the per capita GDP. This table illustrates that the level of available resources as measured by GDP can be used to roughly predict the level of resources that will be spent on the care of AIDS patients. Based on the level of GDP, Malawi spends somewhat less on the care of AIDS patients than other countries.

5. Future Health Care Costs

Table 3 provides information on the recurrent expenditures incurred by the Government of Malawi and the Ministry of Health between FY 1982/83 and FY1991/92.

TABLE 3
Recurrent Expenditures
(000's Kwachas)

Fiscal Year	GOM	MOH	MOH/GOM
1982/83	260,700	17,420	6.68%
1983/84	289,090	21,600	7.47%
1984/85	364,780	28,030	7.68%
1985/86	425,640	39,040	9.17%
1986/87	560,510	47,060	8.40%
1987/88	616,520	40,750	6.61%
1988/89	695,200	50,300	7.24%
1989/90	982,830	71,490	7.27%
1990/91	1,093,570	69,550	6.36%
1991/92 (B)	1,186,810	80,200	6.76%
Annual Increase	18.34%	18.49%	

(B) = Budgeted

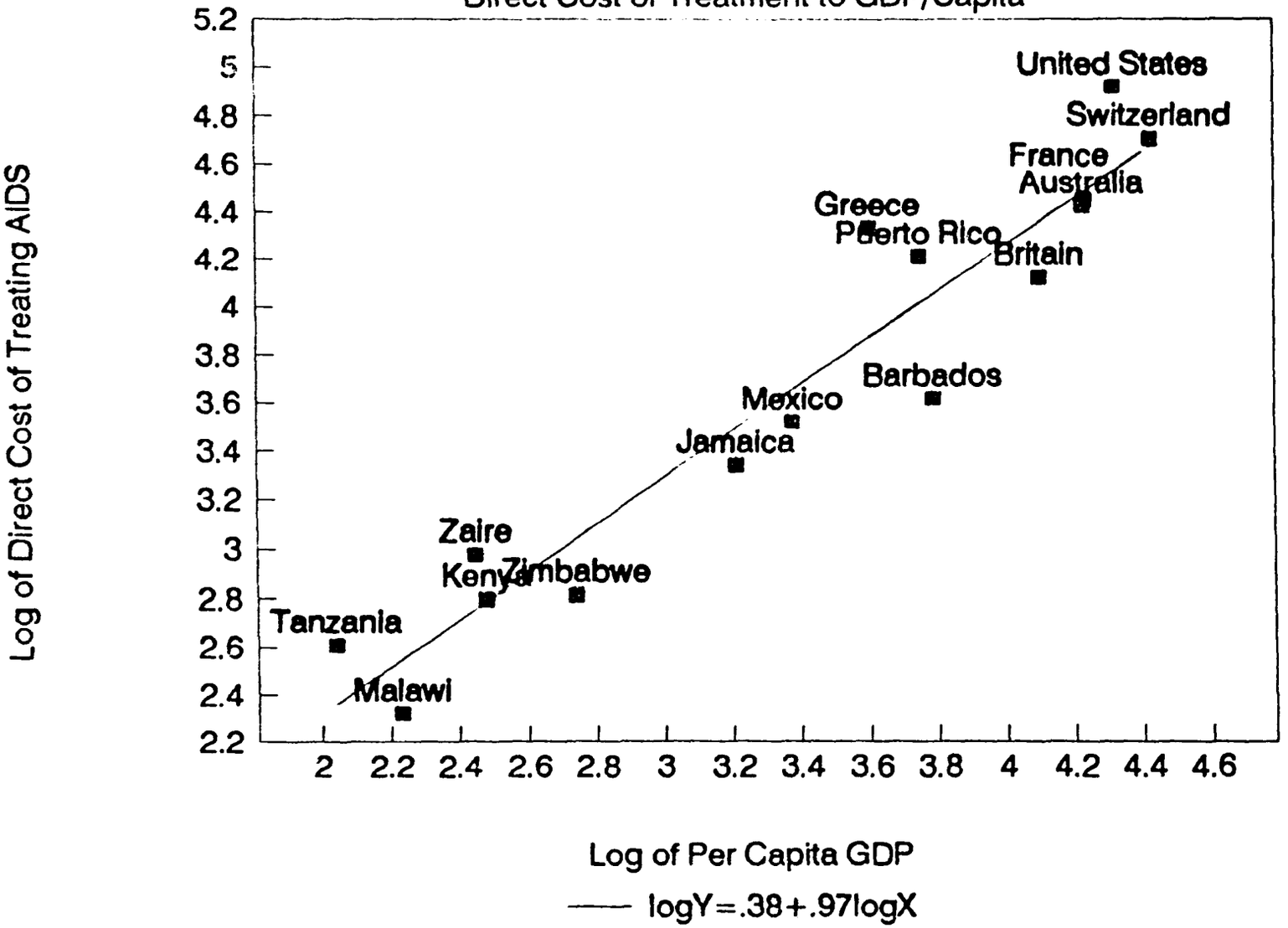
Note: The expenditures identified exclude programs largely supported by international donors, such as the Malawian AIDS Control Programme.

Table 3 indicates that the proportion of recurrent costs allocated to health in FY 1991/92 (6.76 percent) did not differ significantly from the level recorded in FY 1982/83 (6.68 percent).

The Ministry of Finance and the Ministry of Health have indicated, however, that the

FIGURE 1

Direct Cost of Treatment to GDP/Capita



recurrent budget for FY 1994/95 will reach 9.1 percent of the GOM recurrent budget (Chimango, 1991). Table 4 presents projections of the MOH's recurrent curative budget if 1) the nominal GOM recurrent budget continues to grow at 18 percent per year, 2) the proportion of the GOM budget allocated to the Ministry of Health grows to 9.1 percent by FY1994/95 and remains as a constant proportion thereafter, and 3) that curative care expenditures remain at 78 percent of all MOH recurrent costs[1].

Table 4 also provides estimates as to the total cost of AIDS care and the percentage of the MOH curative recurrent budget that will be needed for the care of AIDS patients. These cost estimates are based on the epidemiological projections of new AIDS cases already presented and the critical assumption that 65 percent of AIDS patients continue to obtain inpatient medical care.

TABLE 4
Projected MOH Recurrent Curative Budget and Treatment Costs for Patients with AIDS
(000's Kwachas)

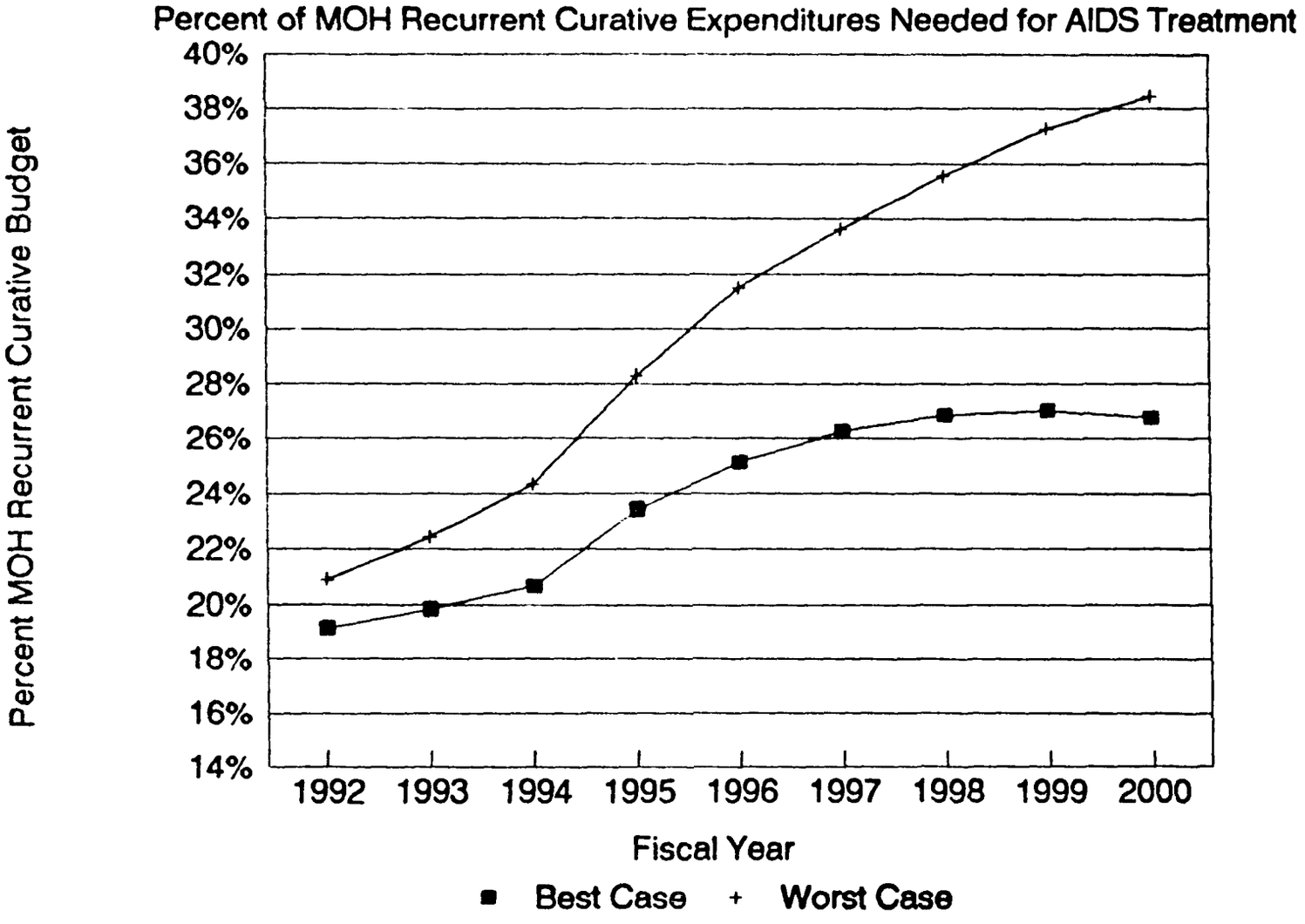
Fiscal Year	MOH	AIDS Cost	AIDS/MOH
FY1992/93	82,336	15,731 - 17,205	19 - 21%
FY1993/94	107,211	21,230 - 24,023	20 - 22%
FY1994/95	138,409	28,573 - 33,652	21 - 24%
FY1995/96	163,322	38,246 - 46,183	23 - 28%
FY1996/97	192,720	48,387 - 60,689	25 - 31%
FY1997/98	227,410	59,652 - 76,429	26 - 34%
FY1998/99	268,344	72,032 - 95,336	27 - 36%
FY1999/00	316,645	85,476 -117,980	27 - 37%
FY2000/01	373,642	99,879 -143,662	27 - 38%

Note: The increased nominal cost of treating persons with AIDS was estimated by assuming a future inflation rate of 13.65% (the average rate for 1989 and 1990).

Table 4 and Figure 2 illustrate that AIDS consumes about 20 percent of the MOH's

[1]Estimates that 78 percent of MOH recurrent expenditures are spent on curative programs is based on the MOH document, "Ministry of Health: Development and Recurrent Expenditure Trends".

FIGURE 2


Percent of MOH Recurrent Curative Expenditures Needed for AIDS Treatment
Percent MOH Recurrent Curative Budget
40%
38%
36%
34%
32%
30%
28%
26%
24%
22%
20%
18%
16%
14%
1992
1993
1994
1995
1996
1997
1998
1999
2000
Fiscal Year
Best Case
Worst Case

recurrent curative budget and is likely to consume an increasing proportion of the MOH's recurrent curative budget. Currently it is estimated that between K15.7 million and K17.2 million are spent on the care of people with AIDS. To maintain current levels of treatment for patients with AIDS, between 27 percent and 38 percent of the MOHs recurrent curative expenditures would have to be spent on the care of patients with AIDS, and seroprevalence among inpatients would reach between 55 and 70 percent by the year 2000. This equates to estimated direct costs for fiscal year 2000 of between K100 million and K144 million. These estimates will be higher if there is any real increase in the cost of treating persons with AIDS.

It is critical to note that these costs will be incurred only if current levels of resource allocation to patients with AIDS is maintained. However, it is likely that hospitals and the MOH will find this increasing level of resource allocation to patients with AIDS unobtainable. Therefore the level of health care available for patients with AIDS is likely to decline substantially in the absence of alternative, cost-effective treatment strategies (e.g., home-based care, hospice care, etc.).

E. Indirect Costs of AIDS

> "This loss of young men and women will have serious implications to a country whose economy is based on agriculture. So there will be a shortage of labour as more and more young men and women die of AIDS."
>
> - Dr. George Liomba, AIDS Control Programme Manager
> Malawi News, September 14-20, 1991

Methodology

In addition to the direct cost of treating persons with AIDS, there are additional indirect costs to families, the economy, etc. The approach used in this analysis for measuring indirect costs is referred to as the "human capital approach". This method involves assigning a monetary

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value to a human life by assuming a value equivalent to that individual's future earnings potential.

For a number of reasons, the human capital approach is flawed. On the one hand, this method underestimates the value of life to family members, since human life is generally valued for more than the future earnings potential of the individual. In addition, activities such as raising children is assigned no value in the human capital approach, because there are no payments involved.

Conversely, the human capital approach overestimates the value of life to society, since labour lost can frequently be replaced, especially where unemployment rates are high and the technical skills of those affected is low. However, the human capital approach is the most generally accepted and widely used approach to indirect cost analysis (for a review of issues concerning indirect cost methodologies and AIDS, see "Econometric Issues in Modeling the Costs of AIDS" by John W. Hay, Health Policy, Vol. 11, 1989).

To identify the indirect cost of AIDS, it was necessary to determine on average how many years of productive life years are lost from each new case of AIDS. For the purpose of this analysis, a number of simplifying assumptions were made:

- The productivity of an HIV-infected workers is not reduced prior to being diagnosed with AIDS;
- Workers diagnosed with AIDS are no longer productive members of the labour force;

The first assumption may result in an underestimation of indirect costs, since HIV-positive workers may be more likely to miss work due to illness, relative to their HIV-negative coworkers

(Yelin, 1991), even in the absence of clinically diagnosed AIDS.

The second assumption may result in an overestimation of indirect costs, since some individuals with AIDS remain as productive members of the workforce despite their illness. However, in light of the fact that the average time from diagnosed AIDS to death is only approximately 1 year, the extent of this overestimation is not likely to be substantial.

Step 1: Determining the Employed Population

Information on unemployment and labour force participation was collected to determine the likelihood that a person contracting AIDS is employed.

For the purpose of this analysis, sufficient data was not available to indicate that persons contracting AIDS are more or less likely to be employed prior to illness. Therefore it was assumed that those contracting AIDS are typical of the general population within each age category in terms of active participation in the labour force.

A National Statistics Office (NSO) survey (NSO, 1977) estimated that 58 percent of those over 10 ten years old in urban areas and 75 percent in rural areas are members of the labour force (employed or seeking employment). Since no breakdown was available of labour force participation rates by age group for Malawi, data from a study in Kenya was used to scale labour force participation by age group (Aoko, 1991).

The estimates of labour force participation are provided in Table 5.

TABLE 5
Labour Force Participation Rates

Age	Urban	Rural
0-4	0.00%	0.00%
5-9	0.00%	0.00%
10-14	45.47%	58.73%
15-19	50.14%	64.76%
20-24	59.47%	76.81%
25-29	66.46%	85.84%
30-34	68.79%	88.85%
35-39	68.80%	88.85%
40-44	69.37%	89.61%
45-49	68.21%	88.10%
50-54	67.05%	86.60%
55-59	67.04%	86.59%
60-64	65.30%	84.34%
Total	58.30%	75.30%

Source: National Statistics Office, 1977
Aoko, 1991.

A labour force survey in 1983 (NSO, 1983) provided unemployment rates for rural and urban areas by age category. As indicated in Table 6, approximately 16 percent of the labour force in urban areas and 4 percent in rural areas are unemployed. (This estimate, however, does not reflect those underemployed, which is likely to represent a significant proportion of the labour force, especially in rural areas.)

TABLE 6
Unemployment Rate

Age	Urban	Rural
0-4	100.00%	100.00%
5-9	100.00%	100.00%
10-14	24.30%	10.60%
15-19	28.50%	6.40%
20-24	14.10%	3.00%
25-29	14.10%	3.00%
30-34	14.10%	3.00%
35-39	14.10%	3.00%
40-44	14.10%	3.00%
45-49	14.10%	3.00%
50-54	14.10%	3.00%
55-59	14.10%	3.00%
60-64	14.10%	3.00%
Total	16.10%	4.20%

Source: Labour Force Survey, 1983

By combining labour force participation and unemployment rates with a population projection of 8.9 million in Malawi for 1992, it was possible to estimate the employed labour force. This data indicates that of Malawi's population of 8.9 million people, 40 percent, or 3.6 million will be employed in 1992.

Step 2: Determining Employment by Sector

A further breakdown of the employed labour force indicates that 500,000 Malawians are in the wage earning, or "modern sector", with the remaining 3.1 million being involved in informal and small farming (ISF) enterprises.

Table 7 further disaggregates the modern sector by industry. Estimates of 1989 employment figures for these industries were collected from the 1991 Economic Report and used to provide a general breakdown of employees according to sector. These proportions were applied to the estimated 1992 employed labour force to provide a breakdown of employees into each sector. The assumption made was that there were no significant shifts in

employment within each sector between 1989 and 1992.

TABLE 7
Employment by Economic Sector

Economic Sector	Percent	1992 Labour Force
Modern Sector:		
Agriculture/Forestry	6.62%	241,597
Community/Social/Personal Svcs.	2.32%	84,724
Manufacturing	1.90%	69,300
Construction	1.10%	40,007
Wholesale/Retail Trade	1.02%	37,060
Transportation/Communications	0.89%	32,585
Finance/Insurance/Real Estate	0.43%	15,543
Electricity/Water	0.18%	6,726
Mining	0.01%	339
Subtotal	14.46%	527,880
ISF Sector:	85.54%	3,121,888
Total Employed	100.00%	3,649,768

Source: Economic Report, 1991
Poverty in Malawi: Situational Analysis, UNICEF

This table illustrates that the ISF sector of the economy comprises 86 percent of the labour force, while only 14 percent of the employed labour force works in the "modern sector".

Step 3: Determining Mortality Estimates (No AIDS)

In determining an individual's future participation in the employed labour market, it is also necessary to identify the probability of mortality within individual age categories.

In order to assess the probability of mortality, data was obtained from the 1977 Census. This data should reflect mortality in the absence of AIDS, although it may also overestimate current rates of mortality, since it does not include improvements in health care.

Table 8 presents the probability of a Malawian dying within any of the age categories. This data was used to determine the average number of future years of employment that a typical

Malawian can expect.

TABLE 8
1977 Mortality Rates of the Malawian Population

Age	Mortality Rate
0-4	24.54%
5-9	7.07%
10-14	2.52%
15-19	1.51%
20-24	1.43%
25-29	1.09%
30-34	1.25%
35-39	1.11%
40-44	1.66%
45-49	1.56%
50-54	2.59%
55-59	2.34%
60-64	3.97%

Source: 1977 Census

Step 4: Determining Future Productive Life Years

By combining labour force participation, unemployment, and mortality statistics, it was possible to determine that the average Malawian is employed for 25.3 years during the 55 years between age 10 and 65.

Table 9 presents estimates as to the number of future productive life years remaining for individuals in the various age categories.

TABLE 9
Determining Future Productive Life Years

Age	Future Prod. Life Years
0-4	25.3
5-9	25.3
10-14	24.6
15-19	22.6
20-24	20.5
25-29	18.0
30-34	15.5
35-39	12.8
40-44	10.3
45-49	7.8
50-54	5.5
55-59	3.2
60-64	1.2

Step 5: Determining the Age of New AIDS Cases

Based on Sokal's Demproj analysis, the age of new AIDS cases was determined. Table 10 provides a percentage distribution of new AIDS cases.

TABLE 10
1992 Percent Distribution New AIDS Cases

Age	Age Dist. of New AIDS Cases
0-4	33.34%
5-9	0.08%
10-14	0.00%
15-19	7.47%
20-24	14.98%
25-29	14.65%
30-34	10.20%
35-39	6.03%
40-44	4.03%
45-49	2.78%
50-54	1.96%
55-59	1.38%
60-64	1.09%
65+	1.29%

Source: Sokal, 1991

Step 6: Calculating Productive Life Years Lost Due to AIDS

By combining tables 9 and 10, it was possible to determine the average number of

productive life years lost from each new AIDS case. The results from this analysis indicate that, on average, each new adult AIDS case results in the loss of 15.6 years of productive life. When all Malawians are included (adults and children), a total of 18.7 years of productive life years are lost. In other words, **AIDS results in the loss of three-quarters of a victim's productive lifetime of 25.3 years.**

Step 7: Identifying Income by Economic Sector

The next step involves translating productive year's lost into monetary terms. To do this, it is necessary to identify the relevant annual incomes for each economic sector.

Table 11 presents the annual income for the various sectors. While detailed information was available for the modern sector from the 1991 Economic Survey, very little data was available for the ISF sector. ISF earnings estimates were therefore based on a 1989 study of income in rural areas (Jaffee, 1991). All income estimates were updated to 1992 based on an estimated wage inflation rate of 11.9 percent (Economic Report, 1991).

The sector paying the highest annual income, K1,860, is the modern sector, with the ISF sector workers earning less than half at K830. In total, the average annual income for employed Malawians was determined to be approximately K980.

TABLE 11
Annual Income of Employed Individuals by Economic Sector

Economic Sector	Estimated 1992 Annual Income
Modern Sector:	
Finance/Insurance/Real Estate	6,260
Electricity/Water	5,990
Manufacturing	5,190
Wholesale/Retail Trade	2,380
Transportation/Communications	2,120
Community/Social/Personal Svcs.	1,760
Construction	1,140
Agriculture/Forestry	560
Mining	550
Subtotal	1,860
ISF Sector:	830
Total	K980

Source: Economic Report, 1991
Poverty in Malawi: Situational Analysis, UNICEF
Patterns of Rural Development and Impact on Employment & Incomes, ILO
The Migrant Smallholder, 1991.

Step 8: Allocating Prevalence to Economic Sectors by Level of Urbanization

The next step involved determining the average income of a person infected with HIV by determining the prevalence of HIV within the relevant economic sectors. Such an analysis was performed to adjust for the fact that modern sector employment, which pays employees a higher average income, is predominantly located in urban areas, where HIV prevalence is higher. Meanwhile the lower income ISF sector is predominantly located in rural areas, where the prevalence of HIV is lower.

The method that was used in this analysis to estimate prevalence within industries involved assessing the concentration of businesses in urban and rural areas and the regional location of the industries throughout Malawi.

The concentration of businesses in urban and rural areas was obtained from the 1987

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"Employment and Earnings" report. The labour force of businesses located in urban areas was allocated a prevalence rate that was equivalent to the HIV prevalence rate determined for urban areas (24.5% to 27.5% for 1992), and the remaining were allocated a prevalence rate for rural areas (9.8% to 11.0% in 1992).

As table 12 reveals, approximately 39 percent of the modern sector is located in urban areas, while only 3 percent of the ISF sector is located in urban areas. Within the modern sector, 1) finance, insurance, and real estate, 2) construction, 3) transportation/communications and 4) electricity/water are the industries most concentrated in urban areas.

TABLE 12
Urbanization of the Economic Sector

Sector	% of Labour Force Urbanized
Modern Sector:	
Finance/Insurance/Real Estate	95%
Construction	86%
Transport/Communications	82%
Electricity/Water	82%
Wholesale/Retail Trade	59%
Mining/Quarrying	58%
Community/Social/Pers. Services	54%
Manufacturing	53%
Agriculture/Forestry	8%
Subtotal:	39%
ISF Sector:	3%

Source: Employment and Earnings, 1987.

Step 9: Allocating Prevalence to Economic Sectors by Regional Variation

In addition to the differences in urbanization, there are also regional differences which contribute to differences in prevalence rates. To incorporate these differences, a scale was developed to reflect the fact that prevalence is higher in some districts, and lower in others. The 1989 blood donor survey was used to determine a scale of HIV prevalence by district The 1987

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"Employment and Earnings" report provided a breakdown of the workforce within economic sectors by district.

Table 13 provides a distribution of businesses within the various districts in Malawi, and the scale which was used to compare the prevalence of HIV among districts. As this table indicates, the highest prevalence regions are Nkhata Bay and Chitipa in the North, and Mulanje in the South. The industries most concentrated in one high prevalence district are finance/insurance/real estate, transportation/communication, and mining in Blantyre.

Step 10: Determining Prevalence by Economic Sector

By combining the concentration of businesses in urban areas and the scale to reflect variations between districts, it was possible to develop an estimate as to the potential impact within specific industries. Table 14 indicates that HIV prevalence in the "modern sector" (16%-18%) is approximately 50 percent higher than in the ISF sector (10%-12%).

The highest absolute number of HIV infections is likely to occur in agriculture/forestry and the ISF sector. However, the highest HIV prevalence is likely to occur within the "modern sector" industries of 1) finance/insurance/real estate and 2) transport/communications.

...ence by	Scale Agriculture		Mining	Manufacturing	Electricity	Construction	Wholesale Trade	Transport	Financing	Community Svcs
hern:										
ipa	1.31	0.2%	0.0%	0.0%	0.5%	0.5%	0.8%	0.1%	0.1%	0.6%
nga	0.78	0.6%	0.0%	0.2%	1.5%	2.5%	2.6%	0.7%	0.3%	1.7%
ta Bay	1.43	3.0%	0.0%	0.4%	1.7%	0.6%	0.3%	1.0%	0.0%	1.2%
hi	1.29	1.8%	0.0%	.0%	0.3%	0.6%	1.3%	0.3%	0.1%	1.5%
ba	0.92	4.7%	0.0%	.0%	0.6%	0.5%	1.3%	0.2%	0.2%	2.9%
u City (1)	1.07	0.8%	0.0%	1.5%	3.4%	5.6%	2.1%	6.7%	2.0%	3.4%
ral:										
ngu (1)	0.90	10.7%	0.0%	0.0%	1.1%	0.1%	2.7%	0.1%	0.6%	2.2%
takota	1.20	2.9%	0.0%	9.5%	0.0%	1.7%	0.5%	0.4%	0.2%	0.7%
isi (1)	0.90	.0%	0.0%	0.1%	0.0%	.0%	1.3%	.0%	0.0%	0.8%
	0.90	0.5%	0.0%	0.1%	0.0%	0.0%	1.2%	0.2%	0.1%	2.2%
ma	0.82	1.4%	0.0%	0.3%	1.1%	0.1%	2.6%	0.9%	0.5%	3.2%
ngue	0.94	8.1%	1.4%	0.4%	41.3%	46.7%	24.7%	17.8%	24.7%	26.1%
nji	0.74	6.6%	0.0%	6.8%	0.0%	0.0%	0.7%	.0%	0.0%	1.4%
a (1)	0.90	1.3%	0.0%	0.6%	0.5%	0.2%	1.7%	0.2%	0.1%	1.4%
eu (1)	0.90	1.3%	2.4%	0.1%	0.0%	0.0%	1.5%	0.3%	0.1%	2.0%
hern:										
...bi	0.34	10.6%	0.0%	0.2%	1.1%	1.0%	2.6%	1.7%	0.4%	3.4%
...ga	1.25	4.0%	0.0%	0.1%	0.8%	0.8%	3.2%	2.1%	0.3%	1.8%
a (1)	1.02	3.4%	38.5%	2.7%	1.9%	2.6%	1.9%	0.5%	3.2%	13.5%
adzulu	0.99	1.0%	0.3%	1.3%	0.0%	0.0%	3.2%	0.3%	0.0%	1.7%
tyre	1.22	5.0%	57.4%	43.0%	42.3%	31.6%	38.7%	60.6%	66.8%	17.3%
za	0.73	0.4%	0.0%	0.0%	0.0%	0.0%	0.2%	.0%	0.1%	0.9%
lo	0.82	18.4%	0.0%	19.9%	0.9%	1.8%	0.6%	2.0%	0.0%	3.6%
...je	1.37	9.4%	0.0%	8.1%	0.7%	1.6%	1.5%	0.7%	0.2%	3.9%
...awa	0.86	3.8%	0.0%	4.2%	0.4%	1.1%	2.6%	0.6%	0.1%	1.4%
je (1)	1.02	0.1%	0.0%	0.6%	0.0%	0.6%	0.1%	2.2%	.0%	1.2%
l	1.00	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

...lood Bank Data Not Available - Extrapolation from region

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TABLE 14
Prevalence by Economic Sector (1992)

Economic Sector	Prevalence	Number HIV +
Modern Sector:	16 - 18%	83,000 - 93,200
Finance/Insurance/Real Estate	27 - 30%	4,200 - 4,700
Transport/Communications	25 - 28%	8,000 - 9,000
Construction	23 - 26%	9,400 - 10,500
Electricity/Water	23 - 26%	1,600 - 1,800
Mining/Quarrying	21 - 23%	70 - 80
Wholesale/Retail Trade	19 - 22%	7,200 - 8,100
Manufacturing	19 - 21%	13,200 - 14,800
Community/Social/Pers. Svcs.	18 - 20%	15,000 - 16,900
Agriculture/Forestry	10 - 11%	24,400 - 27,400
ISF Sector:	10 - 12%	362,800 -407,200
Total	11 - 12%	445,800 -500,400

Step 11: Determining Income for Persons with HIV

Even though only 6 percent of the Malawian population is engaged in the modern sector, this sector accounts for 28 percent of Malawi's national income, has a prevalence rate of 16 to 18 percent, and incurs approximately 19 percent of all of Malawi's HIV infections. Therefore the impact that AIDS has on this small sector of the economy is likely to disproportionately affect the entire Malawian economy.

By combining the prevalence data in table 14 with the income data in table 11, the average income for someone with HIV was determined to be K1,400, or 50 percent higher than the national average of K980 for all employed individuals. If we assume that the average annual income earned by newly diagnosed persons with AIDS is comparable to the annual income of those infected with HIV, it is possible to estimate that K1,400 also represents the annual lost income from new AIDS cases.

It is critical to note that this assessment of the annual earnings potential of new AIDS

cases is based solely on the location of the businesses (concentration in urban areas and location by district). The very important assumption being made is that newly diagnosed AIDS cases are distributed proportionally among similarly aged people in the population within a particular urban or rural location. In other words, we assume that a 25 year old AIDS patient in Lilongwe would have had the same earnings potential (in the absence of AIDS) as any other 25 year old from Lilongwe.

Some studies suggest that AIDS has disproportionately impacted the higher income elite, even after accounting for urbanization (largely due to the mobility and the disposable income of the wealthy). If this assumption is correct, the estimate that HIV infected workers earn K1,400 per year will underestimate the actual indirect cost from the loss of human capital.

Conversely, if AIDS strikes poorer people, the indirect cost assessment here will be overestimated.

Step 12: Determining the Present Value of Lost Income

In order to determine the present value of future income, it was necessary to discount the future earnings for Malawian workers. For the purpose of this analysis, we have assumed no real increase in wages into the future, and a real discount rate of 5 percent. Since there is no source of data to identify income by age group, it was assumed that annual income does not vary by age.

As indicated earlier, the average number of life years lost to AIDS is 18.7. When combining this with the average annual income estimate of K1,400, it is determined that K26,180 are lost on average from each new case of AIDS. Using the 5% discount rate, this amounts to a total discounted lost income of K10,500 per new adult AIDS case, or 20 times higher than

Malawi's per capita GNP.

Step 13: Comparative Analysis

Relative to studies on the direct cost of AIDS, much less research work has been performed in developed and developing countries to determine the indirect cost of AIDS. Studies have been performed by AIDSTECH/Family Health International in Kenya, the World Bank and the World Health Organization in Tanzania and Zaire, Harvard in Puerto Rico, and by the Population and Community Development Association in Thailand. Table 15 compares the estimates of indirect costs for Malawi with those of Kenya, Tanzania, Zaire, Puerto Rico and Thailand.

TABLE 15
Comparative Analysis of Indirect Cost Estimates
in Kenya, Zaire, Tanzania, Puerto Rico Thailand and Malawi
(U.S. Dollars)

	Year	Per Capita GDP (1989)	Indirect Cost	Indirect Cost/ Per Capita GDP
Zaire	1985	170	$1,780	10.47
Tanzania	1985	290	$3,760	12.96
P. Rico	1988	5,600	$80,000	14.29
Thailand	1991	1,320	$21,675	16.42
Malawi	1992	180	$3,307	18.37
Kenya	1992	370	$7,866	21.26

Source: The Economic Impact of AIDS on Thailand
The Direct and Indirect Cost of HIV Infection in Developing Countries: The Cases of Zaire and Tanzania
Measuring the Economic Impact of AIDS in Kenya: A Preliminary Assessment.
Costs of AIDS in a Developing Area: Indirect and Direct Costs of AIDS in Puerto Rico

Note: Malawi's and Thailand's Per Capita GNP estimates for 1991 were based on 1989 estimates and updated using the existing growth rate (2.0% and 4.2% respectively) recorded from 1980 to 1989. The indirect cost estimates for Zaire and Tanzania represent the midpoint of the high and the low estimates.

Table 15 illustrates that indirect costs are 10 to 22 times higher than the per capita GNP.

Malawi, with indirect costs of USD$3,300, appears to be comparable to estimates from the other 4 countries.

Step 14: Projecting the Indirect Costs

By combining estimates of indirect costs with projections of new AIDS cases, it was possible to determine the future indirect costs in Malawi. As indicated in table 16, the indirect costs from AIDS are likely to amount to between K704 million and K1,012 million by the year 2000, or 14 to 21 percent of the projected GNP for Malawi

TABLE 16
Projected Indirect Costs
(1992 Kwachas)

	Best Case	Worst Case
1992	308,484,000	337,404,000
1993	366,325,000	414,525,000
1994	433,806,000	510,927,000
1995	510,927,000	616,968,000
1996	568,767,000	713,369,000
1997	616,968,000	790,490,000
1998	655,528,000	867,611,000
1999	684,449,000	944,732,000
2000	703,729,000	1,012,213,000

Source: Sokal, 1991

In addition to the indirect costs identified here, there will also be additional indirect costs that result from the increased number of orphans. Even when the child is not infected with the HIV virus, the costs to society from orphans will be substantial. While projections concerning the number of children losing both their parents to AIDS is not available, it is projected that in 1992, there will be between 61,000 and 64,000 children who have lost their mother to AIDS. Furthermore, by the year 2000 it is expected that between 356,000 and 448,000 children will have lost their mothers to AIDS.

F. Sectoral Impact of AIDS

An increasing prevalence of AIDS can create an array of problems for businesses. For example:

- o Skilled workers become in shorter supply;
- o Employees are more likely to be absent from work as they or their dependents fall ill;
- o Health and life insurance costs rise;
- o Hiring employees becomes a longer and more expensive process;
- o Worker morale declines;
- o Cyclical employment creates demand for labor that cannot be met, especially in industries such as agriculture;
- o Consumption of products declines as a consequence of a decreases in consumer's disposable income.

The following analysis will go beyond the estimation of prevalence by location of industries (Table 14), to review two other types of risk. The first involves factors that may indicate that there is a higher prevalence of HIV within certain sectors of the economy. The second issue that will be reviewed involves factors which may indicate that the impact of AIDS may be greater within certain industries.

Some of the factors other than location that may indicate variability in prevalence include: 1) the risks from particular occupations, and 2) the risk from the mobility of the workforce.

Prevalence Risk

1. Risk from Occupations

Certain occupations are likely to place a worker at greater risk of acquiring HIV (e.g., greater mobility, disposable income, etc.). Occupational information was collected from 3,762

Malawian blood donors, 18.8 percent of whom were HIV positive. Table 17 indicated that educated professionals are 58 percent more likely to be HIV-positive than the average blood donor. Similarly, skilled workers are 34 percent more likely to be seropositive than the general donor population. However, unskilled workers are slightly less likely than the general donor population to be HIV-positive. While further analysis needs to be performed to determine the correlation between occupation, urbanization, and HIV-prevalence, this initial data suggests that the "elite" may be more likely to contract HIV.

TABLE 17
Blood Donor HIV Serology by Occupation

	Positive	Prevalence
Military/Police	23/ 37	62.2%
MYP	15/ 53	28.3%
Educated	64/231	27.7%
Skilled	118/486	24.3%
Unspecified	104/510	20.4%
Unskilled	86/483	17.8%
Farmers/Villagers	261/1592	16.4%
Housewives	110/670	16.4%
Students	38/297	12.8%
Total	819/4359	18.8%

Similarly, a study of 5,376 pregnant women in urban areas of Malawi indicated that high socioeconomic status (measured by the husband's educational attainment) "is a strong risk factor for HIV-1 infection" (Dallabetta, 1991).

The industries with the highest average income are 1) finance/insurance/real estate, 2) electricity/water, and 3) manufacturing (See Table 11).

2. Risks from Mobility

Workers who are required to leave their families and travel frequently may be at greater risk of contracting HIV. Thus it is expected, although not verified, that industries such as

transportation, fishing, and farming sectors with a large migrant workforce may incur higher prevalence rates.

Impact Risk

Impact risk refers to the ability or inability of businesses to cope with the impact of AIDS. Research on the impact of AIDS on specific sectors of African economies has, for the most part, been limited to a few studies in mining (Nkowane, 1988), agriculture (Abel, 1988; Barnett, 1989; Norse, 1991), and two large businesses in Zaire (Ryder, 1990). An extensive analysis is currently being performed by the World Bank in Tanzania, although the results are not yet available.

What these studies have indicated is that certain industries incur greater difficulty in coping with AIDS relative to others, due to the difficulty of replacing and retraining workers. Thus, whereas trucking might have a higher HIV prevalence among its workforce relative to banking, it is probably more difficult to replace a banker than a truck driver.

Some of the factors on the impact side that will be reviewed include: 1) the risk of losing educated workers, 2) the risk of lost exports, 3) the risk from unmet seasonal demands for labor.

1. Risks from Inability to Replace Educated Workforce

Due to the relatively small quantity of educated workers in Malawi, it may be difficult or impossible to adequately replace the skills of a highly trained worker lost to AIDS. This means that businesses with a skilled labour force may incur greater costs in hiring and retraining new employees, and in some cases may be incapable of finding replacement workers. Although data indicating the skill level of workers in Malawi was not available, data from a similar analysis in Kenya indicated that community/social/personal services had the highest proportion

of technicians (61 percent of workers), while finance/insurance/real estate had the highest proportion of professionals and managers (15 percent of workers).

2. Exports

Because exports are a necessary component in obtaining hard currency and paying international debts, the impact of AIDS on workers in export-oriented industries may place an additional burden on the Malawian economy. Since agriculture represents ninety percent of Malawi's export earnings, the loss of workers in this sector may have a particularly harmful affect on the Malawian economy.

Of Malawi's agricultural exports, 72 percent are tobacco, 14 percent are tea, and 11 percent are coffee. While it is not currently possible to determine the prevalence within these specific agricultural sectors, additional research should be promoted to identify the prevalence of HIV among farmers and identifying how they cope with the impact of AIDS. For example, an ODA study in Uganda found that farmers in high prevalence areas resorted to planting crops that required less labour to harvest (and contained less nutritional value).

3. Seasonality

Industries such as agriculture hire workers during peak periods of demand (e.g. harvesting). Due to these seasonal demands for labour, losses in the labour force may seriously impact these industries' ability to deal with their peak demand for labour. The Food and Agriculture Organization (FAO) has done various assessments of how nutrition, food prices, and coping mechanisms have been impacted by the spread of HIV among agricultural workers (Norse, 1991).

Summary

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Table 18 provides a matrix of factors that have been discussed in this analysis and the possible affect that each of the factors may have on specific industries. Prevalence is likely to be high in finance/insurance/real estate and electricity/water because of the location of the businesses and the high socioeconomic status of their workers. Meanwhile transportation/communications are likely to incur high prevalence rates due to location and mobility.

Over the long run, AIDS is likely to most impact Malawi's agricultural sector, which comprises an overwhelming proportion of exports, and is likely to have the most difficulty in coping with AIDS due to seasonal demands for labour.

TABLE 10

Summary of Prevalence and Impact Factors

	PREVALENCE RISKS			IMPACT RISKS		
	Location	Income	Mobility	Education/Training	Exports	Seasonality
Agriculture/Forestry			X		X	X
Community/Social/Personal Svcs				X		
Manufacturing		X				
Construction	X					
Wholesale/Retail Trade						
Transportation/Communications	X		X			
Finance/Insurance/Real Estate	X	X		X		
Electricity/Water	X	X				
Mining			X			
Informal & Small Firms						X

IV. TOTAL COST OF AIDS AND INVESTMENT IN PREVENTION

The total cost of AIDS is expected to amount to K11,015 (K10,500 in indirect costs and K515 in direct costs). In order to compare this cost of treatment to the cost of prevention, it is necessary to determine the present value of treatment costs avoided in the future. If it is assumed that the time from HIV infection to AIDS is 10 years, the present value of treatment costs prevented is K6,760 (K11,015/(1+.05)^{10}, or approximately USD$2,700. Thus prevention programs can spend up to USD$2,700 to prevent each case of HIV infection in order for the benefits to exceed the costs.

National AIDS control activities were initiated in Malawi in 1986, and a five year Medium Term Plan was implemented in 1988. Funds for these interventions have come from WHO/GPA and international donors. Identifying the total amount of money expended to date in AIDS Control has been difficult, due to the various sources of funds. This problem is compounded by the fact that the Government of Malawi does not include donor-supported activities in annual budgets or reports of expenditures.

However, it was possible to determine an estimate of WHO/GPA expenditures, and a rough estimate of other donor contributions based on records from donor pledging meetings[2]. Table 19 presents estimates of expenditures incurred by WHO/GPA and other donors.

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[2]Donor pledges are likely to represent the upper estimate as to the amount that was actually spent on AIDS prevention.

TABLE 19
AIDS Prevention Expenditures
(U.S. Dollars)

Year	Through WHO/GPA	Bilateral	Total
1989	$1,152,600	$1,153,900	$2,306,500
1990	$1,177,000	$3,560,700	$4,737,700
1991	$1,366,800	$1,038,300	$2,405,100
1992	$1,302,000	$3,638,200	$4,940,200
1993	$ 730,000	$3,153,000	$3,883,000
Average	$1,145,700	$2,508,800	$3,654,500

Note: The fiscal year for the Malawi National AIDS Control Programme has not been consistent during the life of the medium term plan. Therefore it was necessary to estimate annual budgets by allocating fiscal year budgets to calendar year budget. Year 1 ran from 1/89 - 7/90, Year 2 ran from 8/90 - 12/91, Year 3 runs from 1/92 - 12/92, and Year 4 runs from 1/93 - 12/93.

The models project that approximately 70,000 new HIV infections per year will in Malawi between 1992 and the year 2000. It is unclear what percentage of these new infections can be prevented through interventions.

If it is conservatively estimated that 10 to 20 percent of these new infections can be prevented (7,000 to 14,000 infections) each year through a combination of IEC, condom distribution, STD control, etc., then an investment up to $5-10 million per year on AIDS prevention would result in the following cost-benefit ratios.

TABLE 20
Benefit to Cost Ratios

	Reduction in New Infections	
Annual Prevention Investment	10%	20%
USD$5 million	3.8:1	7.6:1
USD$10 million	1.9:1	3.8:1

Table 20 reveals that the economic value of the benefits will be from 1.9 to 7.6 times

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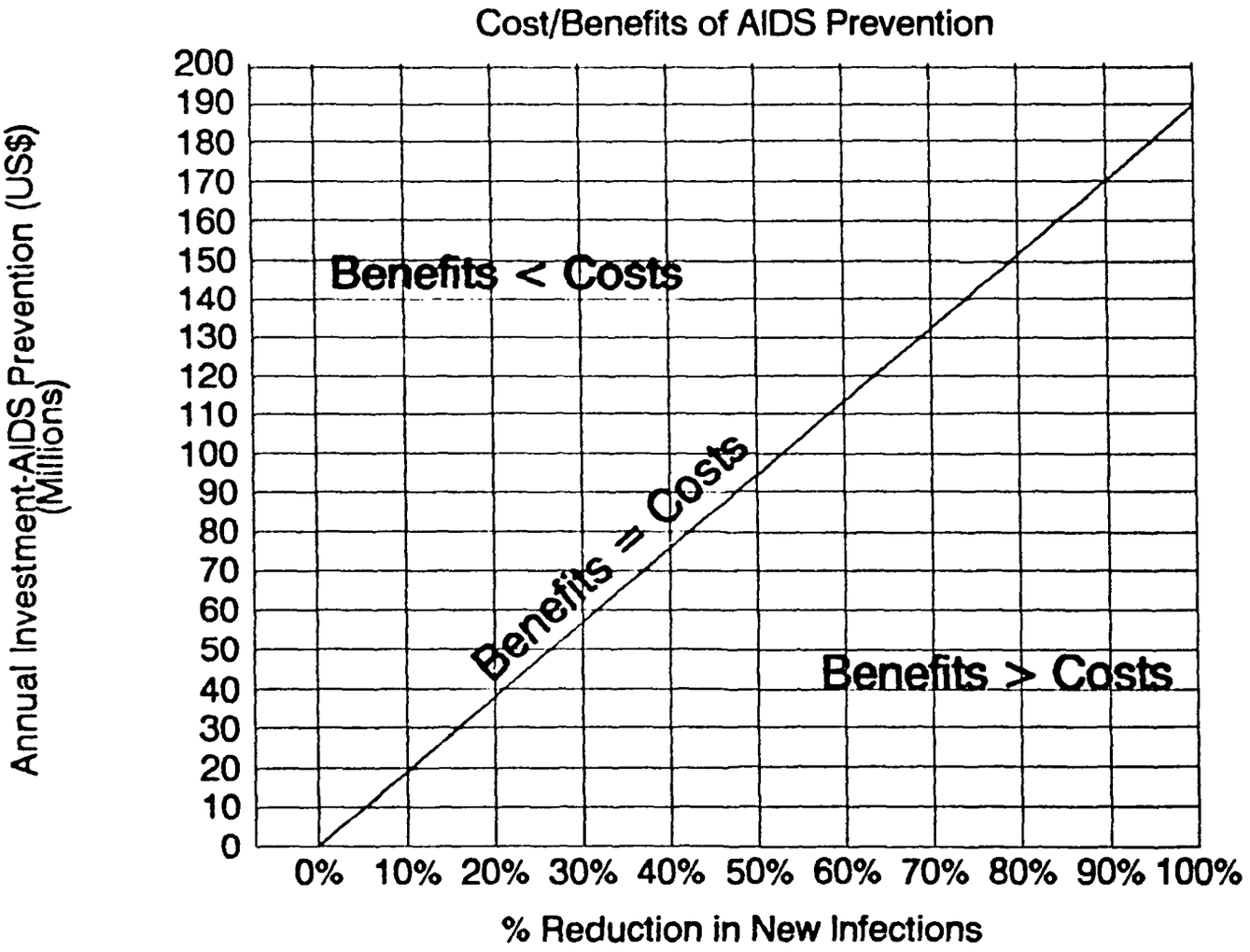
greater than the costs of prevention given the above assumptions. It is estimated that an annual investment of USD$10 million in AIDS prevention in Malawi would provide economic benefits which exceed the costs if only 5 percent of new infections were prevented.

Figure 3 presents a graph identifying the benefit to cost ratio based on the amount of money expended on prevention and the effectiveness of prevention in preventing new infections. At current levels of investment in prevention (USD$3.7 million), the number of new infections needs only to be reduced by 2 percent in order for the benefits to exceed the costs. In fact, if 10 to 20 percent of new infections could be prevented, an investment toward such a goal of between $18.9 million (7,000 X $2,700) and $37.8 million (14,000 X $2,700) per year would have economic benefits that exceed the costs.

FIGURE 3


Cost/Benefits of AIDS Prevention
Annual Investment-AIDS Prevention (US$)
(Millions)
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
Benefits < Costs
Benefits = Costs
Benefits > Costs
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
% Reduction in New Infections

V. CONCLUSIONS

This review of economic impact has indicated that over the short-term, the burden of AIDS is likely to fall upon businesses in the modern sector that employ a well trained and educated workforce (e.g., banking, finance, insurance, real estate, etc.). On the one hand, the concentration of these businesses in urban areas places their workforce at greater risk. Concurrently, the shortage of well educated and trained workers makes it more difficult to find people who can adequate replace those who fall ill from AIDS.

Over the longer term, it is likely that an increasing HIV prevalence in rural areas will shift the burden from the modern sector to the agricultural sector. The impact of AIDS on the agricultural sector could potentially result in a substantial decline in exports and a deterioration of nutritional intake.

Meanwhile, the problem of caring for AIDS patients is likely to create a tremendous burden on hospitals and their staff. As stated by UNICEF, "The number of AIDS patients will rapidly overwhelm the capacity of the health care system to offer care." (UNICEF, 1991)

In addition, the number of orphans in both urban and rural areas could also have devastating impacts on the social and economic structure of Malawian society. Projections from the AIDS Impact Model indicate that there will be between 61,000 and 64,000 orphans (children whose mother has died from AIDS)in 1992 and that this will rise to between 356,000 and 448,000 by the year 2000.

VI. RECOMMENDATIONS

1) At current levels of spending (approximately USD$3.7 million), even small changes in behavior will result in substantial economic benefits. Therefore, overall AIDS prevention programmes should be expanded so as to contain the spread of the disease and to limit future economic impacts;

2) AIDS prevention programmes should assure that the educated populations are being addressed, since they seem to represent a higher risk group. To this end, it is imperative that efforts particularly concentrate on AIDS prevention in schools and universities.

3) "AIDS in the workplace" educational programs should be reviewed to assure that the higher level management are vested in AIDS prevention and are "getting the message."

4) To avoid an even greater burden on the Malawian health care system, it will be imperative that planning begin for the development of alternative treatment facilities. Cost-effective treatment facilities, such as home-based or hospice care, can provide better and less expensive care by allowing the patient to be cared for in dignity and minimizing inpatient hospitalizations.

5) Additional research needs to be performed in Malawi to determine future resource requirement for treating patients with AIDS and to provide greater detail as to the impact that specific sectors of the economy are likely to incur.

6) The cost-effectiveness of specific AIDS prevention programs should be calculated so that the most effective mix of projects can be implemented.

APPENDIX A-1

Symptoms of 352 Patients with

HIV-Related Illnesses at Zomba District Hospital

	Number	Percent
Weight Loss	277	79%
Chronic Cough	182	52%
Fever	174	49%
Diarrhea	136	39%
Gen. Lymphadenopathy	95	27%
Herpes Zoster	32	9%
Candidiasis	30	9%
General Rash	28	8%
Herpes Simplex	2	1%

Source: National Workshop on Population - Development Projects and Programmes. July 11-13, 1990.

BIBLIOGRAPHY

Abel N, Barnett T, et al. The Impact of AIDS on Food Production Systems in East and Central Africa over the Next Ten Years: A Programmatic Paper. The Global Impact of AIDS, p. 145, 1988.

ABT Associates, Inc. A Proposed Study of the Economic Impact of the Disease AIDS: A Case Study of Zaire. March 16, 1987.

Aoko M, Barber G. The Implications of Recent Trends in Fertility Rates on Population, Labour Force Growth and School Enrolment: 1990-2010. Long Range Planning Division, Ministry of Planning and National Development.

Armstrong J. Socioeconomic Implications of AIDS in Developing Countries. Finance and Development, p. 14, December 1991.

Auvert B, Moore M, et al. Dynamics of HIV Infection and AIDS in Central African Cities. International Journal of Epidemiology, 19, 2, p. 417, 1990.

Barnet: T, Blaikie P. AIDS and Food Production in East and Central Africa: A Research Outline. Food Policy, p. 2, February, 1989.

Barnett T, Blaikie P. Community Coping Mechanisms in the Face of Exceptional Demographic Change. July, 1990.

Bertera R. The Effects of Behavior Risks on Absenteeism and Health-Care Costs in the Workplace. Journal of Occupational Medicine, 33, 11, p. 1119, November, 1991.

Bertera R. The Effects of Workplace Health Promotion on Absenteeism and Employment Costs in a Large Industrial Population. American Journal of Public Health, 80, 9, p. 1101, September, 1990.

Bond C, Linden R. AIDS: Race Against Mounting Odds. South, p. 109, April, 1987.

Centre for Health Policy. AIDS in South Africa: The Demographic and Economic Implications. University of the Witwatersrand. September, 1991.

Center for International Research, U.S. Bureau of the Census. HIV/AIDS Surveillance Data Base. February 26, 1991.

Chimagno LJ. Letter of Health Development Policy, Ministry of Finance, January 25, 1991.

Dallabetta G. High Socio-Economic Status (HSES) is a Risk Factor for HIV-1 Infection But not for Sexually Transmitted Diseases (STD) in Malawian Women. Seventh International Conference on AIDS. Florence, Italy. 16-21 June, 1991.

Delay P. AIDS in Malawi. Malawi Medical Journal, October 1990, Vol. 6, No. 1.

Desmond GM. The Impact of AIDS on Economic Development: An Approach to a Case Study in Africa. October 30, 1989. Unpublished.

Department of Economic Planning and Development. Malawi Government: Economic Report, 1991.

Economic Planning and Development Department. Population Dynamics, Employment Implications and Labour Market Considerations in Malawi. July, 1990.

Economic Planning and Development Department. Population and Development in Malawi. October, 1991.

Economist Intelligence Unit. Malawi: Country Profile 1991-1992. 1991.

Forsythe S, Sokal D, Lux L. Measuring the Economic Impact of AIDS in Kenya: A Preliminary Analysis.

Forsythe S, Schvartz E, et al. AIDS Prevention = Investment for the Future: Measuring Cost-Effectiveness and Benefits of Targeted Condom Distribution Programs in Mexico, Dominican Republic, and Antigua.

Fox D, Thomas E. AIDS Cost Analysis and Social Policy. Law, Medicine, and Health Care, 15, 4, p. 186, Winter 1987/88.

Hassig S, Perriens J, et al. An Analysis of the Economic Impact of HIV Infection Among Patients at Mama Yemo Hospital, Kinshasa, Zaire, 1988.

Hay J. Econometric Issues in Modeling the Costs of AIDS. Health Policy, 11 (1989) 125.

Huddart J. Report on an Assignment Conducted with the Ministry of health, Malawi, in Preparation for the Proposed World Bank Health Sector Credit. February 19, 1990.

Hunt C. Migrant Labor and Sexually Transmitted Disease: AIDS in Africa. Journal of Health and Social Behavior, 1989, Vol 30 (December), 353.

International Labour Organization. Patterns of Rural Development and Impact on Employment and Incomes: The Case of Malawi. 1985.

International Monetary Fund. Malawi - Recent Economic Developments. January 30, 1991.

Jackson H, Pitts M. Company Policy on AIDS in Zimbabwe. Journal of Social Development in Africa, 6, 2, p. 53, 1991.

Jaffee, S, et al. The "Migrant Smallholder", April, 1991.

Kelly, P, et al. HIV Seropositivity and Tuberculosis in a Rural Malawi Hospital. Transactions of the Royal Society of Tropical Medicine and Hygiene (1990) 84 (5) 725.

Koech DK, Obel AO. Treatment of HIV Infections and AIDS: New Horizons. East African Medical Journal, 67, 7, July 1990.

Kristensen, J. The Prevalence of Symptomatic Sexually Transmitted Diseases and Human Immunodeficiency Virus Infection in Outpatients in Lilongwe, Malawi. Genitourin Med, 66, 244, 1990.

Makadon H, Seage G, et al. Paying the Medical Cost of the HIV Epidemic: A Review of Policy Options. Journal of Acquired Immune Deficiency Syndromes, 3, 2, p. 127, 1990.

Malawi National AIDS Control Programme. A Five Year Medium Term Plan for the Prevention and Control of AIDS in Malawi (1989-1993). January, 1989.

Malawi National AIDS Control Programme. Reprogramming Document, August 1990 to July 1991.

Malawi National AIDS Control Programme. Reprogramming Document, 1992-1993.

Malawi News. Impact of AIDS on Malawi's Socio-Economic Development. September 14-20, 1991.

Malawi News. Over 300,000 People May be Infected with HIV in Malawi. February 15-21, 1992.

Mburu FM. Rhetoric-Implementation Gap in Health Policy and Health Services Delivery for a Rural Population in a Developing Country. Social Science and Medicine, 13A, p. 577, 1979.

Ministry of Finance. Budget and Performance Report on Treasury Funds, 1990/91.

Ministry of Health. Complement and Grading Review Report. October, 1988.

Ministry for Planning and National Development. National Development Plan for the Period 1989 to 1993.

Misztal B, Moss D. Action on AIDS: National Policies in Comparative Perspective. 1990.

Moses S, Plummer, F, et al. Controlling HIV in Africa: Effectiveness and Cost of an Intervention in a high Frequency STD Transmitter Core Group.

Nagelkerke N, Plummer F, et al. Transition Dynamics of HIV Disease in a Cohort of African Prostitutes: A Markov Model Approach. AIDS, 4, 8, p. 743, 1990.

National Statistical Office. Employment and Earnings Annual Report 1985 - 1987. September,

1989

N'Galy B, Ryder R. Epidemiology of HIV Infection in Africa. Journal of Acquired Immune Deficiency Syndromes, 1, p. 551, 1988.

Nkowane B. The Impact of Human Immunodeficiency Virus Infection and AIDS on a Primary Industry: Mining (A Case Study of Zambia). The Global Impact of AIDS, p. 155, 1988.

Norse D. Socio-Economic Impact of AIDS on Food Production in East Africa. VII International Conference on AIDS, June 16, 1991.

Nyangulu DS. Tuberculosis and HIV Infection. Malawi Medical Journal. October, 1990, Vol 6, No. 1.

Over M. The Effect of Scale on Cost Projections for a Primary Health Care Program in a Developing Country. Social Science Medicine, 22, 3 p. 351, 1986.

Over M, Bertozzi S, et al. The Direct and Indirect Cost of HIV Infection in Developing Countries: The Cases of Zaire and Tanzania. The Global Impact of AIDS, p. 123, 1988.

Over M, Bertozzi S, et al. Guidelines for Rapid Estimation of the Direct and Indirect Costs of HIV Infection in a Developing Country. Health Policy, 11, 2, p. 169, April 1989.

Over M, Piot P. HIV Infection and Other Sexually Transmitted Diseases. April, 1990.

Reinke, W. Health Personnel Needs in Malawi. 8-29 June, 1989.

Rockwell R. The Socioeconomic Impacts of AIDS: Many Questions, Few Answers. April 22, 1989.

Roemer M. National Health Systems of the World. p. 473, 1991.

Rowley J, Anderson R, Ng TW. Reducing the Spread of HIV Infection in Sub-Saharan Africa: Some Demographic and Economic Implications. AIDS, 4, p. 47, 1990.

Ruff A, Quinn T, et al. The Impact of AIDS on Allocation of Resources in Developing Countries. Pediatric AIDS and HIV Infection: Fetus to Adolescent, 1, 4, p. 55, 1990.

Ryder R, Mibandumba N, et al. Heterosexual Transmission of HIV-1 Among Employees and their Spouses at Two Large Business in Zaire. AIDS, 4(8), p. 725, 1990.

Scitovsky A, Over M. AIDS: Costs of Care in the Developed and the Developing World. AIDS, 2 (supp), p. s71, 1988.

Shepard DS. Cost of AIDS in a Developing Area: Indirect and Direct Costs of AIDS in Puerto Rico. Economic Aspects of AIDS and HIV Infection. 1990.

Sokal, D. Update on Modeling and Analysis of the AIDS Epidemic in Malawi. March, 1991.

Tapia-Conyer, R. The Economic Impact of AIDS in Malawi: Research Project Feasibility Visit. September 21 - October 7, 1989.

Tuju R. What Will AIDS Cost You? Now Magazine, September 29, 1991.

Turchi B. How Economics, Psychology and Sociology Might Produce a Unified Theory of Fertility and Labor Force Participation, January, 1990.

UNDP. Human Development: From Poverty to Self-Reliance - A Focus on Local Participation. 1991.

UNICEF. The Situation of Children and Women in Malawi. Sept. 4, 1987.

UNICEF. Global Goals\Malawi Situation 1990. 1990.

UNICEF. Poverty in Malawi - Situational Analysis. August 27, 1991.

USAID. Africa - Malawi: Selected Statistical Data by Sex. July, 1983.

USAID. Malawi. Annual Budget Submission, FY 1993. July 1991.

Viravaidya M, Obremskey S, et al. The Economic Impact of AIDS on Thailand. October 1991. Unpublished.

West P. The Cost of AIDS: Discussion Paper. Journal of the Royal Society of Medicine. 81, September, 1988.

World Bank. Malawi: Employment Aspects of Economic Development. May 6, 1981.

World Bank. Staff Appraisal Report: Malawi Second Family Health Project. 1987.

World Bank. Malawi Public Expenditure Review. April 7, 1990.

World Bank. Staff Appraisal Report: Republic of Malawi Population Health and Nutrition Sector Credit. February, 1991.

World Bank. Malawi PHN Sector Credit and 2nd Family Health Project, Mission AIDS-Memoire. Nov. 25, 1991.

World Health Organization. Evaluation of the Strategy for Health for All by the Year 2000. p.143.

World Health Organization. Malawi Faces Shortage of Counsellors. AIDS Analysis Africa, September/October, 1991.

World Health Organization. AIDS: Beyond a Health Crisis. World AIDS Day Features, 3, 1991.

Yelin E, Greenblatt R, et al. The Impact of HIV-Related Illness on Employment. American Journal of Public Health. 81, 1, p. 79, January 1991.

Volume II

ANNEX C-1

ASSESSMENT OF MOH IMPLEMENTATION CAPACITY FOR THE USAID STAFH PROJECT

DIANE CHARRON
LILONGWE, MALAWI

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1. Introduction

1.1 Background

USAID is in the process of defining a project aimed at supporting Malawi in the expansion of its national population/child spacing and AIDS prevention programmes through the 1990s. This project will consolidate, rationalise and expand on the present activities currently being sponsored by the US mission through an eight year allocation programme called "Support to AIDS and Child Spacing" (STAFH)

This paper is to assess the capacity of the Ministry of Health to expand and sustain Child Spacing and HIV/AIDS prevention services within the framework of the USAID STAFH project.

The Government and the Ministry of Health have developed policy and programme documents as well as strategy papers on strengthening the structure and the delivery of services in the health sector. The donor community has produced an impressive number of studies, assessments and review documents on the sector, on the organisations involved as well as on the different health programmes in Malawi. Position documents for the programme elements of this particular project have also already been developed: the USAID/Malawi AIDS Prevention and Family Health Paper, and the Detailed Outline for Child Spacing Strategy for STAFH Project. They describe the present situation of these programmes, propose appropriate strategies and implementation plans to achieve STAFH objectives.

This paper assumes that the readers are already aware of most of this information, It presents a succinct description of the present situation, focusing on those that have particular implications for STAFH, then discusses the interventions that must or should be included in the design of the project to lift or alleviate the major MOH constraints to its success.

In order to identify the constraints that would affect the Ministry of Health in its capacity to implement the activities of the STAFH project, we will review the following:

(1) The relevant national policies for the health sector in general and for the two programmes that will be included in STAFH

(2) Management practices and systems in the Ministry of Health (MOH)

(3) Availability of resources, both finance and human resources.

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II. Requirements of the STAFH Project

Based on the position papers already mentioned, the management and implementation of STAFH will add significant requirements to what is already in place in MOH.

Briefly, the strategies recommended for both programmes will have the following requirements:

1. Policy

The implementation of STAFH will be influenced by the policy position taken in many areas: some related to management structure, some to the AIDS programme, the Child Spacing programme and eventually, to the Population Policy.

2. Management Practices and System

The strategies proposal for the project will require:

- additional service delivery sites for the child spacing activities,
- better facilities and equipments,
- better availability of appropriate supplies,
- logistic support and record-keeping,
- increased IEC material,
- an increase supervision network at administrative, motivational and technical levels and
- extended coordination with existing community systems.

3. Availability of Resources

(A) Funding: The expansion of services will require significant financial input, which will initially be covered by the project. Some of those costs will eventually have to be born within the MOH or GOM budgets.

(B) Human Resources: The implementation of the strategies will imply:

- increase in number of health staff on delivery sites,
- training of health service providers,
- training of CBD agents and supervisors,
- operation research capacity.

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III. Policy

1. Management Policy

The major policies for the Health sector are contained in Devpol and the National Health Plan of Malawi (1985- 1995). They spell out the following policy issues that may influence that STAFH project: the GOM will:

- expand the amount of resources allocated to the Health Sector,
- decentralise health services through allocating more funds to the peripheral units,
- add more emphasis on preventive health services,
- adopt Primary Health Care as the major philosophical underpinning of the health delivery systems,
- promote the concept and practice of child spacing, and
- encourage the coordination and the assistance of all partners in the health sectors.

The GOM also identifies MOH as having the primary responsibility for developing policies, planning strategies and programmes for health care in Malawi and for ensuring the quality of that care through monitoring and evaluation.

Two additional policy documents are now being developed which will have impact on the implementation of the Child Spacing and HIV/AIDS Prevention programmes. These are a Population Policy for the country which is expected to be ready by November 1992 and a Manpower Policy for the Ministry of Health, which is due in June 1992.

2. Programme Policies

2.1. Child Spacing

Policy positions in Child Spacing date back to 1983. As stated, they put constraints on the modernisation of practices and activities that could be supported by the STAFH project.

The Ministry of Health has already undertaken steps to update the country's policy on Child Spacing. In preparing the National Population Policy, a meeting of the Principal Secretaries of the GOM was called in October of 1991. They recommended the following measures:

- that the current contraceptive guidelines be reviewed to expand availability of methods to all who seek it,

- the expansion of facilities and providers of services,

- the involvement of TBAs, HSAs, other extension workers and NGOs in child spacing activities,

- that more and better training be given,

- that a comprehensive multi-sectoral population strategy give priority to child spacing, and

- that all health training institutions include training in this area in their curriculum.

These recommendations are being considered for the new guidelines being developed for the programme. Some raise sensitive issues such as access to contraceptives, requirements for prescriptions of selected methods and who can select or deliver various methods. The Child Spacing Section estimates that these issues will be resolved within a year. The speed and outcomes of these discussions will impact on the results of the activities targeted by STAFH.

2.2 AIDS Prevention

Reprogramming documents prepared by the Ministry in October 1991 for the Malawi AIDS Control programme set priorities which will facilitate support from STAFH. The Ministry stated that it would:

- continue the decentralisation of Aids Control activities to the regions and districts.

- increase targeted education to students, youth, and high risk population

- expand HIV testing and counselling capacities, and

- improve the diagnosis and management of STDs.

As we are seeing, the current policy positions taken by the GOM can be deemed as generally conducive to the type of funding and activities available through the STAFH project.

3. Policy Implementation

However, the degree of implementation of these policies still represent some serious stumbling blocks that could significantly delay or even jeopardise some of the outcomes of STAFH.

3.1 One of these hurdles is the cumbersome and time consuming decision -making and approval structures set up to support or apply these policies. In many instances, the lack of efficiency

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and speed with which decisions are being taken is putting significant stress on the programmes. Examples cited have included the approval of IEC materials which have sometimes taken well over a year, the ratification of the HSA job description, the acceptance of updated information on AIDS and the role and participation of all the relevant organisations and donors in the application of those policies.

3.2 Another key factor to consider is the substantive shift in attitudes required for most Malawians implied in some of the new principles espoused both for AIDS and child spacing. The serious consideration and open discussion of child spacing methods and AIDS prevention by large segments of the population will reuire extensive support by a broad spectrum of organisations, efforts that will probably be spearhead by the health care system. It would be foolhardy to underestimate the effort required to foster these new attitudes to a whole cadre of health management and workers. We are thinking here for example of the implications that a more liberal attitude towards child spacing and a more open and dialogue oriented approach to AIDS prevention will have on the training and delivery systems in MOH. Providers and motivators of these services would require even additional support systems and increased levels of individual information and skills if they are be asked to mobilise and support private organisations, NGOs and/or community groups.

IV. Management Practices and Systems

1. Context

1.1 The GOM is decentralising the delivery of services in the health sector. The Ministry of Health has expanded much effort in rationalising this decentralisation in the public and private sectors. It has clarified roles and responsibilities and developed coordination mechanisms with all relevant partners.

1.2 Within the Ministry itself, a new organisation structure has been drawn up and has been partially implemented. At Headquarters, functional divisions have been set up. In the three regions, the organisation has been partially staffed, although the allocation of establishment and financial resources has been going very slowly. Some activities are gradually being sent and supported at the regional and district levels.

1.3 To consolidate the decentralised structure, the Ministry has recognised the need to proceed to a formal delegation of authority to all levels of the organisation. This extensive delegation review will include the planning, financial management and personnel management activities within the Ministry. Clearer delineation of authority in these management areas, especially with increased delegation to lower level managers, would simplify the administration of project activities.

2. Management Capacity

Numerous studies and reports emphasize the need to strengthen the management capacity of the MOH. The Malawi Institute of Management for one did an assessment of the management training needs for middle and senior managers of the Ministry in April of 1991. It did highlight key issues in terms of management capacity in the Ministry.

The study acknowledged some key management issues that are having impact on the Ministry: lack of clarity of roles and responsibilities, the need to define, design and implement planning, budgeting and control mechanisms within the Ministry and the need to identify information requirements for management purposes

The study also found that twenty-five per cent (25%) or more of the managers sampled acknowledged performance in areas dealing with planning, managing the financial resources of their units, managing their staff and assessing the performance of their unit.

As to the management and supervision skills available at more junior levels and at the peripheral service levels, no information is available. We can safely assume that training in management has been almost non-existent for supervisors in these positions.

Such findings denote the importance of including management support activities in a project such as STAFH.

3. Implications for STAFH

The decentralisation of service delivery of the Ministry does support the potential STAFH strategies of focusing on peripheral and community involvement. However, considering the lack of decentralised systems, of strong management skills and of required management information, STAFH should support most of the functional activities of the headquarters units that will administer the project; that will include planning, budgeting, advising, training and monitoring capacities.

3.1 In terms of planning, both the AIDS and Child Spacing programmes have set-up a planning exercise where the districts, through the regional offices, propose a plan to be implemented in the next fiscal year. The PHICS provides the necessary support on the AIDS programme. What remains to be done on the Child Spacing side is to set up a budgeting exercise that would operationalise this planning.

3.2 The project will also have to identify and come to agreement with Ministry as to the network of supervisors, providers and motivators that will implement the activities.

V. Availability of Resources

1. Financing

1.1 GOM Financing

The GOM has set its national priorities for the country in the "Statement of Development Policies 1987-1996" (Devpol). In this document, the government states that the health sector will be one of the few to be allowed an increased in resources over this ten year period. Through the Population, Health and Nutrition Sector Credit of the World Bank, the GOM has been more specific; it is committed to provide an increase in the annual health recurrent budget so that the health share of the national budget would reach at least 9.1 per cent by 1995/1996 fiscal period. According to figures provided through the government, it is increasing its allocation to health, going from 7.2% in 1988-89, 7.3% in 1989-90, 7.2% in 1990-91, 7.2% in 1991-92 and 6.6% in the projection for the 1992-93 fiscal year.

The budget of the Ministry for the Personnel Emoluments related expenses (mostly salary) is estimated to be around 21.8 million Kwachas out of the 84.3 million Kwachas budget allocated in the Estimates of Expenditures on Revenue Accounts for 1992/93. This represents 25% of the budget.

So far, the degree of government funding in the recurrent budget of MOH poses serious questions and perhaps limits on the sustainability of such a substantial input into MOH health activities. The capacity of the government to expand the budget support needed to integrate significant additional salary expenditures that would result from such a project cannot be taken for granted.

1.2 Donor Funding

The Ministry is heavily supported by donor funding. In the development budget of MOH, between 80% to 85% of expenditures are usually donor funded. We have been unable to ascertain the proportion of the recurrent expenses that are now being donor funded. A paper assessing the financing elements as it pertains to the STAFH project is to identify the extent of donor funding in the Child Spacing and AIDS programmes.

2. Human Resources

There are two main issues relating to the availability of human resources in MOH that are linked to implementing additional

services in the child spacing and AIDS prevention programmes. These are the number of personnel available within and to the Ministry, and the level of knowledge and skills in the two programme areas.

2.1 In 1988, the Complement and Grading Review Report done by MOH provided a comprehensive establishment review of the Ministry to determine the appropriate levels of staffing for the reorganised MOH. The report based its recommendations on a conservative estimate of the minimum number of staff in each category of health care to serve the total population of Malawi. The establishment of the Ministry at that time was 4,958. The projected requirement for 1996, if the planned system was to be adequately staffed, was an establishment of 10,000. Over the last four years, the Ministry has not kept pace with the level of staffing required to achieve this level. As of 1992-93, the Ministry has an allocation of5,726 posts. There are no reliable figures as to the number of employees actually occupying these positions.

The vacancy rate could be a very significant factor in assessing MOH capacity. There is great difficulty in obtaining accurate up-to-date statistics on vacancies. The Malawi Institute of Management undertook a study in February,1991, which provides us with some data: they estimated a 34.9% vacancy rate for positions of Administrative Officer/Professional Officer and above for government as of December 31, 1990.

The MOH vacancy rate for that same category was set at 68.7%, which means that over 60% of the Ministry's administrative and management positions could in fact be vacant. This information indicates that the already inadequate resourcing situation described at the establishment level is compounded by very significant vacancy rates in this crucial employee categorie which represents about 6.2% of the total establishment.

In addition to its establishment, the Ministry is maintaining what is estimated to be a significant numbers of non-established posts. The numbers are unavailable from the Ministry. Non-established posts imply lower salary structures, no job security and minimal benefits for the occupants.

The above paragraphs illustrate clearly that the country does not have the number of health personnel it requires to meet its needs. Increased efforts are being expanded, especially through the support of the donor community,to accelerate the output of the country's health training institutions. Taking these efforts into consideration, the projected results for some of the key health cadre over the next eight years are shown in table 1. This table shows a continuing shortage of trained resources in the health groups that are likely to be involved in the implementation of STAFH activities at service delivery levels.

MOH's Manpower Development Unit is preparing an assessment of what has been achieved so far and what the Ministry should now be planning for over the next 5 years. This plan is scheduled to be available for June, 1992.

In order to expand the Ministry's capacity to deliver programmes at the periphery level 3,500 new HSAs are going to be recruited and trained through donor support in the next four years. Funding has been found and recruitment and training has started. MOH management is still in the process of developing the implementation plan. This cadre of personnel has been identified as the potential coordinator and implementer of STAFH activities.

2.2 Specific units within the Ministry for which the Stafh project is likely to provide significant support are the Child Spacing Units, the AIDS Secretariat, the Health Education Unit and the Central Medical Stores.

2.2.1 The structure for the Child Spacing programme is as follows: at the central level, the Child Spacing Section is in the Health Preventive Services, under the Family Health section. The Unit presently has .5 staff on an acting basis out of a possible establishment of one on the organogramme. (Annex 1)

The World Bank is presently sponsoring the staffing of three more positions in the unit. The Ministry is negotiating to establish two more position that would work for both the Child Spacing and the Traditional Birth Attendants sections. The role of this unit is being modified with the setting up of the National Family Welfare Council. The MOH will now be concerned solely with the Ministry's activities. Its focus is on planning, training and data gathering activities.

At the regional level, The Public Health Nurse is responsible for the child spacing activities. Her activities include guiding the districts technically, interpreting policy for them and supporting them through training and supervision. Her workload also encompasses many other activities.

At the district level, the District Public Health Nurse is designated responsible for the implementation of services through static and mobile clinics, where they exist. She is assisted by one or two Family Health Coordinators. All this personnel is also involved in many activities besides child spacing.

In rural hospitals and health centers, one of the Enrolled Nurses is assigned to be responsible for the child spacing duties among others.

At the community level, few activities are presently being coordinated. Some TBAs have been trained to act as motivators.

2.2.2 The AIDS Control programme organogrammes(Annexes 2 & 3) describe the national management structure chosen for the programme. The National AIDS Committee plays the policy role while the AIDS Secretariat, reporting directly to the Principal Secretary of Health in MOH, coordinates and manages the AIDS programmes for the country.

The structure provides each region with two Regional AIDS Coordinators (RAC) which work exclusively for the programme. These are staffed in two of the regions. Each regional AIDS programme also has full-time accounting capability. The RAC are supported in each district by a coordinator that cumulates AIDS activities with their other duties.

In-service orientation for the Ministry workers is being done though the support of the PHICS project. Almost all Ministry personnel have had an information session on AIDS. Over 160 doctors, nurses and clinical officers have been trained as trainers in the counselling skills required for AIDS clients. They, in turn, have trained about 1,000 health workers at the district level and within the PHAM network.

2.2.3 A new structure for the Health Education Unit (HEU) was proposed in 1990 (Annexes 4 & 5). One of the objectives of this exercise was to expand the services of the unit, adding a social mobilisation capacity to the IEC mass media and material production activities already partly staffed and operating. A second objective was to decentralise and expand services to the regional and district levels.

At headquarters, the unit has no permanent management staff and has 14 (about 35%) of its technical positions filled. In the regions, Regional Health Education Officers have been staffed while the Ministry is still awaiting the nomination of its 24 District Health Officers which were interviewed in May 1991.

The Ministry is instituting a HEU Programme Planning and Operating Committee to better priorise and coordinate its activities among its many clients.

3. Implications for STAFH

3.1 In order to rationalise and utilise the resources made available through STAFH and to support the labour intensive activities that will have to be performed, coordinated and or supervised by its personnel in these two programmes, the Ministry would have to decide that these objectives shall become priorities for MOH, knowing that there will be a cost to other activities that also need to be performed. (At this point, with the fragmented information available, no one can specify what or how much of other activities will have to be curtailed, and what will be the real impact on clients to devoting resources to these two programmes.)

3.2 Should these programmes be deemed to take priority over others, a concern for the implementation of STAFH still remains.

3.2 Should these programmes be deemed to take priority over others, a concern for the implementation of STAFH still remains. That is the issue of how momentum for the programme can be sustained over many years, knowing that its implementers are besieged by numerous other activities that they will perceive as just as important and at times much more urgent.

3.3 HSAs have been cited in other papers as possible implementers of some activities of STAFH within MOH. Before the HSAs can be considered as a viable workforce for STAFH, many issues still remain to be dealt with, issues such as: (1) finalising the description, (2) developing an effective training package and plan, (3) conducting the training, (4) devising a recruitment and deployment strategy, (5) clarifying roles and relationship to other community level workers and (6) identifying an appropriate supervisory relationship with health center staff.

3.4 In Child Spacing, the key constraints that the Ministry has identified for the programme in the personnel area are the limited amount of trained personnel to provide services; difficulty in Child Spacing Services in deploying the trained personnel due to shortages of staff in the general pool; graduates from training institutions not being fully qualified in this area, leading to large numbers of in-service training courses; and, inadequate supervision because of the number of other activities these supervisors are involved in.

3.5 In addition to these concerns, the new policy recommendations alluded to in section II.2.1 of this report are already being addressed through the development of new Contraceptive Guidelines supported by a procedures manual. This creates the need for a reorientation programme for all supervisors, providers and motivators.

3.6 One type of training that has not been available is related to the community mobilisation skills that are useful for expanding child spacing and AIDS prevention activities into the community.

VI. Strategies for STAFH Support to MOH

We will now focus on the support STAFH can provide to the Ministry of Health in view of the project objectives.

Ideally, the design of a project of this magnitude should strive to benefit the host organisation on as many levels as possible. In this case, while the objectives are aimed at two programmes in particular, the description of the constraints faced by MOH strongly support the need for organisational development, through building and/or expanding management and technical capacity.

As much as possible, the strategies and funding should accommodate the extra efforts required to develop and integrate

the types of skills, systems and coordination mechanisms that go beyond the parameters of the project and that can be extrapolated and used by other parts of the organisation.

Some guiding assumptions are retained for the strategies proposed: there is a limited number of health personnel in MOH which has to cope with a heavy workload and inadequate resources; there is no other pool of trained health personnel to build up other sectors for this project; and the more likely scenario for the project will be a TBD approach with supervision and training required both within MOH and in community settings.

1. Coordinate STAFH project in the Public Sector

The Ministry will coordinate and manage the project in the public sector. The main activities involved will be linked (1) with coordinating the project with the USAID STAFH personnel, (2) with implementing specific services, (3) with managing expansion agents especially in the areas of training and providing technical supervision, (4) and also with monitoring of the programmes.

The coordination of the project for the Ministry will require sustained effort and consistent follow through. With this in mind, there should be one officer within the Ministry who can be devoted exclusively to the coordination of the project. STAFH should provide the Ministry with a project coordinator, one that is already familiar with coordinating projects in the health sector in Africa and is capable of providing support in management practices and systems. This project coordinator would be housed within the Ministry either in the Planning Unit.

2. Strengthen Functional Role within the Ministry

2.1 STAFH will need to strengthen programme units so that they can more easily perform the functional activities assigned to them. The main activities involved will be steering policy direction, doing programme planning, providing expertise and training in Child Spacing or AIDS prevention, evaluating the programme and playing a coordination role for the programme.

To achieve this, an activity to be built into the initial setting up of the project should be a five day workshop with all the senior management teams involved with the MOH segment of the project, i.e. AIDSCAP and the MOH Planning, Child Spacing, AIDS Secretariat, HEU and CMS units. The objectives of this workshop would be to clearly define the roles and responsibilities of each, to spell out the management practices and systems that will be needed to successfully support this project and to come to terms with the expectations of the project.

Periodically during the project there should be general national conferences, joint planning and review workshops as well as coordination meetings at different levels of the MOH organisation.

2.2 For the Child Spacing programme, support will center around providing additional staff at the central and regional levels. In a first phase of the project, that staff should concentrate primarily on providing technical and motivational supervision to the delivery units, on training, on setting up support to build the training and monitoring capacities.

At the regional and district levels, the structure implemented by PHICS for the AIDS programme would serve as a good model to organise Child Spacing activities.

2.3 One noticeable characteristic of the staffing situation in the AIDS Secretariat is the amount of technical assistance already in place, heavily supported by the donor community. This project should be designed to promote local capacity.

In AIDS Secretariat, particular support is required in its IEC activities. STAFH should promote an overall plan to integrate the production of all IEC material in the most efficient manner, through supporting the HEU.

The AIDS programme group will also need strengthening in setting up numerous systems, for example, a partner notification system and additional information systems.

The training capacity building described in section VI.4 of this report should also include the training activities conducted in the AIDS programme.

2.4 In the proposed strategies for the implementation of the project, the availability of adequate training and information material plays a prominent role. The Health Education Unit is the main source of this material. As we have seen, much support is still required to resource the HEU to a level where it can comfortably achieve its role especially within additional requirements put upon it by the two programmes in STAFH.

This ideally will imply combining Headquarters IEC resources. The AIDS IEC group is presently being moved into the HEU premises in an attempt to increase and speed up production of needed material.

The Unit also needs to be provided with some technical assistance which would compensate for local capacity gaps. These gaps would be identified through a short study that would assess private sector as well as Ministry capacity. Local private organisations which can reliably produce the quality material needed by

Ministry programmes should be encouraged to do so especially in the Material Production activities such as audio-visual production and graphics skill and in the reproduction and printing of materials.

The unit will need project support to staff some of its positions. Skills they are requiring may be filled through requests to international volunteer organisation: skills in audio-visual, graphics, photography and publication.

Due to serious constraints and delay faced by the unit in getting material printed through the government machinery, STAFH should consider providing HEU with minimal printing capacity for simple pamphlets and posters.

2.5 Support for the Central Medical Stores should focus on better management system for procurement and distribution of contraceptives. Technical assistance will be required to strengthen needs forecasting, monitoring and distribution system and for supporting a training needs analysis in these areas and providing initial training.

3. Support Service Delivery Units

Based on the overall plan of the project, USAID project staff will collaborate with the Ministry to develop subplans for major components of the implementation activities such as recruitment and development plans, training programmes, evaluation strategies... . These exercise will be managed by the MOH Project Coordinator.

These plans will aim at reinforcing and resourcing units that will have to implement the programmes. This will be done by developing and maintaining decentralised management systems for planning , accounting and monitoring purposes, probably at the district level, depending on the configuration chosen for CBD activities.

Supervision responsibilities allocated at district and peripheral levels will be supported by minimum of basic training and a reliable supervision structure. This implies that the roles and responsibilities will be defined, reporting relationships will be spelled out and accepted, contacts point for problem situation will be specified and contacts and feedback maintained from one level to the next. Again, the Project Coordinator will be key supporting the development and maintaining of the network.

4. Set up a Training Capacity

4.1 The strategies proposed for the project imply a capacity to develop and conduct extensive training in the Child Spacing and AIDS prevention programmes. This capacity does not exist in the Ministry at this time. The project will have to set up and

sustain a well developed training system if it hopes to attain the level of intervention it is aiming for among the health workers and community at large. This will include adopting a systematic approach to training, developing a strong cadre of training of staff and supporting an infrastructure for the training activities.

The goal is to develop and implement the most cost-effective and efficient in-service training interventions for MOH programmes, in this case child spacing and AIDS prevention. Considering the significant amount of resources that will be devoted to training and information in the next year in these programmes, systems and expertise should be put in place to ensure the relevance, the quality and impact of those activities. A viable scenario follows, describing the major roles and responsibilities, the type and level of resourcing required.

4.2 In Headquarters

The Training Section will develop a policy that will guide all training programmes within the Ministry (such as a System Approach to training) and provide expertise on how to implement programmes that are consistent with the approach. They will support and gather information on training plans related to the programmes of this project. The incumbents will also monitor the quality of the training materials developed by the programme or services units involved. The Unit already has two unstaffed positions available on the training side that could be earmarked to provide the services.

The programme units (Child Spacing and AIDS Secretariat) will:

(1) elaborate, in collaboration with USAID STAFH project, effective training and information strategy to meet Programme and STAFH objectives,

(2) plan all needed training

(3) identify trainers and negotiate their availability,

(4) develop curricula for training the trainers of the programmes and the service providers,

(5) conduct Training of Trainer as required,

(6) initiate and coordinate production of IEC material that will support the training.

The HEU will develop and reproduce the training and information materials required.

4.3 At the Regional Level

Coordinators will be responsible for monitoring the implementation of the training plan, for conducting TOT and or other training as identified in the plan, and for adapting training materials to fit local circumstances and for providing supervision to staff responsible for implementation the training.

For AIDS prevention, coordinators have already been set-up in two out three of regions under the PHICS project and assuming the responsibilities pretty much as described. It has already been recommended in this report that a similar structure be implemented for child spacing.

5. Provide Orientation Training for Programmes Implementers

In child spacing all supervisors, providers and motivators will have to undergo an orientation workshop that will minimally inform them of the MOH's new approach to child spacing, familiarise them with the revised Guidelines and any new protocols. Ideally, this training will also equip them to foster attitude and behaviour changes within the health worker support community as well as for clients coming in for treatment or counselling. In terms of numbers, aside from the technical staff, if the project were to use the HSAs as their main contact point at the periphery level, we can estimate that 3,500 to 4,000 would have to be trained as providers and motivators. In addition, the HSAs in turn would have to provide minimal training and supplies to a community network in order to have a reasonable catchment area covered.

In HIV/AIDs prevention, basic orientation training is already covered by the PHICS project. However, the strategies described in the USAID/Malawi AIDS Prevention and Family Health Project Paper require a strong component of work at the patient and community level to develop awareness and foster behaviour change related to AIDS prevention. Although, as we have stated, some health professionals have already received training, the levels of communication skills needed are not prevalent in health professionals or community workers at this stage. In addition, cultural patterns seem to proclude easy dialogue on such topics. We must then assume that if this strategy were to be adopted, an intense and sustained training effort will have to be initiated, with initial reliance on external technical assistance.

Personnel having supervisory duties would also need to be trained on some of the basic supervision, through a 3 days module added on to their other training.

6. Strengthening Technical Assistance

Most literature assessing the impact of technical assistance have assistance have voiced serious concerns about the amount of benefits derived from the resources being invested when transfer of skills is a major objective of the contract.

In contemplating the strategies forwarded for the STAFH project, we can assume that there will be a significant amount of resources earmarked for this type of technical assistance.

In the same light as this paper has recommended supporting a strong management effort for the MOH component of this project, it is recommending that specific attention be given to support and maximise technical assistance efforts.

Specialists for technical assistance are recruited based on competency in their professional domain. We are recommending that in order for these individuals to adapt, understand the situation they are dealing with and get to a level of influence with their counterparts quickly enough to be successful, the project should explicitly manage and support their transfer of skills efforts.

The activities will include:

(1) giving orientation to the country and the Ministry, specifically dealing with the values, rituals, decision-making structure and influence networks in place,

(2) setting up a work review process with learning objectives set for the counterpart, and regular discussions on the progress achieved and the difficulties encountered.

(3) and having a support network set up for the expatriates (perhaps headed by the MOH Project Coordinator).

VII. Summary of the Report Recommendations.

In the light of the complex environment and numerous constraints faced by the Ministry, STAFH can be of support to MOH in numerous capacities. Here is a brief summary of recommendation from this report, where MOH and STAFH can be mutually supportive.

1. For the Ministry, it is recommended:

1.1 That priority be given by MOH senior management to amending and adopting policy and/or guidelines for the Child Spacing Programme.

1.2 That an explicit decision be made by MOH management as to the priority that should be given to AIDS and Child Spacing in

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light of its other programmes and as to the resourcing and support it deems necessary for these programmes both from inside the Ministry and projects such as STAFH.

1.3 That clear direction be given to training institution as to the requirements of the Child Spacing training in their curriculum.

1.4 Extended efforts be put in staffing positions as quickly as possible.

2. For STAFH, it is recommended:

2.1 That the STAFH project develop its management system and tools to support the decentralisation efforts of the Ministry. Specifically, this implies:

- strengthening the planning systems already in place, especially on the Child Spacing programme;

- strengthening the budget system of the Child Spacing programme, possibly through using the same disbursement mechanism used by AIDS at the regional and district levels and by providing accounting procedures and staff at those two levels;

- defining the information and control requirements at the onset of new project and assigning specific monitoring responsibilities in the Headquarters units of both programmes. STAFH will need to provide technical assistance to support these task and staff a local position in each unit to perform these duties.

- including a workshop of all key implementation management teams at the onset of the project to deal with and strengthen management of the project.

2.2 That feedback mechanisms, planning and review meeting and other incentives be built into the implementation of the project activities.

2.3 That the Project Coordinator for the public sector be staffed and included in the Planning Division of MOH.

2.4 That the MOH Headquarters programme units be supported through the following activities:

- For Child Spacing, that two positions be staffed, supported by one position of technical assistance. In the first phase of the project, focus will be in providing technical and motivational supervision and training support to delivery sites, on setting up support systems and on monitoring activities.

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For the AIDS Secretariat, support should focus on providing counterparts to the technical assistance already in place and on providing additional staff to focus on coordination with other GOM organisations and building monitoring and evaluation systems. This will require technical assistance supported by 2 -3 Malawian counterparts.

2.5 That a training capacity be built within the Ministry which will include:

- specialists training expertise in the Training Unit;

- development of well targeted and effective training programmes in Child Spacing and AIDS for training institutions and for providers and motivators within the Ministry and in the community;

- that the training network be strengthen for these programmes, through training of trainers.

2.6 That IEC capacity be enhanced through

- faster approval of material;

- easier access to basic material reproduction for the HEU, through provision of simple production capacity;

- strengthening the HEU. Part of the HEU needs should be met through private sectors capacity. The unit also needs staff in many area such as audio-visual production, graphics and its social mobilisation group.

2.7 That support be provided to the service delivery units by:

- providing district units with information on programme status and funding available at the onset of the planning exercises for the two programmes;

- making funding available to support activities forecasted in the plans;

- defining an adequate supervision network, in collaboration with Ministry management, and insuring that these are well communicated to staff;

- providing orientation training to all supervisors, providers and motivators involved in child spacing to update them on the new guidelines;

- providing basic supervision orientation to staff;

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- identifying and providing counselling skills to all providers and motivators that have not been trained;

2.8 That the technical assistance involving transfer of skills be supported and managed by the MOH Project Coordinator.

Table 1

A. PROJECTED STAFFING 1998 BASED ON CURRENT & PROPOSED TRAINING INTAKES

STAFF CATEGORY	TOTAL STAFF 1989 (A)	STAFF REQUIRED 1998 (B)	CURRENT TRG. INTAKES	1998 STAFF AT CURRENT INTAKE & DROPOUT RATE No. (C)	% (C)/(B)	1998 STAFF AT CURRENT INTAKE & 10% DROPOUT No. (D)	% (D)/(B)	PROPOSED TRAINING INTAKES	1998 STAFF AT PROPOSED INTAKE & 10% DROPOUT No. (E)	% (E)/(B)
Clinical Officer	212	448	25	273	61%	279	63%	50	314	71%
Medical Asst.	590	1897	60	878	40%	896	40%	260	982	56%
Registered Nurse	526	901	70	602	67%	634	70%	120	803	87%
Enrolled Nurse/M	1979	3548	151	2066	59%	2114	60%	260	2281	64%
Health Assistant	189	809	30	256	42%	257	42%	40	289	47%
Total	3476	7197		3885	54%	3970	55%		4469	62%

B. PROJECTED STAFFING 2000 BASED ON CURRENT AND PROPOSED TRAINING INTAKES

STAFF CATEGORY	TOTAL STAFF 1989 (A)	STAFF REQUIRED 2000 (F)	CURRENT TRG. INTAKES	2000 STAFF AT CURRENT INTAKE & DROPOUT RATE No. (G)	% (G)/(F)	2000 STAFF AT CURRENT INTAKE & 10% DROPOUT No. (H)	% (H)/(F)	PROPOSED TRAINING INTAKES	2000 STAFF AT PROPOSED INTAKE & 10% DROPOUT No. (I)	% (I)/(F)
Clinical Officer	212	480	25	294	61%	313	65%	50	437	91%
Medical Asst.	590	2036	60	744	37%	763	37%	260	1788	87%
Registered Nurse	526	1081	70	661	61%	761	70%	120	927	86%
Enrolled Nurse/M	1979	4254	151	2152	51%	2220	52%	260	2771	65%
Health Assistant	189	731	30	313	43%	315	43%	40	378	52%

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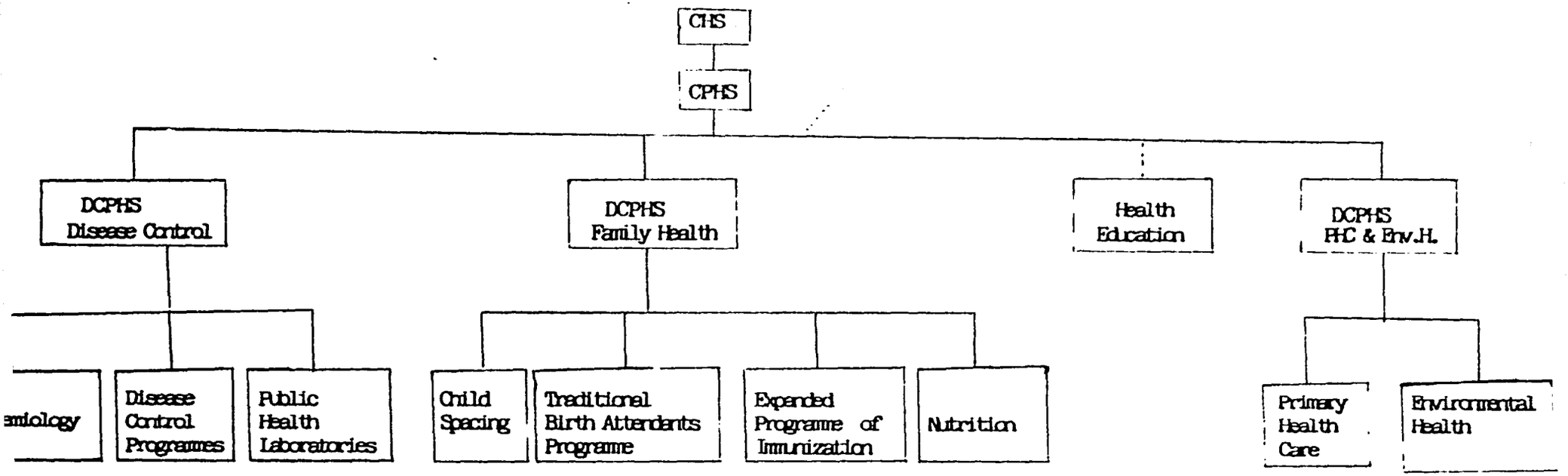
PREVENTIVE HEALTH SERVICES DEPARTMENT



Key

CHS —Chief of Health Services

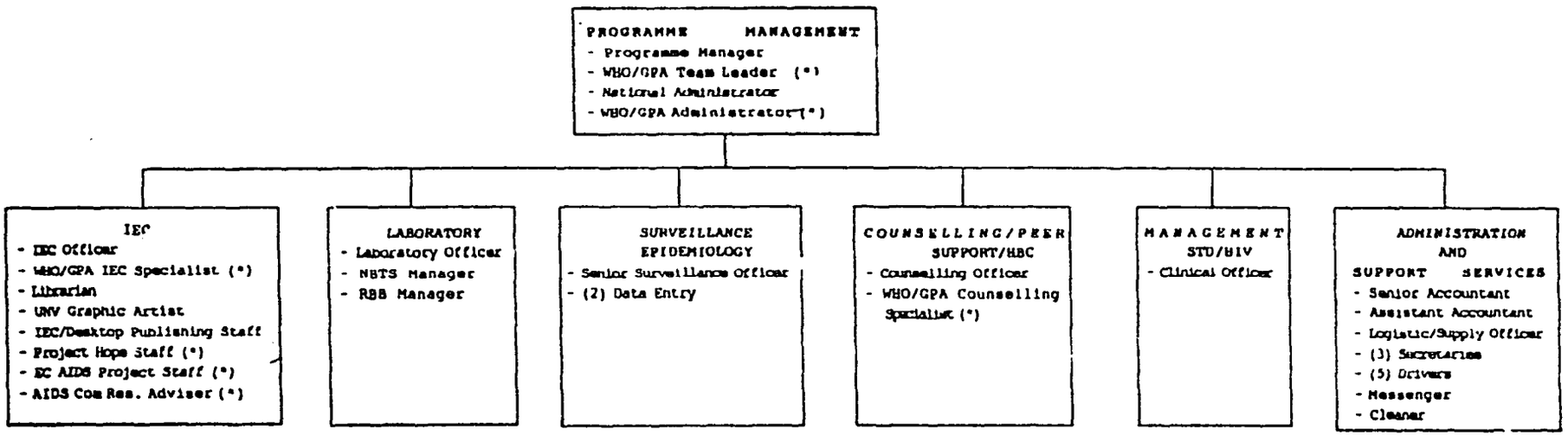
CPHS —Controller of Preventive Health Services

DCPH —Deputy Controller of Preventive Health Services

PHC & Env.H -Primary Health Care & Environmental Health

ANNEX 1

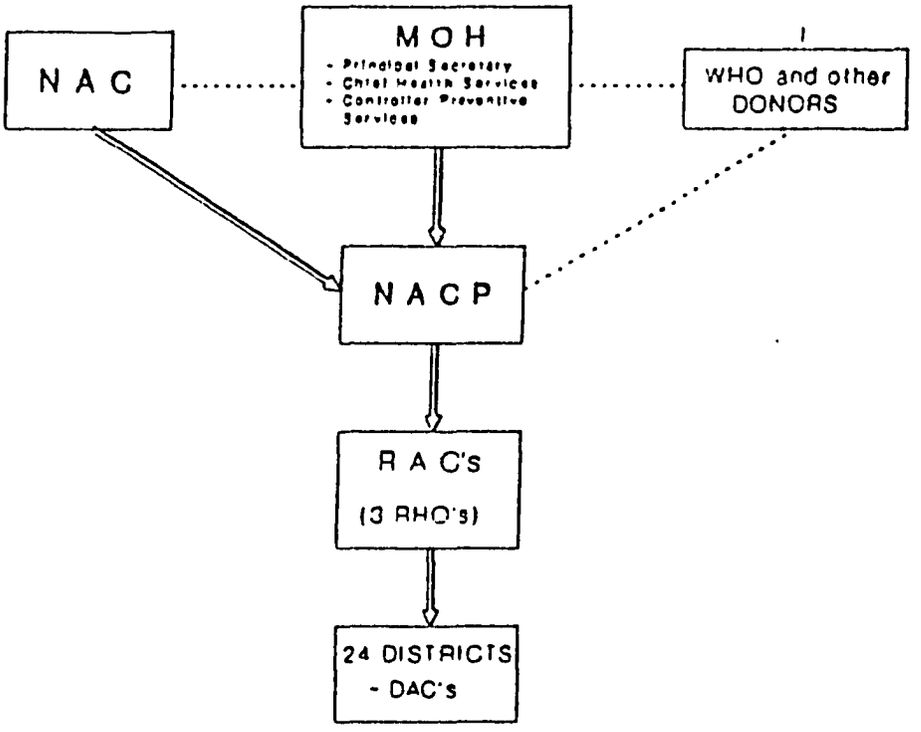
ORGANOGRAM FOR MALAWI NATIONAL AIDS CONTROL PROGRAMME



(*) - International Staff

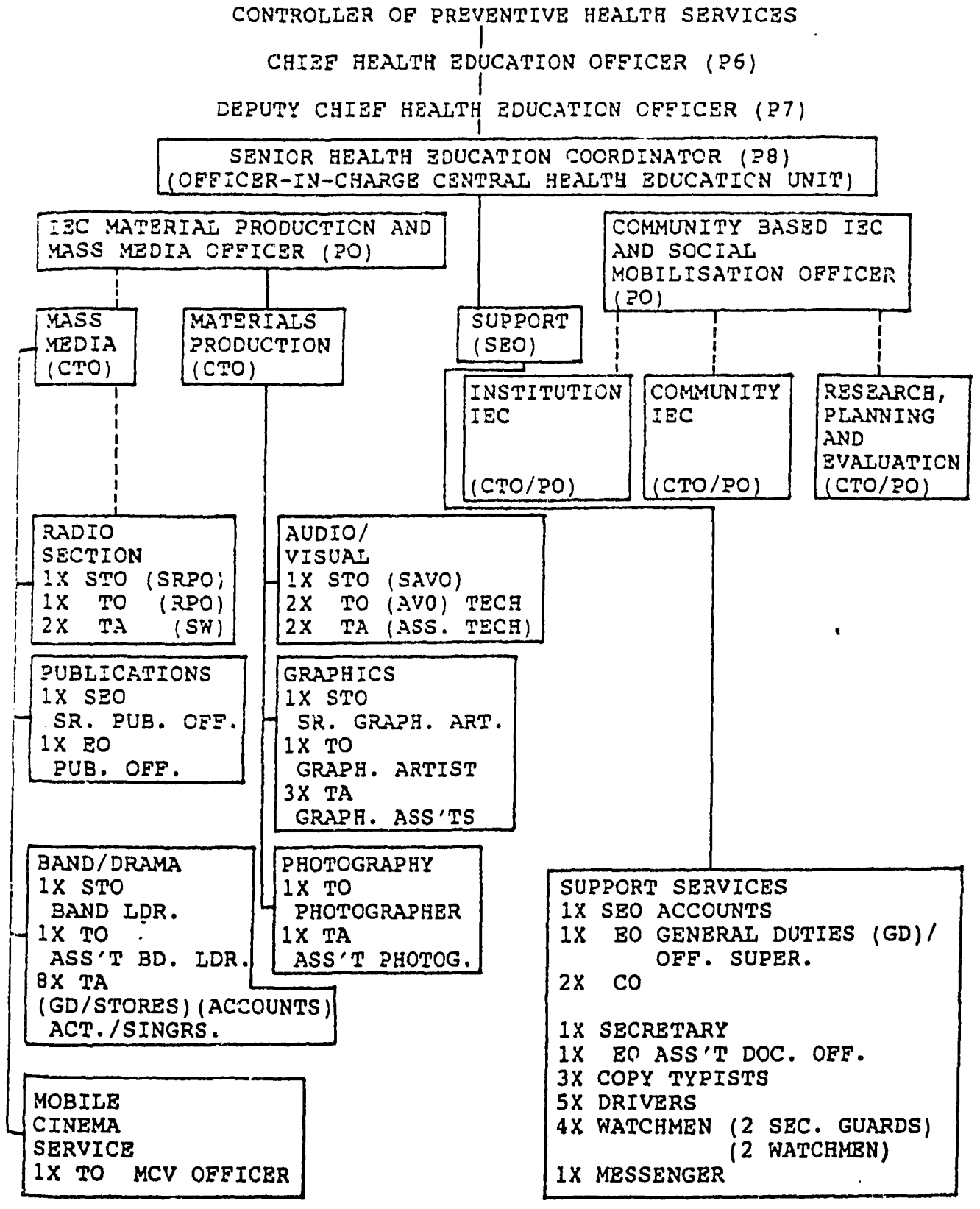
ANNEX 2

MINISTRY OF HEALTH ORGANOGRAM
FOR AIDS ACTIVITIES



ANNEX 4

CENTRAL IEC AND SOCIAL MOBILISATION UNIT



REGIONAL IEC AND SOCIAL MOBILISATION UNIT

REGIONAL HEALTH OFFICER

REGIONAL HEALTH EDUCATION OFFICER (P8)

COM.-BASED IEC
HEALTH ED. OFFICER (PO/CTO)

INST.-BASED IEC
HEALTH ED. OFFICER
(PO/CTO)

MATERIALS AND RESOURCES
Materials/Resource Officer (STO)

1X Senior Graphic Assistant (STA)
1X Mobile Van Officer (STA)
1X Puppeteer (TA)

1X Technician (TO)
1X Copy Typist (D3)
2X Drivers

DISTRICT IEC UNIT

DISTRICT HEALTH OFFICER

DISTRICT HEALTH EDUCATION OFFICER (STO)

ASSISTANT D.H.E. OFFICER (TO)

2x HEALTH EDUCATION ASSISTANTS (STA)

SPECIAL DISTRICTS (Zomba, Blantyre, Lilongwe)

DISTRICT HEALTH OFFICER

HEALTH EDUCATION OFFICER (PO/CTO)

SENIOR ASSISTANT H.ED. OFFICER (STO)

2X ASSISTANT H.ED. OFFICERS (TO)

2X HEALTH EDUCATION ASSISTANTS (STA)

HEALTH CENTRE

The Health Assistant and the Community Health Nurse will incorporate IEC activities into their daily work.

COMMUNITY

4000 Health Surveillance Assistants (GD) - Included in their overall daily activities will be IEC activities as stipulated on page 15.

ANNEX C-2

May 1, 1992

OPTIONS FOR THE MANAGEMENT OF SUBGRANTS IN THE PRIVATE SECTOR UNDER THE STAFH PROJECT

JOHN D. BLUMGART

PURCHASE ORDER 612-2-0111

TABLE OF CONTENTS

EXECUTIVE SUMMARY

A major aim of the STAFH Project is to support the strengthening and expansion of services for AIDS prevention and child spacing within the private sector. To this end, the project contemplates the provision of subgrants and services to private sector entities i.e, (a) non-governmental organizations, (b) agricultural estates, (c) private enterprises, and (d) parastatals. To accomplish this objective, consideration has been given to exploring whether several Malawian institutions might serve as subgranting intermediaries for USAID. Specifically, attention has been given to the Christian Hospital Association of Malawi (CHAM), the Council of Non-Governmental Organizations of Malawi (CONGOMA) and the National Family Welfare Council (NFWC).

1. CHAM and CONGOMA

Both CHAM and CONGOMA are "umbrella" organizations in that they each serve a group of independent entities. Each group wishes its umbrella to serve a liaison and information function, but neither group would wish to see its umbrella organization exercising grant making powers to its members. Histoically, the secretariats of both organizations have been quite weak and have limited resources. Therefore it has been concluded that neither organization has potential for becoming a subgranting intermediary for the STAFH project.

On the other hand, the CHAM Secretariat could provide valuable services to its member hospitals and clinics that would complement STAFH financial assistance and make it more efficient. Of particular note would be the strengthening of CHAM's national and regional primary health care facilities to support PHC work of CHAM's members with particular attention to CS and STD/HIV services. A second measure would be setting up a CHAM communications network so as to establish linkages with isolated units and enable them to draw on and share professional experience and lessons learned by other units. A third improvement would be establishing a CHAM management information system so that data from CHAM units can be stored and analyzed, trends detected and the impact of CHAM services can be measured. Such data would be of great value for STAFH monitoring and evaluation purposes.

CONGOMA may eventually have a role as a liaison and information sharing body among other Malawian NGOs providing health services. At present it is beset by problems arising from the dissatisfaction by its members and its donors for its lack of

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performance as a liaison, information center and advocate for the NGO community and, more recently, in connection with drought response preparations. CONGOMA's main donors, UNDP, UNICEF and OXFAM are planning to work with USAID's SHARED project in helping CONGOMA chart a new course. Thus, its situation is presently in flux and CONGOMA's relationship to STAFH, as well as the timing and nature of SHARED assistance to CONGOMA is a matter for the future.

2. National Family Welfare Council

The NFWC, although still in its infancy, is a parastatal institution to which the GOM attaches great importance. Other positive factors are its autonomous status, its authorization to serve both public and private sectors and its mandate to broadly promote the cause of "family welfare". Such a broad mandate could be construed to include not only child spacing but AIDS prevention. In addition, its founding legislation endows the Council with the "power ... to enter into any contract or agreement" and "with the approval of the Minister, to raise and receive funds and donations to be applied for family welfare activities." Thus legally the NFWC should be able to serve as a recipient or as a donor of subgrants.

However, the Council is not far enough along in its work to determine how these authorities will work out in practice. It is not clear at this time whether the Council could receive funds directly from a donor for subgrant or whether it would be obliged to deal through its parent ministry (MWCCS) as an intermediary. Neither is it clear whether donor funding would count toward, or be additive to, the annual budgetary "ceilings" imposed by the Ministry of Finance on government agencies. Relationships with the MOH and its AIDS Secretariat with respect to possible NFWC work in AIDS prevention remain to be sorted out. In any case, the NFWC is not staffed at this time to exercise a subgrant function. However it appears to have considerable potential for such a role if provided with technical assistance and encouragement.

3. A Management and Subgranting Mechanism for STAFH

It is therefore concluded that during the early years of the project a U.S. PVO or contractor should perform the subgranting function. The U.S. entity would be competitively selected on the basis of strong management as well as child spacing skills. The U.S. entity would work in coordination with specialists in AIDS prevention/control under a USAID buy-in to the AIDSCAP contract.

The U.S. PVO/contractor would establish from the very beginning close ties and linkages with the NFWC. STAFH should contemplate NFWC as its potential Malawian partner as a recipient of technical and management assistance from its PVO/contractor and AIDSCAP experts. Assistance from these two sources could perform a useful function in broadening NFWC's outlook to include greater emphasis on AIDS prevention and to encourage the coordinated approach - at least in the private sector - that STAFH is seeking. To this end, the project would provide CS and AIDSCAP advisers for the NFWC, finance training for present or potential NFWC staff and perhaps provide temporary funding to hasten NFWC staff recruitment until regular NFWC budgeted position become available.

The relationship between the U.S. entity and NFWC would evolve with time and experience. Initially, the U.S. entity would promote, help to prepare and receive proposals from the private sector, making subgrants to successful contenders and monitoring implementation. However, from the start, the U.S entity would work through a Malawian proposal review committee which would draw on the advice and viewpoints of such concerned agencies as NFWC, CHAM, the MOH and its AIDS Secretariat. The review committee might establish subcommittees in AIDS prevention and child spacing but their recommendations would be subject to review by the full committee to assure that both problems were taken into consideration.

Gradually, as the NFWC grows in experience and administrative capability and as the Malawian professional staff of the U.S. entity becomes increasingly proficient in their jobs. A gradual shift of function and staffing can be visualized with U.S. advisers to the NFWC being replaced by Malawian experts and administrators and the NFWC assuming a more and more substantial role of subgrant making and technical assistance provision in support of private sector child spacing and AIDS prevention.

OPTIONS FOR THE MANAGEMENT OF SUBGRANTS IN THE PRIVATE SECTOR UNDER THE STAFH PROJECT 1/

I. STAFH and the Private Health Sector

Given the severity of the population increase and AIDS epidemic problems in Malawi and the constraints faced by the GOM in dealing with them, it is logical and important that the STAFH project include a major private sector component. The private sector is a significant element of health care in Malawi and includes (a) non-governmental organizations (NGOs), (b) private companies,and (c) estates, and (d) parastatals (i.e. autonomous GOM entities, often revenue producing, like the airline).

Church affiliated NGOs have been in existence in Malawi for many years. More recently their work has been supplemented by the arrival of foreign voluntary groups (including U.S.) working not only in health but in other fields as well. Many of the Malawian parastatals (such as the railways, the airline and the electric company) provide health services to their employees and sometimes also to their dependents. The same applies to agricultural enterprises such as the tea, sugar, coffee and tobacco estates. The aggregate of these private health services, profit and non- profit, are said to account for some 30-40% of total health services in the country.

II. Umbrella NGOs and Parastatals

Within the first two categories (NGOs and Parastatals) a few "umbrella" organizations have been established for the purpose of strengthening and rationalizing their activities through the liaison, coordination and representation functions such structures can provide. They include CHAM (the Christian Hospital Association of Malawi), CONGOMA (Council of Non-Governmental Organizations in Malawi) and the NFWC (National Family Welfare Council).

The purpose of this section is to briefly review the structure and functions of these organizations with a view to their potential role as subgranting entities under the STAFH project.

1/ This paper was prepared pursuant to the scope of work shown in Annex D

A. CHAM

CHAM (the Christian Hospital Association of Malawi), hitherto PHAM, the Private Hospital Association of Malawi, was established in 1965 and is a loose association of 148 independent church- sponsored health units, both Catholic and Protestant. About half of these are engaged in community-based health care work. CHAM also operates nine training schools for various cadres of health personnel as well as training seminars in various subjects including primary health care and AIDS prevention.

Organizationally, CHAM is headed by an interdenominational Policy Council which function through an Executive Committee and five functional committees (see attached diagram). Day-to-day administration is performed by an Executive Secretary who heads CHAM's Secretariat. The Secretariat includes the following departments: Primary Health Care, Accounts, AIDS Control and Prevention, Administration, Nursing and Training. The Secretariat's operating budgets are largely financed by membership fees from CHAM's units and by overseas donations. The budget is subject to serious year-to-year fluctuations and straitened circumstances. Observors and parties that deal with CHAM, are critical of the Secretariat's leadership and of its financial management practices and capabilities.

CHAM's achievements, problems and plans were recently the subject of a three day "diagnostic workshop" (August 1991) sponsored by the AID-financed and EIL-managed SHARED project. The workshop identified a number of structural and management weaknesses in the CHAM organization including (a) the need to strengthen and reorganize its Secretariat , (b) improve manpower training and equipment, (c) reinforce its data collection and information dissemination system and (d) integrate its programs in primary health care, health centre supervision, maternal and child health work, and HIV/AIDS prevention and control.

Somewhat similar conclusions were reached in an OXFAM - sponsored evaluation of CHAM's primary health care (PHC) program conducted in February 1991. While the OXFAM report noted that CHAM had made "remarkable progress" in expanding the provision of PHC services among its member units through the work of its three Regional Coordinators, areas of weakness in the program included "support structure, program planning and implementation, community involvement and health information system."

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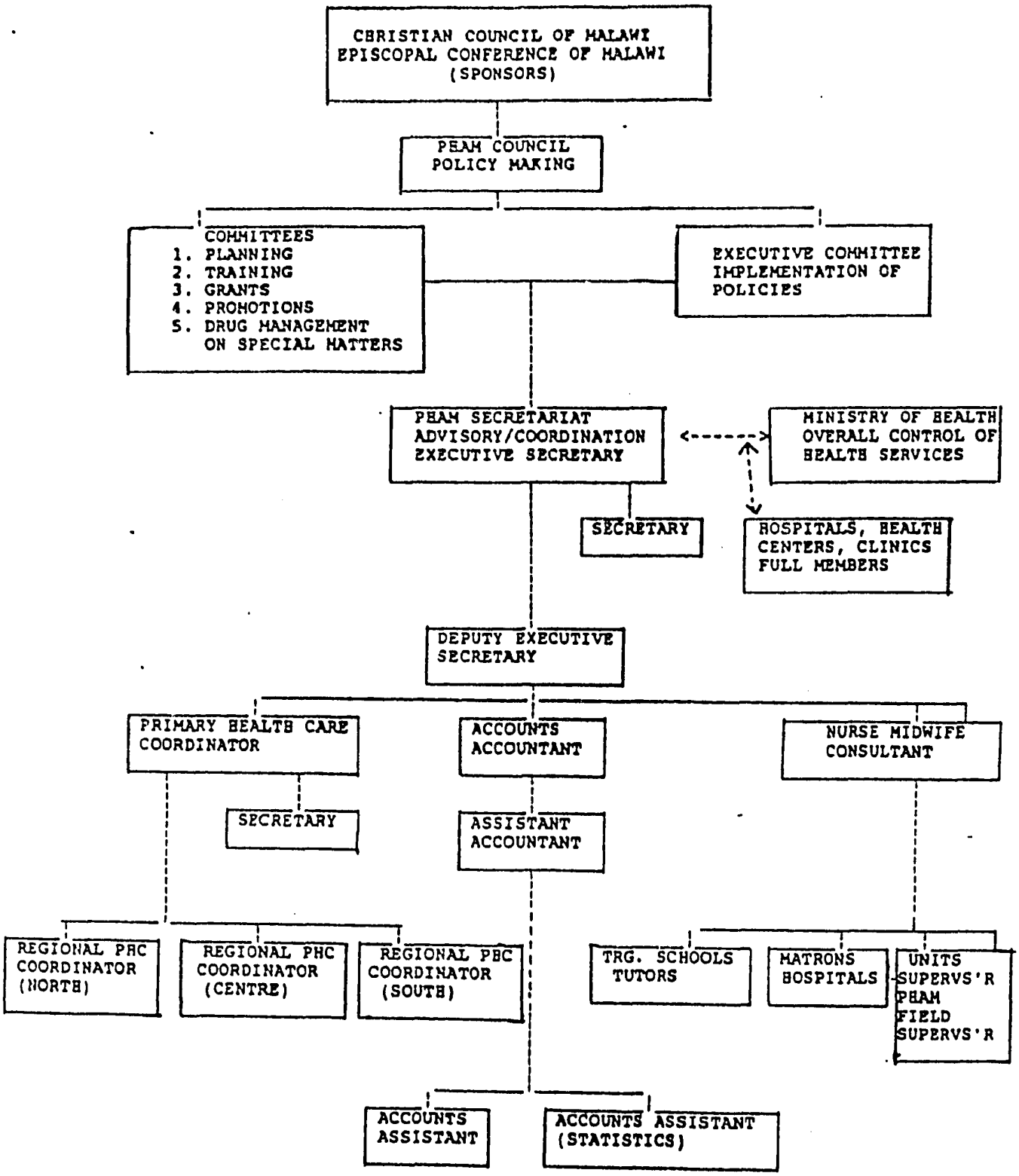

A problem with CHAM from the STAFH perspective is that about half of its hospitals and other facilities are Catholic funded and administered and thus affected by Church doctrine against modern family planning methods.2/ In addition, given CHAM's structure as a loose assembly of independent entities, the policy making CHAM Council and Executive Committee may not be enthusiastic about vesting subgrant making authority in its Secretariat or of risking disputes and charges of favouritism among its Protestant and Catholic members.

CHAM has recently submitted a concept paper to SHARED for a development assistance grant (DAG) to strengthen the CHAM Secretariat's ability to (a) coordinate and integrate medical activities, (b) provide a computerized data base on the activities of membership units, (c) install a telecommunications network, (d) strengthen staff training and (e) engage in long term planning (with technical assistance from the University of Malawi or from CEDPA, a U.S. health PVO under contract to EIL). The concept paper is currently being reviewed by SHARED's Project Management Unit (PMU).

B. CONGOMA

CONGOMA is the recently reorganized outgrowth of the former Council for Social Welfare Services (CSWS) which, in addition to a large number of Malawian NGOs, also included parastatals and even some enterprises and international agencies in its membership. It has aspired to be the coordinating, liaison, information disseminating and advocacy center for the Malawian NGO community. With a small Secretariat in Blantyre headed by an Executive Secretary, it circulated an occasional newsletter and held meetings on sponsored workshops from time to time on NGO subjects. It collects dues from its members and external assistance from OXFAM, UNDP, UNICEF and Japan.

However, in recent times the shortcomings of CSWS have come under increasing criticism, both in studies done by outside consultants and by its NGO membership itself. Such criticism came to a head at a SHARED-sponsored diagnostic workshop in March 1991 at which NGO representatives complained about the lack of direction to the organization, attributable to its heterogeneous membership, and the absence of tangible benefits of membership including failure to forcefully champion

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2/ In terms of service delivery, Catholic facilities provide slightly more than 50% of the total.

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NGO interests with the GOM. Consequently, at the annual meeting of its members in February 1992, the constitution of the Council was revised, a two-tier membership structure was set up with only NGOs as voting members and the Board of Directors was changed as was the Council's name. At present writing, CONGOMA is attempting to plan and coordinate NGO participation in efforts to distribute food supplies in preparation for severe shortages that are expected as a result of the current drought. However CONGOMA has been handling this role with such ineptitude that the NGOs are considering setting up a new and possibly competitive coordinating body.

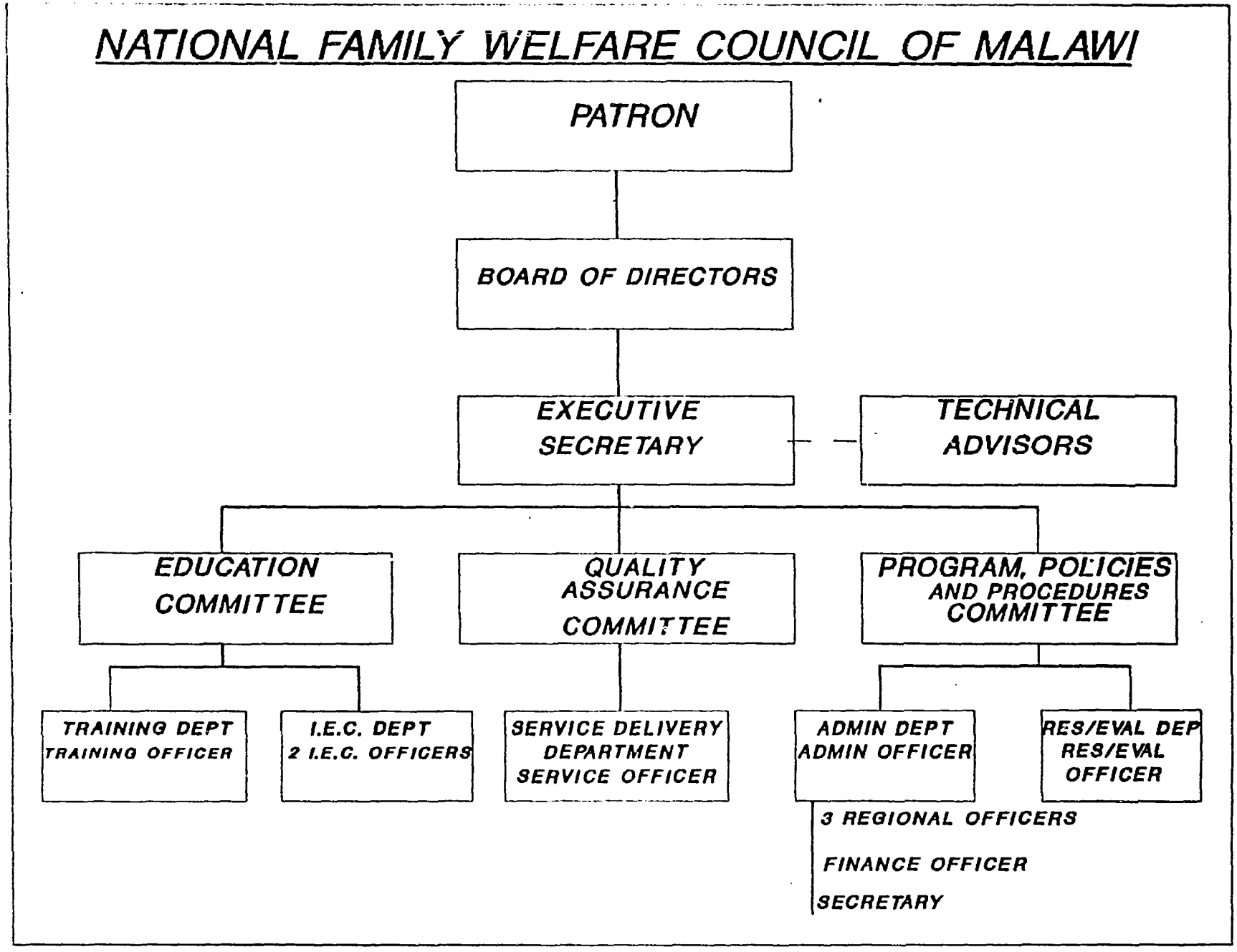
CONGOMA, like CHAM, has submitted a concept paper to SHARED for a three year $400,000 grant to finance staff and operating expenses for a training program, an information and communications center, research, needs assessments and to finance a financial and administrative officer. USAID's Project Implementation Committee has approved the concept paper but on condition that substantial modifications are made and incorporated into CONGOMA's eventual subgrant proposal.

In conclusion, CONGOMA has just changed direction and structure and is, in consultation with the donors and its NGO clientele, attempting to define its new role. There are important differences between the Executive Secretary's perspective on that role and those of the membership and donors and it may take some time for a concensus to emerge. Meanwhile, CONGOMA is poorly positioned to provide a grant making function to its PVO/NGO clientele. More basically, it is doubtful, based on experience with PVO umbrella organizations elsewhere in Africa, whether CONGOMA should be a grant making body or whether its members would wish it to perform such a function.

C. NFWC

Unlike CHAM and CONGOMA which are non-governmental umbrella entities, the NFWC is a parastatal which was created in November 1990 by an Act of Parliament. It operates under the administrative sponsorship of the Ministry of Women and Children and Community Services (MWCCS), hitherto the Ministry of Community Services, but has strong technical linkages with the Ministry of Health.

The creation of the NFWC embodies a major Malawian policy decision to give increased importance, resources and "dynamism" to dealing with the country's burgeoning population problem. In the words of its legislation, "The Council shall be responsible for coordinating, promoting, fostering and implementing family welfare programs in Malawi." Headed by an Executive Secretary,


NATIONAL FAMILY WELFARE COUNCIL OF MALAWI
PATRON
BOARD OF DIRECTORS
EXECUTIVE SECRETARY
TECHNICAL ADVISORS
EDUCATION COMMITTEE
QUALITY ASSURANCE COMMITTEE
PROGRAM, POLICIES AND PROCEDURES COMMITTEE
TRAINING DEPT
TRAINING OFFICER
I.E.C. DEPT
2 I.E.C. OFFICERS
SERVICE DELIVERY DEPARTMENT
SERVICE OFFICER
ADMIN DEPT
ADMIN OFFICER
RES/EVAL DEP
RES/EVAL OFFICER
3 REGIONAL OFFICERS
FINANCE OFFICER
SECRETARY

the Council's role is to (a) provide high level support for child spacing (CS) policies and strategies, (b) coordinate all CS services and (c) strengthen and expand CS service delivery in both the public and private sectors. The latter point is particularly important for the purpose of this analysis since the Council's mandate includes facilitating and increasing financial and other support to private CS entities and serving as a means to link potential donors with the providers of CS services.

The policy body of the NFWC is the Council itself which is made up of representatives of government ministries as well as religious organizations, CHAM, CONGOMA and others. In addition to the Executive Secretary, the staff of the NFWC is to be organized in five technical departments, i.e. service delivery, training, IEC, research and evaluation, and finally, administration and finance. The departments will be assisted by three technical committees (a) policies programmes and procedures, (b) quality control and (c) education. Plans call for a senior staff of six officers, one heading each department and two for the IEC department. The establishment of three regional officers is also contemplated. The NFWC is just now in the process of getting organized in temporary office space prior to moving to new facilities financed by the World Bank. A USAID-funded senior adviser is scheduled to arrive momentarily.

It should be noted that the Council's mandate is to serve the broad cause of "family welfare" not merely child spacing. This implies a broad approach to family health services including the treatment of STDs and AIDS prevention. The Executive Secretary indicates that the Council would support the provision of AIDS prevention services when they complement and strengthen other health services including child spacing. She would also welcome strengthening the technical and administrative capacity of the Council to support a subgrant function of the Council through a "partnership" with a U.S. PVO or Contractor. This possibility and its implications for the STAFH project are discussed in Section III. E.(2) and IV. B below.

III. Experience in Malawi with Subgrant Programs

Malawi has had some limited experience with programs that include subgrant components. This section will review that experience and apply the lessons of it to the design of the proposed STAFH project.

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A. The SDA Project

Most subgrant programs in Malawi have been financed by USAID. An exception is the Social Programme Support Fund (SPSF) which is part of the Social Dimensions of Adjustment Project (SDA) sponsored by the World Bank with co-financing or contributions by the U.K., the African Development Bank, Germany and Norway. The purpose of SDA is to address problems of poverty and social distress caused in part by macro economic structural reforms financed by the Bank. The SPSF is a fund of $1.6 million which is administered by the SDA Project Unit within the Department of Economic Planning and Development in OPC. The function of the Unit is to finance small proposals (up to K200,000 and three years) in both the private and public sectors for activities that will address or shed light on problems of poverty in Malawi and ways of dealing with it. Priority is being given to proposals by NGOs, community organizations and local government entities.

The Unit has gotten organized and has approved its first set of subprojects including one for municipally administered child health clinics in the Zomba area, another for skills training and community leader training by a local NGO, a third for a rural development activity in Livingstonia and a grant to the U.S. PVO, Africare. Subprojects will be monitored by the Unit and an evaluation procedure has been set up.

B. HRID

The AID-funded Human Resources and Institutional Development Project, encompasses both public and private sectors and is managed by the Academy for Education Development (AED) in collaboration with USAID and the Department of Personnel Management and Training of OPC. It has developed an efficient process for reviewing proposals for institutional strengthening and training presented by various entities. An earlier two-tiered system turned out to be deficient since those serving on the first tier had little incentive to provide a critical review so as not to antagonise their colleagues and to smooth the way for proposals that the former favoured. Subsequently, in June 1989, the project was reorganized its focus made more specific and the review process more critical and demanding.

The mechanics of the subproject/subgrant procedure have similarities and differences with those of the SHARED project. Requesting entities submit proposals in accordance with a prescribed format and judged under specific criteria. Most of the cost elements of proposals are foreign exchange items (U.S. experts, imported commodities and equipment, training in the

U.S. or third countries). These costs are paid by AED to the entity or person providing the services or goods. HRID is not set up as a project to make grants to Malawian entities so its applicability to STAFH procedures lies in its proposal review process.

C. PHICS

The Promoting Health Interventions for Child Survival Project includes $518,000 for operational research subgrants under the auspices of the Research Unit of the Ministry of Health. Subgrants of up to $10,000 for research proposals are vetted at quarterly meetings of the Health Sciences Research Committee of the Department of Research and Environmental Affairs of the OPC. Awards are subject to USAID concurrence. Implementation of the studies will be monitored by the Research Unit. Although the aim is to award ten grants per year, only three have been made so far, but word is getting around and the pace of the program may pick up.

D. SHARED

The SHARED (Services for Health, Agriculture and Rural Enterprise Development) project represents USAID's and Malawi's most extensive experience in subgrant administration and offers the most insights for shaping future subgrant procedures and modalities. SHARED is a stand alone, USAID-financed project being managed by a U.S. PVO (Experiment in International Living - EIL) under a competitively selected cooperative agreement. The agreement covers the first five years of the nine year project after which it may be recompeted or extended.

1. Purpose and Funding

SHARED works exclusively through NGOs (which may sometimes involve the participation of U.S. PVOs) as outreach intermediaries. Its institutional target is to strengthen and expand the Malawian NGO community, thereby stimulating, guiding and encouraging local development initiatives. Priority subject matter areas are agriculture, rural enterprise, health and an open-ended "other" category. The $10 million cooperative agreement provides $4.3 million for EIL management and technical assistance and $5.7 million for subgrants. Funding for USAID management, audits and evaluations of the project is included in a separate AID/GOM project agreement which brings EIL within the purview of the US/GOM bilateral agreement and therefore obviates the need for EIL to go through the GOM's lengthy PVO registration procedure. However, only GOM-registered NGO's are eligible for SHARED subgrants.

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2. Subgrants Procedures

SHARED's subgrant funding matrix provides an organized but flexible range of assistance options. Basically, there are two categories, institutional development subgrants (ISGs) and development assistance subgrants (DAGs). The first is limited to Malawian NGOs and focuses on capacity building with a funding range of $10,000 (or less) to $100,000 over 1-2 years. DAGs may be up to $400,000 for Malawian NGOs and up to $1 million for partnership proposals with a U.S. or international PVO and may be 3-5 years in duration. Institutional strengthening activities may be included in DAGs.

Grants can cover both local and foreign exchange costs. Imported items (vehicles, computers, etc.) are purchased by EIL for the grantee (as AED does for its HRID grantees). Such purchases enter duty free under AID's bilateral agreement with the GOM. With respect to local items, the grantee opens a special bank account and an imprest fund is established through an advance by EIL. The grantee draws down on the account to finance goods and services shown on the subgrant budget and replenishment is accomplished by the expenditure reports and requests for reimbursement it furnishes to EIL.

EIL, which manages PVO umbrella projects in a number of developing countries, has designed a logical, sequential process for handling NGO/PVO requests for assistance. The initial step involves extensive contact and exchange of ideas with the interested NGO to see whether there is a "fit" between its aims and qualification and SHARED goals and criteria. The next is the preparation by the NGO of a "concept paper", in accordance with a prescribed format, which briefly describes the theme and nature of the proposed activities, their aims, intended benefits and cost.

Approval of a concept paper is followed by the submission of a proposal, again using a standard format, in which the NGO goes into greater detail and reshapes the document to reflect whatever comments and guidance have been offered in concept paper reviews. Review of both concept papers and proposals is spearheaded by EIL's field office, the Program Management Unit (PMU) which forwards its recommendations to USAID (which has set up a special committee that meets regularly for that purpose) for final review. The length of the review process (averaging 8.7 months for the first ten submissions) has been a source of dissatisfaction by all concerned but there are strong indications that the process is speeding up as procedures are simplified and both the NGOs and the review staffs gain in experience.

3. Preparations for Grant Making

The EIL's first resident staff arrived in Malawi in October 1990 and its first Subgrant Agreement were signed in February 1992. Most of the intervening 17 months were devoted to getting the PMU physically established, staffed, organized, developing procedures, familiarizing itself and communicating with the Malawian NGO community, identifying their interests, problems and needs and beginning the process of encouraging or responding to specific requests for assistance. Much effort, time and expense was also devoted by SHARED to surveying Malawi's NGO sector by carrying out a "demand/needs assessment", preparing a profile of NGOs in Malawi conducting three "NGO sectoral workshops" on health, enterprise development and agriculture, each in one of the three regions of the country.

4. Subgrant Management

To assist NGO/PVOs to formulate proposals and to assist PMU/USAID to review them, PMU developed an operations manual (OM) that explains the SHARED project, its goals and resources, the kinds of assistance it can offer, eligibility criteria and the grant review and selection process, see Annex F. The OM includes a concept paper and proposal formats for NGOs to follow. Once a grant is made a subgrant agreement is prepared by the PMU following a format derived from AID procedures. PMU has also prepared for subgrantees a manual "Interpreting Your Subgrant Agreement", a Financial Management manual as well as financial planning, and implementation reporting forms for NGOs to use to meet the requirements of the subgrant agreement, see Annexes G and H.

5. Assistance to Subgrantees

Helping newly awarded NGOs to get organized to participate and to meet the project's record keeping and reporting requirements has become a major task of EIL's expatriate Chief of Party (COP) and its Finance and Administration Officer and their staffs. EIL has experimented with various techniques for helping NGOs (or would be NGOs) to understand and adopt the systems and procedures they must follow if they are to manage subgrant funds. At first the major means used was to organize a "diagnostic workshop" for the potential recipient. As noted in EIL's Second Annual Report, "Diagnostic Workshops serve as a means for assessing and further identifying institutional support and training needs for NGOs.... They have been a key tool in helping participating NGOs through a process of self-examination which has led to the informed preparation of concept papers...". To date diagnostic workshops have been held for five NGOs including CHAM and the Herbalist Association of Malawi.

In the future more reliance for institutional analysis and advice will be given to the less expensive and time consuming "rapid institutional appraisals" (RIAs) see Annex I. As explained in the EIL report, "The RIAs generally involve a two step process: administrative systems being assessed by the SHARED Financial and Administrative section, while institutional/organizational capacity is assessed by the Chief of Party in collaboration with the Programme Coordinators. Guidelines have been prepared for both parts of the exercise. "In addition, a financial audit of the NGO is conducted prior to subgrant award.

For would-be ISG recipients, EIL conducts a financial consulting visit rather than an RIA. "Since systems and procedures are usually not yet in place to permit an appraisal of the institution's financial and administrative capability, the visit by SHARED staff focuses more on explaining the SHARED financial reporting and administrative procedures and presenting sample financial books of record and administrative forms which can be adapted for use by the NGO."

6. SHARED and Health

As of March 31, four SHARED subgrants have been approved representing a funding commitment of about $660,000. Eight proposals with approved concept papers are waiting in line for further review with budgets totalling $3.1 million but some of the budget submissions are very soft. Two of the 12 proposals (accounting for $124,000 of the funds requested) are in the health sector. They are ISG proposals for Cheshire Homes (assistance to the handicapped) and the Herbalist Association of Malawi. The CHAM request and a $100,000 request by DEMODA (assistance for AIDS orphans) are still at the draft concept paper stage.

The lessor participation of the health sector in SHARED (despite its leading role in the NGO community) is partly attributable to USAID guidance that consideration of health proposals should emphasize their management and institutional support requirements. This position makes sense given USAID's major involvement in current and prospective health programs. Thus most of the proposals and an overwhelming proportion of SHARED funding is presently being directed outside the health sector.

If SHARED is to provide a supportive role for STAFH activities in the private sector, care must be taken to earmark a reasonable portion of SHARED funding for NGO's that will need institutional strengthening in order to participate in STAFH activities. In fact, SHARED could provide such assistance

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prior to and during the early years of STAFH. A major case in point is CHAM. From the perspective of preparing for STAFH, priority should be given by SHARED and USAID to helping CHAM prepare a solid proposal addressing its organizational and management weaknesses. Such attention might be accompanied by discussions with the organization's Board of Directors and Executive Committee to obtain their views and enlist their support.

E. Lessons Learned from Subgrant Experience in Malawi

The foregoing experience with subgrant programs in Malawi leads to a number of conclusions and lessons learned:

1. Limited Track Record

The Malawian experience has been limited and what there is has mostly been derived from the private NGO sector.

2. Limited Choice of Subgranting Entities

There are at present no Malawian agencies -- private or parastatal -- that are organizationally equipped to manage a subgranting function for STAFH. Neither CONGOMA nor CHAM are in a position to play such a role and the members of both organizations would probably be opposed to their doing so.

NFWC may have potential for such a role in the later years of the project, subject to the concurrence of the GOM (especially MOH and MWCCS), the installation of a subgranting procedure acceptable to the Ministry of Finance and the provision of considerable technical assistance and training in grant management. To put it differently, if the provision of subgrants is to be a component of the project over its first few years, that function should be performed by a U.S. PVO or contractor. That entity would work in close liaison with the GOM, especially the NFWC, GOH, MWCCS, CHAM and private sector bodies. The arrangements developed for the implementation of the Kenyan Family Planning Private Sector project suggest some of the modalities that could be used in Malawi, see Annex A.

3. The Need for Subgrant Award Preparations

SHARED's activities represent the most extensive subgranting experience to date. That experience must take into consideration that SHARED is a private sector project that does not work through a Malawian counterpart organization. Even so, despite pressure from USAID and the NGO community, it took SHARED nearly a year and a half of preparatory work before it was in a position to begin making subgrants and the NGO

community in a position to handle and utilize them. The preparatory period for STAFH may be comparable in length, particularly if STAFH will also be involved in building the capacity of a counterpart institution.

4. "Early Starts" and Needs/Demand Assessments

USAID has evidence from the receipt of requests from the AIDS Secretariat and from its experience with Project Hope and other activities that there exists a strong underlying unmet demand for CS and AIDS prevention services by firms in the estate, enterprise and parastatal sectors and a potential capability for the expansion of such services within the NGO sector. Therefore STAFH should contemplate the desirability of a "two track" approach in the first few years of implementation. On the one hand, the project should be capable of responding to pending requests for subgrants or technical services, and stimulating such requests, especially from NGOs. At the same time, much of the project's level of effort in the early years should be devoted to laying the foundation for a broader and larger program over the long haul.

Needs/demand assessments will be an important component of such planning. Such surveys will help STAFH project planners to (a) better measure the interest in and unmet demand for AIDS prevention and CS services, (b) identify institutions (companies, estates, parastatals) which would be interested in being helped by STAFH subgrants and/or services, the size of their catchment areas and the medical, financial and management resources they could contribute, (c) investigate potential private sector/parastatal participants to be contacted later on in the project.

It is instructive to note that when USAID/Kenya was planning in 1990 a follow on project to its first private sector family planning project, it commissioned a needs assessment survey. The survey identified and particularized significant potential unmet demand for assistance in providing family planning services among 90 companies, 80 NGO-run medical facilities, twenty teacher training colleges as well as 35 organizations identified but not helped by the previous project.

STAFH surveyors should come equipped to explain the project, perhaps using audio/visual equipment, distribute brochures, provide examples of the format to be used to prepare subgrant/subproject proposals and pre-proposals. The STAFH personnel should also explain the availability of follow-up help, if needed, to advise on the preparation of proposals and pre- proposals. Surveys should be organized by sub-sector (parastatals, companies, estates) or by geographic region. No

survey is needed for the NGO/PVO subsector given the amount of information available from the SHARED needs assessment and workshops which can be selectively updated with the assistance of the SHARED staff.

5. Workshops

Another technique which the SHARED project used to good advantage was the convening of introductory and technical workshops. STAFH workshops could bring together private sector representatives and health staff, GOM and church officials and donors with programs in the health field. The purpose would be to explain the goals, components and techniques of the project, indicate modes of participation and get a sense of local perceptions, reactions and suggestions on ways the program could be made most effective and "user friendly". SHARED's three workshops made a significant contribution to introducing and publicizing that program and gave it a valuable visibility and momentum. STAFH workshops, perhaps one for each region, would complement the assessments discussed in the previous section.

6. Technical Assistance for Planning and Implementation

The importance of STAFH-provided technical assistance to organizations proposing subgrants or projects cannot be over emphasized. Planning, management, financial controls and fiscal accountability are often not the strong suits of Malawian NGOs. The situation is undoubtedly better among parastatals and private companies but even these will be in need of guidance to adopt prescribed financial procedures and reporting requirements. Technical assistance and monitoring will also be a major STAFH preoccupation after subgrants have been made or subprojects funded. The first several months following awards are likely to be particularly demanding as recipients grapple with initial implementation and reporting requirements of their subproject/subgrant agreements.

Planning for the subgrant component of the STAFH project should take advantage of two successful SHARED experiences, i.e. a financial management workshop and the conduct of rapid institutional appraisals (RIAs) as noted in Section E (5) above. The workshop was helpful in introducing NGO financial officers with the project's financial requirements and formats for budgeting, bookkeeping, financial records, financial controls, audits, etc. Such a workshop should be conducted for potential STAFH private sector entities, especially the health NGOs and the financial officers working in CHAM facilities. An output of the workshop might be a financial management manual similar to the one SHARED produced but geared to health

considerations and also appropriate for income generating entities like parastatals and estates. RIAs should be conducted for entities slated to receive grants award to assure that both their management and financial systems are in good order.

IV. Conclusions and Recommendations

A. CHAM and CONGOMA

Neither CONGOMA nor CHAM are presently suitable as entities for carrying out subgranting functions for the STAFH project even assuming major technical assistance from a U.S. PVO or contractor. CONGOMA is in the process of a major reorganization, is coping unsuccessfully with its role in the drought crisis and is held in low esteem by its members. The CHAM Secretariat would be eager to establish a grant making facility within its structure but its leadership and staffing are weak and it is doubtful whether its governing bodies or member organizations would wish it to assume that function.

On the other hand, a strengthened CHAM secretariat would have much to contribute to STAFH outreach, grant assistance and services to the private medical sector. With reinvigorated leadership and improved facilities, the CHAM Secretariat could provide valuable services to its member hospitals and clinics that would complement STAFH assistance and make it more efficient. Of particular note would be the strengthening of CHAM's national and regional primary health care facilities to support PHC work of CHAM's members with particular attention to CS and STD/HIV services. A second measure would be setting up a CHAM communications network so as to establish linkages with isolated units and enable them to draw on and share professional experience and lessons learned by other units. A third improvement would be establishing a CHAM management information system so that data from CHAM units can be stored and analyzed, trends measured and the impact of CHAM services can be measured. Such data would be of great value for STAFH monitoring and evaluation purposes.

Some of these improvements are included in CHAM's concept paper to the PMU for a SHARED grant. USAID/HPN should collaborate with SHARED Project Assistant in USAID and the PMU staff toward encouraging CHAM to shape its proposal so as to increase its effectiveness as a vehicle for complementing and enhancing STAFH services to CHAM units.

CONGOMA may eventually have a role as a liaison and information sharing body among other Malawian NGOs providing health services. At present it is beset by problems arising from the dissatisfaction by its members and its donors for its lack of performance as a liaison, information center and advocate for the NGO community and, more recently, in connection with drought response preparations. CONGOMA's main donors, UNDP, UNICEF and OXFAM are planning to work with SHARED in dealing with CONGOMA's problems. Thus, the situation is presently in flux and CONGOMA's relationship to STAFH, as well as the timing and nature of SHARED assistance to CONGOMA is a matter for the future.

B. National Family Welfare Council

The NFWC, although still in its infancy, is an institution to which the GOM attaches great importance. Other positive factors are its autonomous status, its authorization to serve both public and private sectors and its mandate to broadly promote the cause of "family welfare". Such a broad mandate could be construed to include not only child spacing but AIDS prevention. In addition, its founding legislation endows the Council with the "power ... to enter into any contract or agreement" and "with the approval of the Minister, to raise and receive funds and donations to be applied for family welfare activities." Thus legally the NFWC should be able to serve as a recipient or as a donor of subgrants.

However, the Council is not far enough along in its work to determine how these authorities will work out in practice. It is not clear at this time whether the Council could receive funds directly from a donor for subgrant or whether it would be obliged to deal through its parent ministry (MWCCS) as an intermediary. Neither is it clear whether donor funding would count toward, or be additive to, the annual budgetary "ceilings" imposed by the Ministry of Finance on government agencies. Relationships with the MOH and its AIDS Secretariat with respect to possible NFWC work in AIDS prevention remain to be sorted out. In any case, the NFWC is not staffed at this time to exercise a subgrant function.

C. A Management and Subgranting Mechanism for STAFH

STAFH should finance during the early years of the project, U.S. PVO or contractor under a project-funded cooperative agreement or contract. The contract or cooperative agreement would be competively selected and solicitation should specify that USAID is seeking a U.S. entity with strong management as well as child spacing skills and that USAID would entertain proposals for joint ventures or subcontracting

arrangements. It should also note that the U.S. entity would work in coordination with specialists in AIDS prevention/control under a USAID buy-in to the AIDSCAP contract.

Functionally the U.S. entity would perform the kind of organizing, review, subgranting and monitoring function that characterized SHARED's PMU. It could and should draw on SHARED's experience with getting organized, local staffing, establishing professional ties, becoming known and accepted and developing subgrants preparation, review, approval and monitoring procedures. Many of the SHARED's forms can be adapted to needs of the new organization.

But unlike SHARED, the U.S. PVO/contractor would establish from the very beginning close ties and linkages with the NFWC (as well as liaison relationship with CHAM and CONGOMA). STAFH should contemplate NFWC as its potential Malawian partner as a recipient of technical and management assistance from its PVO/contractor and AIDSCAP experts. Assistance from these two sources could perform a useful function in broadening NFWC's outlook to include greater emphasis on AIDS prevention and to encourage the coordinated approach - at least in the private sector - that STAFH is seeking. To this end, the project would provide CS and AIDSCAP advisers for the NFWC (taking into consideration the CS advisers already being provided by USAID/SEATS), finance training for present or potential NFWC staff and even provide temporary funding to hasten NFWC staff recruitment until regular NFWC budgeted position become available. Both NFWC and the AIDS Secretariat would have representation on the PVO/contractor's proposal review committee.

The relationship between the U.S. entity and NFWC would evolve with time and experience. Initially, the U.S. entity might operate much like SHARED's PMU, promoting, helping to prepare, receiving and reviewing proposals from the private sector, making subgrants to successful contenders and monitoring implementation. However, from the start, the U.S entity would work through a Malawian proposal review committee which would draw in the advice and viewpoints of such concerned agencies as NFWC, CHAM, the MOH and its AIDS Secretariat. The review committee might establish subcommittees in AIDS prevention and child spacing but their recommendations would be subject to review by the full committee to assure that both problems were taken into consideration.

Gradually, as the NFWC grows in experience and administrative capability and as the Malawian professional staff of the U.S. entity becomes increasingly proficient in their jobs. a gradual shift of function and staffing can be

visualized with U.S. advisers to the NFWC being replaced by Malawian experts and administrators and the NFWC assuming a more and more substantial role of subgrant making and technical assistance provision in support of private sector child spacing and AIDS prevention.

NOTE: All Annexes available at USAID/HPN.

LIST OF POTENTIAL SUBGRANTEES AND MAP DENOTING NGO ACTIVITY IN MALAWI

A. Integrated AIDS and child spacing service delivery projects.

1. Project HOPE: to replicate and expand AIDS/CS project on rural agricultural estates in Thyolo and Mulanje
2. Banja La Mtsogolo: to expand AIDS/CS in the Workplace Program
3. U.S. PVOs in-country

    a. International Eye Foundation
    b. Save the Children Federation
    c. Project HOPE
    d. World Vision
    e. Adventist Development Relief Agency

B. Community-based distribution (CBD) child spacing projects

1. CHAM
2. Malawi Red Cross

C. Core child spacing services

1. CHAM
2. Private commercial
3. Private practitioners

D. Contraceptive social marketing (CSM)

1. Malawi Health Social Marketing Project (MHSMP) with Lever Brothers, Napolo, SoBo, Chibuku

E. Assessments and research

1. University of Malawi
    a. Medical College
    b. Kamuzu College of Nursing
    c. Center for Social Research
    d. Chancellor College

F. Training

1. University of Malawi Medical College
2. Kamuzu College of Nursing
3. Center for Social Research
4. MOH Lilongwe School for Health Sciences
5. CHAM Nursing and paramedical schools
6. Malawi Institute of Management (MIM)
7. Zomba School of Nursing
8. Other programs which train community health and development workers and volunteers

G. Institutional strengthening of central coordinating and service delivery support organizations

1. NFWC
2. CONGOMA
3. CHAM Secretariat

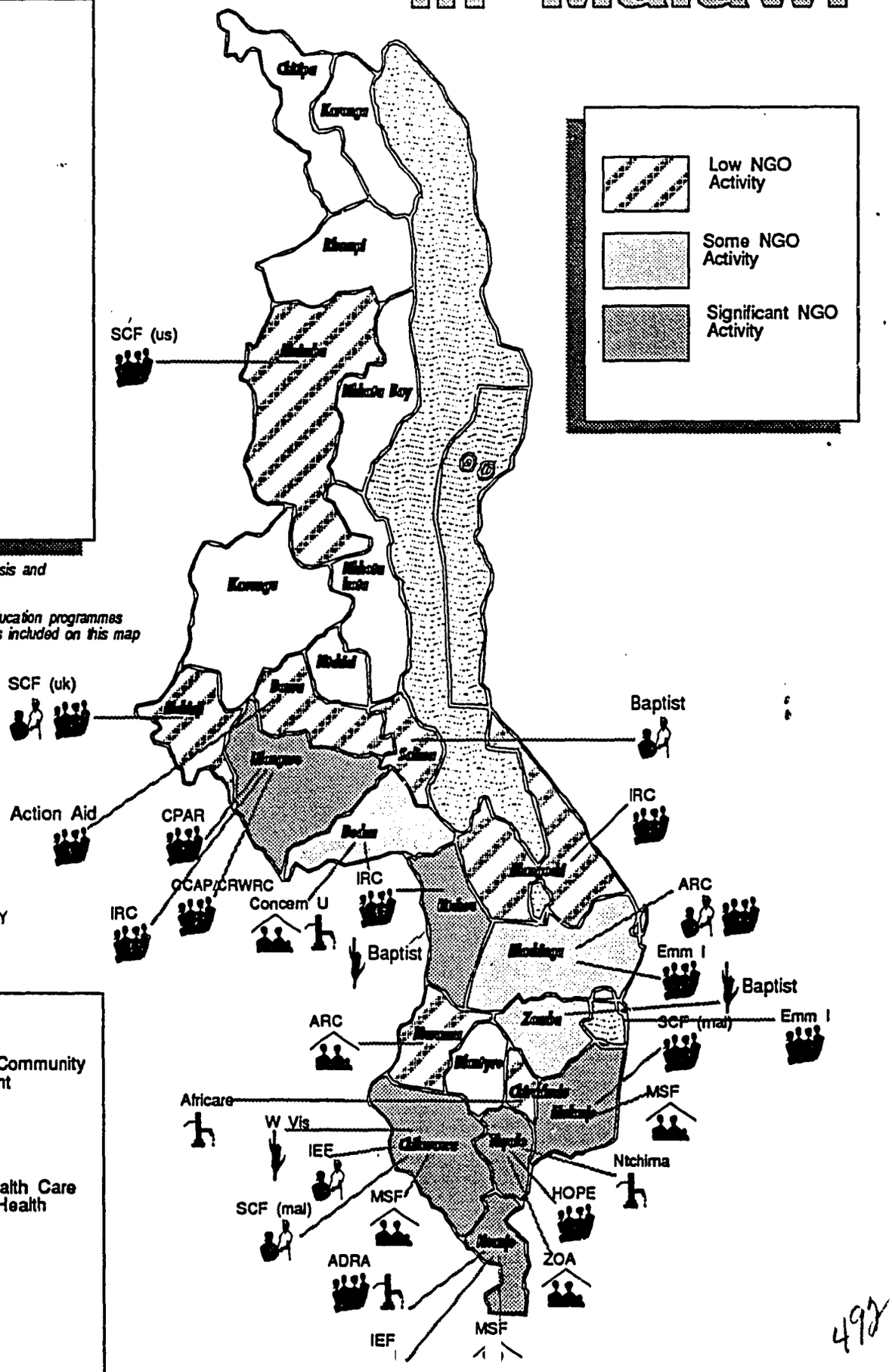
NGO Activity in Malawi

Data based on information from the following NGOs

- Action Aid
- ADRA
- Africare
- ARC
- Baptist Mission*
- Cheshire Homes**
- CPAR
- CCAP/CRWRC
- Concern Universal
- ELCM/LWS*
- Emmanuel Int.
- GTZ*
- IEF
- IRC
- MSF
- Ntchima Trust
- Project "HOPE"
- SCF (uk)
- SCF (malawi)
- SCF (us)
- Salvation Army*
- Baha'is*
- VSO*
- World Vision*
- ZOA Holland

* *NGOs working on a country-wide basis and therefore not included on the map*

** *Cheshire Homes work in special education programmes and are therfore outside the categories included on this map*



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Legend

- Integrated Community Development
- Refugees
- Primary Health Care and other Health Services
- Water and Sanitation
- Agricutural Extention

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ECONOMIC AND FINANCIAL ANALYSIS

I. INTRODUCTION

The STAFH project provides technical assistance, commodities and grants to the MOH and private organizations concerned with child spacing and AIDS. Project activities involve no revenue collection, with the exception of a condom social marketing program. Most of the project activities are in the private sector, where there is no requirement for recurrent cost support by the MOH. As a result, many of the issues normally considered in an economic analysis are not of major importance here.

However, there are a number of issues to be examined, including the value of the benefits of the project and the likelihood of sustainable project effects. Thus, the economic analysis will be concerned with the following issues:

Economic Benefits

Cost Effectiveness

Sustainability

This section of the Economic Analysis first discusses the general economic background of Malawi and the health sector. Then the three issues listed above are considered.

II. CURRENT ECONOMIC SITUATION

Since 1988, the Government of Malawi has been operating under structural adjustment agreements with the major donors. These agreements appear to have had a positive effect in stimulating economic growth in the 4-6% range. However, government expenditures in the health sector are growing very modestly while wage pressures on public sector salaries will continue to constrict the resources available to support non-salary costs.

A. Growth

The Malawi economy has been growing at over 4% per annum in recent years. The current drought is expected to result in a contraction next year, but the long term prospects for the economy are good.

B. Government Revenues and Expenditures

Under the structural adjustment agreement, government expenditures are expected to be maintained at about 25% of GDP. Expenditures for 1991/92 are estimated at 18.6%. There are also caps on government deficit spending. Education and health are to be given priority.

MOH actual recurrent expenditures for 1989/90 are estimated to be MK 70,845,159. This is about 6.4% of all government expenditures and 7.4% of government expenditures excluding public debt charges. For 1990/91, MOH expenditures were MK 76,146,032, which is 7.2% of government non debt expenditures.

It seems likely that the MOH will maintain their per capita real spending over the long run, but are not likely in the near future to increase it. Spending in the next few years is likely to be depressed as a result of the drought.

C. Private Sector

The Christian Health Association of Malawi (CHAM) provides about 40% of all inpatient health care and about 20% of all ambulatory visits. Thus, working with the NGO organizations of the country will be very important to have comprehensive coverage for both child spacing and AIDS prevention. The National Family Welfare Council (NFWC) is also assuming an important place in the Malawi health sector. The NFWC is taking a leading role in child spacing activities within the country.

III. OUTPUTS OF THE PROJECT

The STAFH project will have a number of significant impacts in Malawi, both in STD/AIDS prevention and in child spacing. Both child spacing and AIDS activities will lower dependency ratios, reduce health care costs, increase savings, and increase the per capita income in the society. This will come about because a society's growth and income is directly dependent on the proportion of the population that is able to work and contribute to growth. High fertility and AIDS both increase the proportion of the population that cannot currently contribute to economic growth, either because of an increased number of children or an increased number of ill and dying adults.

These impacts are in terms of changes in rates by the year 1998:

A. AIDS: The project proposes to reduce HIV prevalence among urban pregnant women 15-24 years of age from 25% in 1992 to 15% in 1998.

B. Child Spacing: The number of modern method child spacing users should increase from 82,000 to 437,000.

C. STDs: The project proposes a decrease in the percentage of urban and semi-urban pregnant women with positive syphillis serology from 8-14% in 1992 to 4-7% in 1998.

D. Maternal mortality: Reduction from 500+ (per 100,000 live births) in 1992 to 300 by 1998.

The economic value of these benefits to society is considerable. It includes the value of the potential AIDS victims who are prevented from contracting the disease, the increased economic potential of persons whose morbidity from STDs is reduced, the value of reducing maternal and infant mortality and the value of reducing the birthrate in Malawi.

The value of reducing the number of AIDS patients can be determined from a recent study of the economic impact of AIDS in Malawi by Steven Forsythe. His study uses current AIDS SEC projections that indicate by the year 2000 there will be 642,000 to 1,076,000 persons with HIV in Malawi. Each AIDS death is expected to cost Malawi about MK 11,015, or about $2,700 in discounted lost earnings and treatment costs. If the activities of this project are successful in cutting the HIV prevalence in half, this would reduce AIDS deaths by 250,000 to 450,000. The economic value of this impact, at $2,700 per life saved, would approach $1 billion.

Increasing child spacing in Malawi also has significant benefits for society. By reducing the dependency ratio, it frees up members of households to engage in other, economically productive activities. Income that would have been invested in raising children can also be invested in increasing physical or human capital in the population. This is particularly true in the case of delayed first births, which allow the woman to engage in other activities besides child care.

The increase in families practicing child spacing from 82,000 to 437,000 is likely to reduce annual births by an additional 40,000 to 50,000, on average by 1998. If the project is able to effect this increase at a steady rate from 1993 to 1998, it would result in 250,000 - 350,000 births averted. This would represent about a two percent decrease in the projected population of about 12 million in the year 1998, which is likely to shift the dependency ratio by 4 to 5 percent. If this shift then has a similar effect on the GDP per capita, it would rise in 1992 dollars by about $10 per capita. By the year 1998, this would represent an increased GDP of about $120,000,000. With increases in per capita income during the years from 1993 to 1998, the total value of project effects is likely to be as much as $500 million.

IV. PROJECT BENEFIT-COST ANALYSIS

A. Child Spacing

A substantial proportion of project funding is dedicated to child spacing activities. Approximately $25 million will be spent over the life of the project on these activities. However, it can be seen in the section above that the value of this part of the project far exceeds the costs, providing as much as $500 worth of benefits.

B. AIDS

The AIDS component of the project is budgeted at approximately $20 million. Analysis by Forsythe indicates that this component has an even larger benefit than the child spacing portion of the project. If the HIV prevalence rate is reduced by the amount projected, benefits of the $20 million expenditure could be as high as $1 billion

V. COST EFFECTIVENESS

Issues of cost effectiveness are important in the Malawi health sector, where resources are very constrained. This section first looks at general measures of the cost of project outputs, and then discusses the mode in which these outputs are delivered.

The child spacing portion of the project is projected in the project paper to provide services for up to 437,000 users of modern contraceptive methods by 1998. Beginning from the current number of 82,000 contraceptives users, and assuming a steady increase to 1998, this would imply an additional 1,225,000 couple years of protection (CYPs) through the life of the project. With a budget of $25 million, the cost of a CYP would be about $20.40. This is slightly higher than most estimates of a CYP, which average about $20. However, the project is working in a country with a low contraceptive prevalence rate, and the difficulty of institutionalizing child spacing activities may drive the cost higher.

Within the AIDS component, the project is projected to be responsible, ultimately, for preventing 250,000 to 450,000 AIDS deaths. With a budget of $20 million, this indicates a cost per life saved of $44 to $80. This cost is very competitive with the measures of cost per life saved from other interventions, such as EPI or ARI programs, and lower than many other interventions.

As these calculations indicate, this project appears to be a cost effective means of investment in the health sector. In addition, the project appears to be approaching the accomplishment of these outputs in as efficient a manner as possible. The structure of the project utilizes several approaches that have been shown to be effective in similar projects. These include:

Private/Public blend of services. There are a number of advantages to this approach, including a more comprehensive coverage, and the ability to utilize each part of the health delivery system for its relative strengths. Each part can be used to reinforce the desired outcome.

Benefits from integration of AIDS and child spacing. Much of the administrative, supervisory and training activities of the project will be able to do double duty in this project, benefiting from economies of scope. Projects in general are now trying to develop more integrated approaches that avoid the duplication endemic in vertically organized programs.

Social Marketing activities. There are important demand and supply reasons for using social marketing activities. The social marketing program is important for developing demand for the project services. In addition, it will have important implications for the sustainability of the project outputs.

VI. SUSTAINABILITY OF PROJECT BENEFITS

Sustainability is an important aspect of all projects, and is vital in health projects. As noted in the introduction, there may be some problems with sustainability of the project activities, since the project generates little revenue. Programs must eventually pay for their own commodities and recover their operating costs when grants run out.

However, the social marketing programs may be able to help with this. In addition, working through estates and formal employers should help with sustainability. These organizations can be shown that it is to their economic advantage to provide these services to their workers and families. Because the formal sector provides a disproportionate share of the AIDS cases, this will reach a large section of the target population. It is important to note, however, that the formal sector in Malawi represents a small proportion of households, as shown in the following table.

Employment Patterns in 1990

Sector	Number	Percentage
Formal Sector	498,000	16
Agriculture	260,000	8.3
Industry	129,000	4.1
Services	169,000	5.4
Informal Sector	2,644,000	
Smallholder farmers	2,338,000	
Small enterprise	136,000	
Unemployed	170,000	
Total labor force	3,649,769	

Source: Rapid Population Growth (1991), Population Unit, Department of Economic Planning and Development

Household expenditure surveys in Malawi have shown that households currently spend about two percent of their income on health care. This would indicate an expenditure for the average household of about $25 per year. Thus, an expenditure of about $20.40 for a couple year of protection would be prohibitive for most households. Social marketing of condoms, however, may be able to bring this cost down to an affordable level. It is likely that the average household would be able to afford an annual supply of condoms in the range of $5-6.

In general the project appears feasible, beneficial, cost effective, and somewhat sustainable.

Social Soundness and Gender Analysis

Support to AIDS and Family Health (STAFH) Project

I. Introduction

The goals of the STAFH Project are to effect a closer alignment between population growth rates and rates of economic growth; and to decrease the incidence of HIV infection in Malawi. Compatibility of population and economic growth will be accomplished by expanding the acceptance and utilization of modern methods of contraception (child spacing) among Malawians; incidence of HIV infection will be reduced by interventions aimed at lessening high-risk behaviors associated with the transmission of HIV.

Specific project activities involve the expansion of service delivery in public and private institutions and at the community level, increased social marketing efforts, expanded IEC activities in schools, and service delivery support through such mechanisms as training, IEC, and research activities.

The socio-cultural feasibility of these proposed interventions, and potential impacts on the basis of gender, must be considered in light of the social, economic, cultural and demographic characteristics of Malawi, and the limited knowledge base on matters related to sexual and reproductive health in Malawi.

II. The Malawian Context

With a total population estimated at some nine million people, and an estimated population density of 229 persons per square kilometer of arable land (UNICEF 1991), Malawi's natural resource base and institutional capacity, particularly in the education, health, and social services sectors, are under serious stress. The total fertility rate (TFR) has apparently held steady at 7.6 live births per woman between 1977 and the present (UNICEF 1987, 1991; House and Zimalirana 1991), yielding an annual population growth rate of some 3.2 to 3.3% between 1977 and 1987, although the impact of AIDS will reduce this growth rate to an estimated 2.8% (GOM 1991). Even at this reduced level, however, population growth will continue to outpace Malawi's capacity to produce food and provide essential services to its citizens (House and Zimalirana 1991; Jaffee et al. 1991).

Malawi also provides sanctuary to close to one million refugees from Mozambique. According to the government these refugees comprise 9% or more of the population (GOM 1991). Virtually nothing is known about the demographic characteristics of this population (but see Ager et al. 1991 and Long et al. 1990).

According to Long, however, many Malawian men are marrying Mozambican refugee women as second or third wives. Because of this, the situation of the refugees becomes pertinent to consideration of child spacing and HIV/STD transmission issues in Malawi. Additionally, since most refugee women have little access to income, the possibility of commercial sex between Malawian men and Mozambican women cannot be overlooked (although neither of the cited studies made any mention of it).

Approximately 47% of the total population is aged 15 years or less, yielding the high dependency ratio characteristic of African countries. However, both the infant mortality rate (150+/1,000 live births) and the under-5 mortality rate (250-350/1,000) are higher than those of most other countries in the region (UNICEF 1987, 1991; GOM 1991). Maternal mortality is also exceptionally high; a study conducted in Thyolo District by Chiphangwi et al. concluded that maternal mortality was 456 to 474 per 100,000, forty or more times greater than in Europe and North America. Continued high fertility and pressure on existing health services contribute to excessive morbidity and mortality among young children and women in their childbearing years. Furthermore, many births take place among women in high-risk categories; 14% of all births occur to women aged under 20 years, and 7% to women over 40 (GOM 1991). Sixty percent of births occur at intervals of less than three years, and about half of all deliveries take place outside of health care facilities (GOM 1984, 1991; UNICEF 1987). According to Chiphangwi, abortion is the third-leading cause of maternal death in Thyolo District.

Although the government has made serious efforts to expand the quality and availability of health care services, both facilities and personnel are inadequate in capacity to meet continually increasing demand. As House and Zimalirana note, "Access to health clinics is limited by the problem of transportation, there is an acute shortage of trained doctors, registered nurses, and medical assistants, and much overcrowding or congestion in most central hospitals" (1991:44). The Family Formation Survey (1984) noted that demand for child spacing services was not being met.

The private sector, in particular the Christian Hospital Association of Malawi (CHAM), also provides considerable health care resources in the forms of facilities, personnel and training, but the total of private and public interventions falls short of what is needed to make substantive improvements in the current health situation. At present, only a minority of the facilities offer any child spacing services (94 government facilities and 18 CHAM facilities according to Asiedu, 1992; out of a total of over 400 stationary facilities).

These demographic characteristics are unlikely to be affected in the short to medium term by formal educational interventions. Although the gross enrollment ratio for primary schools is over

500

50%, classroom overcrowding and high repetition and dropout rates dilute the quality of education; the proportion of children who receive full primary education is reduced to less than 25% of those who enter Standard I. Although the literacy rate has more than quadrupled since independence, over half the population remains illiterate, and women more so than men (House and Zimalirana 1991, UNICEF 1987, GOM 1984, 1991).

Malawi is a predominantly rural country, with over 85% of the people living in rural areas and engaged in smallholder or estate agriculture. Smallholder households, of which there are approximately 1.3 million with an average of five members each, cultivate their holdings primarily in food crops. Only 30% of these households can satisfy their food needs from their own production, however, and more than half of all smallholdings are one hectare or less in size (Jaffee et al. 1991, UNICEF 1991, House and Zimalirana 1991). As a consequence, migratory wage labor, movement from independent small holdings to tenancy on agricultural estates, and temporarily or permanently female-headed households, estimated to total 30 to 40% of rural households and significantly poorer than male-headed units, are common. An effectively landless class with an estimated mean holding of just 0.25 ha comprises one quarter of all smallholder households (House and Zimalirana 1991).

Virtually all of these rural households must involve themselves in off- and/or non-farm employment, locally or at a distance, in rural or urban areas, in order to sustain their members. Available data on income levels are few and in the main outdated. Recent studies of the urban poor have found that average household income is less than K 140 (USD 45) per month; expenditure exceeds income, and 56% of expenditure is on food; less than one percent of expenditure goes to health care (Chilowa and Shively 1989; Roe 1992). In sum, the majority of Malawians live in poverty, with cash and in-kind incomes of probably less than K 500 per household per year; and female-headed households are significantly worse off than male-headed ones.

Considerable variation in ethnicity, resource availability, size of landholdings, population density, and the nature of agricultural activities exists between the different regions of the country. The Northern Region has an estimated density of 34 persons per km sq, but productive potential is lower and larger holdings are required in order to achieve household food security. The Central and Southern Regions have estimated population densities of 83 and 125 people per km sq respectively, and are more dominated by commercial crops and estate production of tobacco, tea, and sugar.

The North is also distinctive in that the predominant ethnic groups are characterized by patrilineal forms of social and political organization which they share with closely-related

societies in neighboring Tanzania. These societies stress the importance of female virginity prior to marriage; young girls are instructed by their parents to be clean, respectful and humble (Demographic Unit 1986). Since the institution of bridewealth has been maintained, wherein the family of the prospective groom compensates (in cash or livestock) the bride's family for their loss of her productive and reproductive services, marriage may be relatively stable.

The matrilineal societies of the Central and Southern Regions do not have the institution of bridewealth and emphasize female initiation, with explicit ceremonies held at menarche, marriage and pregnancy. Ritual specialists (anankungwi) who instruct young women in appropriate conduct, including sexual conduct, prior to, during, and between marriages, still play prominent roles in these societies. Although there are no statistics available, divorce is relatively common and easy to obtain among such groups as the Yao, Lomwe and Chewa; this has been noted both by the standard ethnographic works of such anthropologists as Mitchell and Marwick, and by contemporary observers. Phiri (1986) notes that of 100 female household heads interviewed in Thyolo District, 24 were currently divorced, 24 separated, and 25 married polygynously with their husbands resident elsewhere. According to the Family Formation Survey conducted in 1984, 15.3% of women aged 45-49 years were currently divorced. Polygynous marriage is found throughout the country; 27% of currently married women are thought to be in polygynous unions (UNICEF 1987). Among the matrilineal groups, polygynous relationships often presage divorce or abandonment. However, Nkaliainga (personal communication) notes that in the Northern Region, wives may encourage their husbands to marry another wife, as the social position of the first wife is enhanced by such a move, and her work burden often lightened.

Malawi is a predominantly Christian country, with numerous missionary-introduced churches having claimed the allegiance of the population. Protestants outnumber Catholics; significant denominations include the Church of Scotland, the Anglican and Presbyterian churches, and assorted evangelical denominations. Muslims are the smallest, in terms of numbers of adherents, of the world religions, but seem to have substantial influence. However, it should be kept in mind that, particularly in rural areas, adherence to Christianity or Islam is often situational.

Apart from the importance of ritual specialists who play dominant roles in the initiation and education of the youth, strong beliefs in witchcraft still prevail, and traditional medical specialists (asinganga) remain an important source of health care for rural and urban people. The recent UNICEF poverty analysis notes that "The dominance of traditional medicine in many areas is due, not only to its availability, but because many people, including the well-educated, believe in its efficacy" (16).

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Ethnographic studies have documented the roles of these healers, the categories of illness for which traditional interventions are sought, and the interaction between the domains of traditional and modern medicine (cf. Kafumba-Utonga 1981; Mwanza 1982; Peltzer 1983, 1987). These healers are particularly important in the treatment of such sexually-related disorders as infertility, impotence, and STDs.

Matrilineal social organization should not be taken to mean that positions of leadership in political and economic matters are allocated to women. Malawian women are subject to numerous disadvantages as a consequence of their gender. They are socially, economically, and educationally disadvantaged in comparison to their male counterparts. The economic situation of female-headed households has already been noted above. In addition, women have less access to employment in the modern sector, and as agricultural laborers or tenants on estates are paid considerably less than men (and the men themselves are often paid less than the minimum wage; cf. Jaffee et al. 1991). They rarely own land or livestock and their labor is often allocated to commercial crops, the income from which they do not control. In addition, both rural and urban women are seriously time-constrained, often devoting twice as much time to productive and household maintenance tasks as men, and having little opportunity to engage in leisure, social, or self-improvement activities (Clark 1975, Chikufenji 1987). Socially, women are less able than men to negotiate marriage or to maintain marital relationships. Divorce is often at the initiative or the will of husbands. Nkaliainga (personal communication) states that the payment of 10t (US 3 cents) by a husband to his wife's matrilineal kin signifies divorce among the Yao of Zomba. Particularly in the Central and Southern Regions, the decision to negotiate polygynous marriage is a male one. The emphasis in the later stages of the initiation process in matrilineal societies is on the proper conduct of a wife towards her husband, characterized by solicitude and submission. Since they are disadvantaged in access to education and income, women often have little choice but to remain in difficult relationships, and are often pressured to do so by their relatives and fellow community members. Divorced women seek to remarry as quickly as possible since their status and identity are defined by marriage. However, as women grow older, having a husband becomes less necessary to the maintenance of social position; of women without husbands, widows are more secure than divorced or separated women.

Women are not completely powerless and at the mercy of men, however. Butler (1976) has discussed the means by which Malawian women in Lilongwe District achieve influence in the family and community. The bases of female authority include close residential proximity to matrilineal relatives, age seniority, economic autonomy and control (often associated with widowhood),

absence of the husband (as a labor migrant, or due to polygynous marriage), and consequently low dependence on him; and access to supernatural powers. As a consequence of such characteristics, Butler notes, women "...frequently exercise strong influence both within and outside of the domestic sphere."

More recent research on household decision-making has shown that women exercise considerable decision-making authority in such domains as production, sale, purchase, and consumption of food, having, for example, the capacity to sell food crops and dispose of the proceeds without consultation with the husband (cf. Evans 1981; Mthinda 1981; Phiri 1982; Spring 1983). A recent summary of household decision-making in Malawi concludes, "The survey data reveal that most household decisions are made after consultation between both conjugal partners, and that, despite a matrilineal social organization, in no case did the wife's brother(s) have any say in the decisions....Further, it was shown that even in households headed either temporarily or permanently by a woman that her brothers had little or no influence on her decision-making" (ICLARM/GTZ 1991:269). According to Peters and Herrera (1989) 50% of income in Malawi is controlled by women.

III. Health-related Behavior

The STAFH Project is intended to encourage child spacing and ultimately reduce fertility, and to reduce the transmission of HIV and STDs. In this section available knowledge about Malawian belief and behavior, with specific reference to contraception and sexually-transmitted diseases, including AIDS, will be examined.

A. HIV/STD

A small but growing body of literature indicates that awareness of AIDS in the Malawian population is substantial. The AIDSCAP report notes that "Few research studies have been conducted chronicling HIV transmission risk factors or reporting the impact of behavior change and other intervention efforts", but work by Johnston (1992), Kishindo (1990), Msapato et al. (n.d.), and Nyanda and M'manga (1990), as well as KAP surveys carried out in connection with the work of Project HOPE and the condom social marketing project (SOMARC) provide a basis for making inferences.

In all studies, over 90% of respondents or focus group participants have heard of AIDS, and the majority are aware it is a sexually-transmitted disease. However, there is a very strong tendency to associate AIDS transmission with prostitution. The single most significant unprompted response to the question of how AIDS is transmitted in Kishindo's study was prostitution (58%). Although the majority of respondents seemed aware that AIDS can be transmitted by asymptomatic infected persons, fewer than 20% identified sex with an infected man or woman as a

possible source of infection to themselves. There is greater variation in the extent to which vertical transmission is appreciated; the majority of teen-aged primary and secondary school students in Mzimba District know of it, but fewer than 1% of women respondents in Thyolo are aware (Msapato et al. 1990, Project HOPE 1991), and even those aware of vertical transmission do not necessarily know the mechanism (cf. Kishindo 1990).

Thus, while awareness of AIDS seems quite high, conscious awareness of the modes of transmission is not. In Kishindo's study the second most frequent response to the question "what is the cause of AIDS" is "no idea" (almost half of all respondents), and the proportion giving this response increases with age. In addition, substantial minorities of respondents believe that casual contacts such as shaking hands or sharing clothes are also vehicles for HIV transmission.

High awareness of AIDS/HIV does not yet seem to have been widely translated into specific risk-aversive behaviors. Although in Kishindo's study 61% of the sample of 2,000 respondents felt themselves to be at personal risk of AIDS, and 60% claimed to have changed their behavior as a consequence, the kinds of behavioral changes identified are not sufficient to provide the extent of protection the informants apparently feel they have afforded themselves; their knowledge is not complete enough for them to avoid all risks. The principal behavioral change these respondents say they have adopted is the avoidance of sex with <u>known</u> promiscuous persons and strangers. Those who are infected, they say, may avoid infecting others by abstinence from sex (31%), avoiding pregnancy (9.5%), never sharing needles (14.1%), never sharing clothes (9%), "other ways" (36%; these other ways are not identified), and use of condom/diaphragm [sic] (4.3%). Many (41%) felt they would be safe simply if they avoided having sex with prostitutes. Nyanda and M'manga found that none of the participants in their focus-group discussions was currently using the condom. Diminished sexual satisfaction, identification of condoms as "dirty", complaints of breakage or of the condom being "lost" in the woman's body were all given as rationalizations for not using condoms. Only three percent of the women respondents in the Project HOPE KAP baseline survey said that the use of condoms was a preventive strategy for AIDS.

It seems clear from the SOMARC study and Johnston's survey that the condom is used principally by men to protect themselves against disease with illicit or secondary partners, but even under these circumstances self-protection is far from universal. Bargirls who have been involved in discussion groups and peer education efforts report that they have changed their behavior, particularly increasing their use of condoms, as a result of the educational interventions. However, the use of condoms by prostitutes with their customers is situational. Nkaliainga (1992) reports that very few women who are dependent on the

income from prostitution are in a position to refuse unprotected sex with a client; bargirls also complain that "freelancers", who are not officially registered as "food handlers" and hence escape routine STD surveillance, are much less likely to insist that clients use condoms. In the SOMARC KAP survey, more than half of current users reported using condoms only sometimes. Lack of perceived disease risk to themselves is one of the reasons given for sporadic use; these respondents clearly do not consider that they themselves might pose a risk to others, particularly their spouses. This is particularly pertinent when it is considered that one-third to one-half of the men interviewed for this study admitted having experienced genital sores or symptoms of gonorrhea respectively.

All of these studies suggest that the use of condoms is more prevalent among the young and unmarried than it is among older couples, and that the condom is perceived as a male device; in the social marketing survey 31% of men identified condoms as a child-spacing strategy, but only 6% of women. This reinforces the hypothesis that condoms are employed by men primarily outside of marriage in high-risk sexual relationships. Of the teenagers (ages 13 to 19) surveyed by Msapato et al., over 30% stated that they had had sexual intercourse; 16% had used condoms, but it is not clear how consistent this use is, or for that matter if the sexual relationships involved are regular, or occasional, and who the partners are. Although not well-documented, a putatively risk-reducing behavior said to be employed by older men is to seek sexual relations with adolescent girls, who are assumed less likely to be infected than older women (AIDSCAP assessment; Nkaliainga, personal communication).

In sum, while some men who engage in extra-marital relationships and some women in high-risk professions have modified their behavior by adopting the condom, and others claim they now avoid high-risk relationships, adoption of less risky behaviors does not seem to be widespread. Among men, at least, the primary motivation is self-protection and little consideration is given to the risks to which partners, including spouses and adolescents, may be exposed.

Recommendation: Intervention efforts, especially IEC, should be targeted to high-risk groups such as employed men, bargirls, and young people, but efforts should also be made to reach out of school youth and rural women who are placed at risk by the self-protective (rather than other-protective) motivations of their partners.

B. Child Spacing

The ethnographic record shows widespread knowledge and use of traditional child-spacing methods in Malawi. These methods included abstinence from intercourse for married couples for an

extended period (six months or more) after the birth of a child; the use of spermicidal herbs, herbally-treated strings, and abortifacients; and the practice of prolonged breastfeeding and polygynous marriage. Srivastava and M'manga also mention kin-group or community-wide abstinence in cases of serious illness, death, drought or epidemic.

Modern methods of child spacing became available in Malawi in 1982. The first study to examine attitudes towards and utilization of both traditional and modern methods was the Family Formation Survey conducted in 1984. At that time just over a quarter of the women of child-bearing age interviewed in the survey were aware of at least one child-spacing method; only 1.1% were actually using a modern method. The pill, abstinence, and herbally-treated strings (tied around the waist and apparently employed at the initiative of women; unfortunately there is no information on how effective this technique might be) were the best-known and most frequently-employed methods.

Even at this early point in the availability of information and reliable methods, considerable interest in and demand for services was reported. Sixty percent of non-pregnant women wanted to delay or end childbearing, and two-thirds of men were apparently receptive to the concept of child spacing. More recently, Masanjika et al. looked at the utilization of available child spacing services in Northern Malawi. At first glance the rates are discouragingly low: only 2.7% of the eligible female population had ever registered for child spacing, and only half of those registering had actually ever used a modern method. However, when taking into account the fact that services are available at only 20 facilities in the Region, and women with access to these facilities are counted, rates of registration and utilization rise to 8% and 4% of those eligible respectively. Many female users felt that other women who want to use child spacing are prevented by their husbands from doing so, but this is far from being the only reason for non-adoption. The authors note that with the exception of the condom, all of the available modern methods are used by and targeted to women. This is of concern to men not least of all because they do not have access to information about methods, and feel threatened by the knowledge that women possess.

Further research has shown that over time, knowledge and adoption of modern child-spacing methods has continued to expand. A survey reported by Srivastava and M'manga of the Demographic Unit at Chancellor College in 1991 showed that 79% of male respondents and 77% of women could identify at least one modern method. The pill, injectables, and condoms were the most frequently mentioned. Adherence to traditional methods such as abstinence and waist-strings was also reported, but in this survey ever-use of a modern method had increased to 8% of men and 9% of women. Similar results are reported in a WHO/MOH survey of Nsanje,

Mzimba, and Ntchisi Districts; 54, or 8.5%, of 631 non-pregnant women respondents were currently using a child-spacing method.

The most optimistic results of all were obtained by the social marketing KAP survey conducted in 1991. Only 30% of the respondents sampled in this study had never used a method of preventing pregnancy; almost 98% were aware of child spacing and 96% spontaneously identified one or more methods. Over half of those in marriages or other unions said they had discussed child spacing at least once with their partner during the past year. Current use of modern methods by women in this sample was 15%; "...it seems that a rapid expansion of modern methods has taken place in the last three years...." (p. 53).

Some evolution in attitudes towards decision-making on adoption of child-spacing methods seems also to have taken place over the past ten years. In the early years of implementation both male and female respondents seemed to agree that it was the prerogative of the male to decide whether and/or when it would be used (cv. Srivastava and M'manga 1991). However, Nyanda and M'manga report that women feel it is their responsibility to initiate the idea of child-spacing, after which men make the final decision. Most recently, the social marketing survey indicates that half of the women feel that adoption of child-spacing should be a joint or a female decision. Further, the fact that the pill was cited as ever-used by 26% of women but only 8% of men suggests clandestine use on the part of women--truly unilateral decision-making.

Despite the relatively late and slow introduction and utilization of modern methods of family planning, then, both knowledge and demand for reliable methods is increasing, and consideration is being given, particularly by women, to limiting total family size rather than simply spacing births (cf. Srivastava 1991). Nyanda and M'manga's 1990 study and the social marketing KAP survey both conclude that by far the majority of Malawians find child-spacing to be an acceptable concept. According to M'manga and Srivastava, the principal barrier to fertility reduction is the continued high infant and child mortality rates; "When all other factors are controlled for, increased child survival would therefore be expected to lead to some decline in achieved fertility".

Recommendation: Given that continuing high IMR and U5MR are a disincentive to fertility limitation, the integration of MCH, child spacing, and HIV/STD activities which emphasize child survival and child health, thus contributing to greater acceptance of child spacing as a strategy for fertility reduction, should be undertaken.

C. Sexual Behavior Among Youth

A number of studies and informants have pointed with concern to what they see as rising rates of sexual activity and pregnancy among teenagers. Note has already been made of Msapato et al. who found that almost one-third of 13-19 year old primary and secondary school students in Mzimba District were sexually active. In fact, in 1984, 41% of women aged 15-19 years were already married, and one-third of all women had their first child before age 18. According to participants in an MOH/UNFPA workshop on child-spacing held in 1986, ideals of chastity are not widely held among the matrilineal groups in Malawi, although premarital pregnancy is somewhat shameful and efforts are made to arrange a marriage between the girl and the father of her child.

Teenaged boys are encouraged by older men to test their virility without consideration of potential consequences for their partners. Schoolgirl pregnancy results in expulsion for the girl, a sanction which does not extend to the boy unless he admits paternity. Abortion, although illegal, is the third-leading cause of maternal mortality (cf. Chiphangwi et al. n.d. and is resorted to, often with tragic consequences, by increasing numbers of pregnant adolescents (cf. Nkaliainga, personal communication). However, particularly in urban areas, arranging marriage is becoming more difficult. There is an increasing number of young, single, working-class mothers in the towns whose economic marginality may force them into prostitution in order to survive.

In addition, having sex as a means to get money or presents seems to be widespread, even in villages. Girls who have become pregnant out of wedlock and who have not been able to find a husband may be reduced to "asking for soap" (money or gifts) as a means of survival. Women who have been divorced or deserted and who have no other means of getting money may also adopt this strategy, even in rural areas. In addition, much mention has been made of the "sugardaddy" phenomenon whereby young women and schoolgirls are lured into sexual relationships with affluent older men. Needless to say all of these behaviors increase risks of both unwanted pregnancies and HIV/STD.

Recommendation: At this point most of the available information is anecdotal and documenting the extent of such behaviors is of high priority in the social research agenda.

D. Polygynous marriage and divorce

As already noted, about 27% of Malawian women are in polygynous unions. Nkaliainga (personal communication) says that many women do not know that they have a co-wife until months or years after their husbands have established the relationship. Divorce and subsequent remarriage remain very frequent, especially in the

Central and Southern Regions. The majority by far of village marriages do not involve any legal or religious formalities and the marriages are not registered with any authorities. Consequently movement in and out of marriage is easy; essentially, marriage exists if the relationship is accepted as such by other members of the community. The majority of divorced people, men and women, remarry, and often more than once.

Several other institutions which open up the possibility of multiple sexual partners within marriage are also found in Malawi. Although disappearing, the levirate, whereby a widow is married to her deceased husband's brother, is apparently still practiced in some areas (cf. interview with Chief Mponda, Malawi News, 9-15 May 1992). Also, "In situations where the husband is suspected to be sterile and where all efforts with fertility medicines have failed to produce a child, a married couple without children may hire a 'hyena'--a man who comes in darkness or secretly--to cohabit with and impregnate the wife for an agreed sum of money or any other payment in kind as a fee for his services. This may done with or without the knowledge and consent of the husband" (Demographic Unit 1986:36). Informants with whom I spoke near Zomba confirm that this institution still exists, although again the extent to which it is practiced could not be ascertained.The implications of polygyny, uncomplicated divorce, and remarriage, as well as widow inheritance and the 'hyena', is that multiple sexual partners exist within legally-constituted marriage. Hence, even mutually-faithful couples may unknowingly be at risk of HIV/STD if past or future partners indulge in high-risk relationships. In addition, women's fertility may be affected by the necessity of having a child or children with each of several spouses. The lack of hard data makes it impossible to draw any conclusions at this point.

Recommendation: detailed investigation of the extent of divorce and polygyny, as well as temporary unions which are said to be common on the tea estates in the Southern Region (Davison, personal communication) is needed.

E. Male Involvement in Child-Spacing

At present, with the exception of the condom, all modern child-spacing methods are female-oriented. The majority of service providers are women (usually nurses) and provision is facility-based. Not surprisingly, men who are interested in obtaining reliable information about child-spacing options are somewhat intimidated by the idea of receiving information from women, or in mixed gender groups with women clients. It has also been suggested that men resent the female monopoly of this domain of knowledge, feeling that women have somehow been given power over them. This may account for some of the remaining male reluctance to utilize child-spacing, and their insistence on responsibility for decisions about child-spacing (cf. Alam n.d.).

It is clear that child-spacing clients want providers who are their own age and sex, who have children, and who use modern child-spacing methods themselves and can thus talk about them from experience. Thus, the most direct way to involve men in child-spacing is to recruit or train more male service-providers. As Masanjika et al. note, "The implication here is that there is still a large pool of males who are not reached by the programme. Use of male providers may make a big difference" (p. 29).

Recommendation: Special efforts should be made to target men for child-spacing IEC, using male service providers and ensuring confidentiality. With greater access to information which is seen as being monopolized by women, men will feel less threatened and more receptive to child spacing efforts.

Recommendation: Making information and service delivery available away from facilities may also serve to involve men more directly in child-spacing. Community-based distribution and/or IEC, utilizing members of village health committees, extension workers from health or other ministries, and printed materials which spouses could discuss jointly, are some possible methods for moving away from the facility and into the community.

F. Models for Service Delivery

At the present time such child spacing and HIV/STD services as are available in Malawi are found primarily in fixed facilities in public and private sector health care institutions (Ministry of Health and CHAM). The STAFH project will support expansion of service delivery to larger numbers of MOH and CHAM facilities, as well as to parastatal and private enterprises which have facilities, and private practitioners and clinics. In addition, the potential of Health Surveillance Assistants and/or Traditional Birth Attendants as agents for community-based delivery of services will be evaluated.

As noted above, if services are to reach male clients, male providers must be incorporated into delivery systems. Participants in a 1986 workshop on child spacing, most of them community development and health-care professionals, advocated developing separate men-only clinics for counselling and IEC, and promotion of condoms. Such an approach may not be feasible given financial and personnel constraints in both public and private sectors, but setting aside a time and a place at existing facilities for addressing the needs of men is a potential response to their concerns.

In addition, to the extent possible, issues of child spacing and of HIV/STD transmission and prevention should be integrated and addressed by the same providers. Particularly with regard to treatment/counselling for STDs, it is imperative that the confidentiality of patients be protected. This is often

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difficult to do in fixed-facility settings where clients may often spend extended periods of waiting in company with other clients and patients, and according to Masanjika et al. is a particular disincentive to men. These authors propose community meetings for the dissemination of information, and printed materials which couples considering adoption of child-spacing or individuals concerned that they might be suffering from STDs can read and/or discuss in the privacy of their homes. Such materials would clearly be available only to the literate, but would satisfy a strongly-expressed felt need.

As already noted, Malawian women work hard, and their available time is fully occupied with agricultural and domestic maintenance activities. The time constraints of women would be more effectively addressed both by the dissemination of services to a greater number of sites, and community-based systems of distribution. Lack of accessibility, both in terms of the distance to be travelled and the time required, is a disincentive to utilization and adoption.

Recommendation: models and strategies of service delivery which make effective outreach into the community and which employ the skills of community members with whom potential clients already interact and whom they trust, are likely to have substantial impact.

G. IEC: Strategies and Institutions

1. Public Schools

According to Mackie (1992), AIDS education will be introduced into all of Malawi's schools by the end of 1992. Chichewa-language materials will be used in the lower primary grades, switching to English for upper primary, secondary, and tertiary. However, they seem to be lingering implementation problems in the dissemination of the books and posters, and the directness of the messages conveyed by these materials. The teacher's guide for Standards 5-8 makes it clear that neither child spacing nor non-HIV STD is discussed.

It seems imperative to integrate matters pertaining to human sexuality and reproduction into one instructional package for each grade level, and to make these packages iterative, interactive, and sequential. Again, participants in a 1986 workshop on child spacing in Malawi "...believed that a large number of young men and women of today are deprived of the knowledge about the functioning of the human body which the social institutions passed from generation to generation. This deficiency could lead to serious sex-related problems in Malawian society. Thus the participants strongly felt that the modern educational system should supplement and reinforce the disappearing 'traditional' system by introducing family life

education right from the primary level." Samu also emphasizes this point.

Recommendation: develop a program of integrated family life education for young people in and out of school.

It is possible that considerable social and parental opposition will need to be overcome in sex education efforts in the public schools. There are strong feelings among parents and teachers, among others, that teaching young people about sex and/or making condoms available encourages sexual experimentation and promiscuity. They need to be convinced that the youth are already sexually active, and that the prospect or necessity of receiving financial rewards for sex is probably doing more to encourage young women than is the availability of information or commodities.

2. Religious institutions

Project HOPE has already begun to train religious leaders from the major denominations, as well as youth and women's leaders, as sources of information about AIDS and child-spacing to their adherents and contemporaries. According to Asiedu, however, certain problems have been encountered when it comes time for the religious leaders to pass on what they have learned. Information on condoms has been censored, the issues of extra-marital and pre-marital sex are glossed over, AIDS continues to be associated with immorality, churches do not favor the provision of condoms to young or uninfected people. The training does not focus on prevention, but rather on couples, on abstinence and mutual faithfulness. While self-control and monogamy are both worthy and desirable, they do not reflect the reality of much sexual behavior in contemporary Malawi.

At present very few respondents in surveys and focus groups mention the church or religious leaders as a source of information about either child spacing or STDs. This may be because the churches have not yet themselves articulated their position on these issues, or because religious leaders are not yet prepared to engage in IEC efforts. None of Kishindo's respondents received any information on AIDS through religious organizations; and students at the Polytechnic, surveyed by Tembo (1991), regarded religious leaders as neither credible nor trustworthy as sources of AIDS messages.

On the other hand, most Malawians do attend some church on a regular basis and are accessible to religious leaders and peers.

Recommendation: modify and intensify the training of church representatives as peer educators, to ensure that what they pass on is factual and accurate, to emphasize youth and women in

church-based IEC efforts, and to incorporate HIV/STD preventive messages into religious counselling and Bible/Koran study sessions.

3. NGOs

There is a large array of private voluntary and non-governmental organizations in Malawi, from small to large, local to international. Some of these organizations are more appropriate channels for IEC messages than others. The Malawi Red Cross and other humanitarian or Christian organizations such as the YMCA already have programs of education, skills development, and community mobilization directed to young people and women, and could readily integrate AIDS and child-spacing messages into their existing programs.

It is not clear how large the membership of these organizations is or to what extent they reach rural as well as urban areas. In other countries the YWCA has been very effective in identifying leaders of rural women's groups who are selected to participate in short-term training and workshops on topics as diverse as bookkeeping, leadership dynamics, maize-grinding mill maintenance, and health education. If networks exist which permit this kind of outreach in Malawi, and if the organizations have appropriately-trained personnel who can effectively reach and teach rural women and youth, such organizations have a potentially strategic role in IEC efforts. Given the time constraints women experience, organizing venues in the rural areas where such interventions could be staged, and providing child-care facilities during instructional sessions, is critical.

Recommendation: establish an up-to-date, comprehensive data base on NGOs in Malawi, their existing programs, and their potential for implementation of IEC activities for child spacing and HIV/STD.

4. The Workplace

An integral part of the STAFH IEC and service provision strategy is extension to the workplace: private and parastatal employers in the urban areas, as well as agricultural estates. Although a large number of these businesses already provide health services to their employees, only a fraction incorporate child-spacing services; there is no reliable information on the extent to which peer counselling or other advisory services on AIDS/STDs is available. Given the high prevalence of AIDS among salaried workers in such companies, particularly in the urban areas, these firms are high priority for educational interventions; many businesses and estates have already indicated their interest.

While it has already proven feasible to recruit workers to go for training as peer counsellors, there seem to be some problems in the transfer of knowledge in the workplace. Would-be peer counsellors must be selected carefully; Nkaliainga recounts the case of an employee who was sent for training in HIV/STD peer counselling but who confessed that his principal motive in attending the course was to collect the allowance. He had no intention of imparting any knowledge to his workmates and felt that the content of what he had been taught was both embarrassing and inappropriate. There may be a sizeable potential for wasting time and resources unless candidates are carefully selected and make an up-front commitment to sharing what they have learned, and encouraging their workmates to make use of integrated child-spacing and HIV/STD services available at the work site.

Recommendation: screen employers and peer counsellor candidates for worksite interventions carefully to ensure maximum program impact.

5. Mass Media

By far the majority of teenagers in Malawi do not go to school and consequently will not be reached by the instructional materials on AIDS that have been integrated into the school curriculum. Their low literacy and isolation from structured sources of information mean that special efforts must be made to create communication and distribution channels for this high-risk population.

A number of service and information delivery strategies have been proposed and have a high potential for reaching this audience. These include the churches, political youth organizations, rural literacy centres, radio programs, videos to be shown at rural commercial "theatres", and music/drama/puppetry displays, competitions and activities in the community and at institutions. Of all of these proposed strategies, the radio seems to have the greatest promise. Respondents in a number of surveys have indicated that the radio is among their most reliable, convenient, and frequently-used sources of information on child-spacing and AIDS (cf. Kishindo 1990, SOMARC Kap Survey 1991, Srivastava and M'manga 1991). Many people who do not own radios have access to them through relatives and neighbors, so that ownership is not an accurate indicator of how many people are reached with radio messages. Experiences in other countries (such as Kenya) have shown the effectiveness of this medium for expanding awareness; radio can also be used in an interactive fashion (such as write-in responses and questions which are answered in future programs). There are apparently still barriers to be overcome in expanding AIDS and child spacing relevant programming (cf. Brown 1992) but there is great potential for reaching out-of-school youth.

In addition to the radio, newspapers, magazines, posters and pamphlets are also possible channels for reaching this and other high-risk groups. Newspapers were also mentioned by large numbers of respondents in the various surveys as a reliable source of information. Ugandan and Kenyan newspapers already have regular information features, political cartoons, comic strips, question-and-answer columns, daily AIDS facts and "tips", and personal histories in the print media. One Kenya newspaper includes a glossy weekly "Style" insert in the Sunday edition which highlights a regular column written by the Chairman of a national AIDS awareness and advocacy organization who is himself infected. These papers and magazines are widely distributed and available at the village level and there is no technical reason why similar strategies could not be followed in Malawi.

Video and music/drama activities and materials would be more difficult to implement. Channels for distribution do not necessarily exist at the level (village or community) where they are needed, and the costs of producing videos and staging dramatic or musical events make them less feasible avenues for creating awareness and disseminating information.

Recommendation: Target radio, newspaper and magazine channels as appropriate media for reaching large numbers of people with child spacing and HIV/STD IEC.

6. Traditional Healers and Instructors

Virtually none of the respondents in any of the surveys done on sources of child-spacing services and information made mention of traditional healers (asinganga) or initiation instructors (alangizi, anankungwi). Not surprisingly, University students do not regard them as credible or reliable sources of information. However, these practitioners are still extremely visible, active and trusted in the rural areas (and even urban ones). Both published sources and interviews establish that the majority of the clients seeking the services of healers suffer from sexually-related disorders.

The anankungwi are hired by the parents of girls who are in one of the stages of initiation (puberty, first pregnancy) to impart specific sex and birth-related information (including emphasizing abstinence from intercourse for an extended period after the birth of a child) and to organize public, social recognition in the changes in a girl's sexual status. As Kishindo notes, "Traditional alangizi and anankungwi did not feature in the responses as sources of information on AIDS. Apparently their potential as social communicators was not appreciated and therefore they were not integrated into the public education effort. Alangizi and anankungwi hold positions of great influence over the young in rural communities and they could use these positions to influence behavioral changes in the boys and

girls that they prepare for adult life. Much useful information on AIDS could be passed on to boys and girls during initiation ceremonies" (33).

Both Samu and Nkaliainga report that the respect accorded to healers and initiators, the confidentiality with which they treat their clients, and their integration into their rural communities as neighbors and kin give them a unique position which could be utilized in IEC efforts. It is less clear that they would be effective in service provision (e.g. condom distribution, pill resupply). Interviews were conducted with two asinganga in Zomba and two anankungwi in Domasi. All four of these informants felt that they needed to be educated on child-spacing and AIDS issues, and that providing information and counselling members of their communities would be consistent with their existing roles and strategies. Helitzer-Allen, in the first presentation of results from a study of anankungwi as IEC channels in Thyolo District, concludes that "relying on Nankungwi [sic] as communication channels for HIV is not sufficient" (12); but clearly both healers and initiators have a role as part of a multiple-strategy IEC approach.

Recommendation: give high priority to research to establish the credibility, receptivity and potential of traditional medical and ritual specialists to communicate CS and HIV/STD information in rural areas.

7. Adult Literacy Programs

Malawi has long had a program focussed on introducing literacy to adults who never attended school. Nationwide there are about 45,000 participants in adult literacy classes, virtually all of them female. Most of the instructors are also women. Although facilities are lacking, every district at least has a framework for rural literacy promotion. Councillors in Zomba urban are considering organizing separate classes for men and women as a strategy for encouraging greater male participation.

Given time constraints, the necessity of travelling to an instructional center, and class sessions that occupy only a few hours per week, the adult literacy framework has only limited potential as a channel for service or information delivery. However, in Tanzania the rural adult literacy campaign has effectively delivered messages on agricultural strategies and food production policies by integrating them into the instructional materials that are employed.

Recommendation: explore possibilities for the materials currently being developed and distributed in the schools to be adapted for this adult audience, and literacy teachers to be

provided with instructional guides, at relatively low cost; radio messages could be employed as an adjunct to promote greater enrollment, particularly among younger illiterates.

8. Retail Suppliers of Commodities

Self-treatment of self-diagnosed illness with over-the-counter and/or prescription remedies is widespread in Malawi. For men this is an important treatment option for STDs, which often results in incomplete, inappropriate, and ineffective therapy. Drugs and condoms may be purchased from pharmacies, variety stores, and even village shops, where the pharmacist or shopkeeper may be unaware of the right dosages, proper methods of use, or even the condition for which treatment is being sought. It is important to provide the right information as well as the right commodities to such outlets. Respondents in KAP surveys have suggested over-the-counter sales of condoms and antibiotics in groceries and bottle stores; the proprietors of these facilities need to be able to tell their customers what to buy and how to use it, and also to refer them to facilities for treatment and IEC.

Recommendation: target pharmacists, shopkeepers, and other retail suppliers of CS and HIV/STD commodities for training in dosage, appropriate use, and referral strategies.

9. Women's Groups and Political Organizations

A number of different kinds and levels of women's organizations are found in Malawi. Many women's guilds to which rural women belong are affiliated with churches, and suffer from same kinds of limitations that religious organizations do in terms of service and information dissemination.

The two national women's organizations, CCAM and League of Malawi Women, are closely associated with the Malawi Congress Party. According to Nkaliainga, the CCAM is a more urban, elite organization which has non-Malawian members and which concentrates on raising funds for various charitable purposes. The League of Malawi Women has representatives from the village to the national level; the leadership of the two organizations at the national level overlaps extensively, but at the village level the leadership comes from and is supported by the village women. In the Domasi area, and presumably elsewhere in Malawi as well, some of these local leaders are also anankungwi, schoolteachers, and religious leaders, and could reinforce the importance of IEC messages through their multiple roles. The same is apparently true of the Congress Party itself.

Nkaliainga and Samu both suggest that the most important step that these national organizations could take would be to clearly articulate their position on and support for child-spacing and

HIV prevention, using the mass media. Such a stand would assist in dispelling fears and uncertainties among clients because they are taken as representing the interests of the people. However, as Samu emphasizes, the membership and the national representatives should also be seen to practice what they preach.

Recommendation: encourage both the GOM and organizations closely associated with it to articulate their support for population policies and HIV/STD prevention strategies.

IV. Benefits and Sustainability

There are several categories of potential beneficiaries of the STAFH Project. The largest and most important of these categories are adult men, and women of reproductive age, who together make up about half of Malawi's total population. Women will benefit because the morbidity and mortality associated with pregnancy and childbirth will drop as a consequence of longer birth intervals and delayed or prevented pregnancies. As HIV and STD prevalence rates stabilize and decline as a result of increased educational efforts, treatment, and condom use, the burden of ill-health and premature death borne by women will also be reduced.

Men's health will be less directly benefitted by increased control over fertility, but improved management of HIV/STD will contribute directly to the health and well-being of men, particularly the skilled and well-educated salaried workers who are disproportionately affected by these illnesses.

Malawian children can also be expected to benefit; they will be born healthier if birth intervals are lengthened, total fertility reduced, and chances of vertical transmission of HIV/STDs diminished; and child survival is likely to increase if scarce economic resources in the household do not have to be allocated to as many different competing ends.

As their skills are enhanced by additional training, health care providers in the public and private sectors will also be benefitted. Reduction of ill health in the working population, male and female, will make an indirect contribution to national welfare if fewer working days are lost to illness and/or maternity leave, and levels of productivity improve.

In sum, the potential benefits to the Malawian people from implementation of this project are substantial and far outweigh any possible costs.

The sustainability of project activities once the project is formally closed out depends on appropriate training and development of local capacity for supplies of commodities and IEC materials. The importance of training extends not only to

service providers at various levels of the health care system, public, private, and informal, but also of management staff who can assume the functions that are to be carried out by AIDSCAP and contractor personnel during the eight-year life of the project. The proposed internship strategy is not sufficient to develop the level of skills required. Every effort should be made to recruit competent personnel who would spend one year working with their counterparts, then proceed overseas, for the necessary formal training, then return to work in tandem with their counterparts before taking over full management responsibility for project activities when the project has been completed. Such persons should be hired in addition to the interns.

It remains to be seen whether local manufacturing and marketing capability are strong enough to sustain the supply of condoms and other commodities required at end of project.

V. Research Agenda

The social, cultural and economic variables that impinge on child spacing and HIV/STD control in Malawi have not been fully explored. The inclusion of a cultural anthropologist among the project personnel is crucial to developing and carrying out an appropriate research agenda. The following topics are the starting point for a series of investigations which should be implemented as soon as possible when the project gets under way.

1. The incidence and prevalence of adolescent and out-of-wedlock pregnancy (there is clearly some overlap between these two categories), with particular attention to the social and economic position of unwed, teen-aged mothers. In this context the extent to which young women who are neither bargirls nor freelancers seek and accept financial inducements in exchange for sex should be documented.

2. The frequency of polygyny and frequent divorce and remarriage, as well as leviratic marriage and the institution of the 'hyena', implying multiple sexual partners within legally-constituted marriage, must be studied. How widespread are these practices, how many partners might be involved, and what risks do these institutions impose for HIV/STD transmission and unwanted pregnancy?

3. The extent of economic and sexual transactions between Malawians and Mozambican refugees. Both marriage and commercial sex should be examined and the potential for HIV/STD transmission to both genders in both populations explored.

4. The dimensions of the potential population of AIDS orphans and strategies for assisting orphaned and fostered children at the community level. The Ugandan experience with war and AIDS

orphans has shown systematic discrimination against fostered children; for example, even in high-resource households these children are deprived of educational opportunity and exploited for their labor. Since there are likely to be 400,000 children in Malawi by the end of the century who will have lost one or both parents to AIDS, assessment of the capacity of rural households to absorb additional dependents, and the evolving attitudes of adults towards foster children, is an urgent issue.

5. Intensive, high-quality ethnographic research on the knowledge, roles and responsibilities of asinganga, anankungwi, and alangizi is needed, as a basis for establishing the extent to which these practitioners can become part of an HIV/child spacing IEC network. Information is also needed on the type of clientele they serve (age groups, gender, ethnicity) and the kinds of treatments they provide, particularly for STDs and other reproductive problems.

6. Although it will be extremely difficult to assess, in view of the anxieties expressed by parents and teachers that the availability of child spacing and HIV-preventive commodities contributes to promiscuity, particularly among young people, this putative relationship must be explored. Perhaps a controlled comparison between two rural areas, one with reasonable access to an existing service-providing facility and another without such access but comparable in socio-economic and ethnic characteristics could provide the basis for a research strategy.

7. More information is needed on decision-making privileges and responsibilities for men and women, particularly with reference to sexual, reproductive, and child-spacing matters.

8. Research in Kenya has suggested that the sexual partners of teenage mothers are most likely to come from among their agemates and classmates than from among older men. Nonetheless, popular stereotypes of the "sugardaddy" as the "spoiler" of adolescents remain. The extent to which young girls are impregnated by older, affluent men, and also the extent to which accepting financial rewards for casual or long-term sexual relationships in urban and rural areas needs to be examined.

9. Research on the capabilities of NGOs in Malawi as research organizations, service providers, and channels for IEC on child spacing and HIV/STD should be undertaken, perhaps in conjunction with EIL or the SHARED project.

References Cited

Ager, A. et al.
1991 A case study of refugee women in Malawi. Report for UNHCR. Centre for Social Research, University of Malawi.

AIDSCAP
1991 Technical Assessment (Malawi program).

Alam, S., et al.
n.d. FLE problems as viewed by women, men and teenagers in Malawi. Draft report.

Asiedu, K.
1992 Potential role of church and religious leaders. Report to USAID/Malawi.

Blumgart, J.
1992 Options for the management of subgrants in the private sector under the STAFH Project. USAID/Malawi.

Brown,
1992 Malawi Health Social Marketing Project (SOMARC): current status and potential for expansion. Prepared for USAID/Malawi.

Butler, L.
1976 Bases of women's influence in the rural Malawian domestic group. Unpublished PhD dissertation, Anthropology, Washington State University.

Chikufenji, R.
1987 An assessment of work done by rural women in Unit 33 of the Lilongwe ADD. Degree project report, Bunda College.

Chilowa, W., and G. Shively
1989 Expenditure patterns and nutritional status of Malawi's urban poor. Centre for Social Research, University of Malawi.

Chiphangwi, J., et al.
n.d. Survey report on maternal mortality in the Thyolo District of Southern Malawi.

Clark, B.
1975 Work done by rural women in five areas of Malawi. Bunda College.

Davison, J.
1992 Personal communication. Zomba, Malawi.

Demographic Unit, Chancellor College
1986 The value of children and child-spacing in Malawi. Report of a workshop. In conjunction with MOH and UNFPA.

522

Evans, J.
1981 Rural women's agricultural extension programme in Phalombe Rural Development Project. Bunda College.

Forsythe, S.
1992 The economic impact of HIV and AIDS in Malawi. Confidential draft report to USAID/Malawi.

Government of Malawi
1984 Family Formation Survey.

1991 Population and development in Malawi. Office of the President and Cabinet, Department of Economic Planning and Development.

Helitzer-Allen, D., et al.
1992 Combining structured qualitative and quantitative methods to learn about useful communication channels for adolescent girls and HIV/STD prevention messages. Paper presented at the B. Frank Polk Symposium, Johns Hopkins University.

Herbalist Association of Malawi
1992 Proposal to the USAID SHARED program.

House, W., and G. Zimalirana
1991 Rapid population growth and poverty generation in Malawi. ILO Labour and population series for sub-Saharan Africa, document no. 15.

ICLARM/GTZ
1991 The context of small-scale integrated agriculture-aquaculture systems in Africa: a case study of Malawi.

Jaffee, S., et al.
1991 The migrant smallholders. USAID/Malawi and Bunda College.

Johnston, A.
1992 A note on the calculation of contraceptive prevalence rates for condoms in Malawi. Prepared for USAID/Malawi.

Kafumba-Utonga, C.
1981 Quest of therapy in contemporary Malawi, with special reference to Likoma Island. Undergraduate Research Paper, Chancellor College.

Kishindo, P.
1990 Knowledge, attitudes and beliefs on AIDS. Draft. Chancellor College, University of Malawi.

Long, L. et al.
1990 Report on Mozambican refugees in Malawi. Prepared for UNHCR.

Mackie, W.
1992 Malawi AIDS education for schools project. Presented at the annual conference of the Confederation of African Medical Associations and Societies.

Makhumula, P., et al.
n.d. Differential impact of health talk versus peer group education on risk reducing behavior towards HIV/AIDS in bargirls in Malawi.

Masanjika, J., et al.
n.d. A study of factors contributing to the low utilization of child spacing services in the Northern Region of Malawi, with emphasis on male participation. Health Research Unit, Ministry of Health.

M'manga, W., and M. Srivastava
1991 Socio-economic and demographic determinants of family size in Malawi: a multivariate analysis. Demographic Unit, Chancellor College.

Msapato, K., et al.
1990 Study of knowledge and aspects of attitudes of school teenagers in Mzimba District about HIV infection/AIDS. Health Research Unit, Ministry of Health.

Mthinda, C.
1980 Decision-making in smallholder farms within the Lilongwe Lande Development Programme Area. BSc research paper, Bunda College.

Mwanza, G.
1982 Traditional and western medicine in a changing society: the Tandalala case studies. BA degree research paper, Chancellor College.

Nkaliainga, G.
1992 A report on socio-cultural influences on reproductive and sexual behavior in Malawi after a number of interviews with individuals. Prepared for USAID/Malawi.

1992 Final report on findings after interviews with families in both urban and rural areas, youth, employed women, bar owners and female STD patients. Prepared for USAID/Malawi.

1992 Personal communication. Zomba.

Nyanda, M., and W. M'manga
1990 Focus group exploration of attitudes towards condoms, names, packs and concepts in Malawi. Centre for Social Research, University of Malawi.

Nyanda, M., and J. Shively
1989 Source of and factors influencing the incomes of tenants on agricultural estates. Centre for Social Research, University of Malawi.

Peltzer, K.
1983 Ethnomedicine in four different villages in Malawi. Staff Seminar Paper no. 30, Chancellor College.

1987 The socio-psychological role of traditional healing in Malawi. PhD dissertation, Germany.

Peters, P., and G. Herrera
1989 Cash cropping, food security and nutrition: the effects of agricultural commercialization among smallholders in Malawi. Final report, HIID.

Phiri, C.
1981 Decision-making in smallholder farms within the Lilongwe Land Development Programme. BSc degree project, Bunda College.

Phiri, C.
1986 Women and their economic activities: a comparative analysis of male-headed and female-headed households in the Thekerani Rural Growth Center. Bunda College.

Research International East Africa
1991 SOMARC KAP Survey.

Roe, G.
1992 The plight of the urban poor in Malawi. Centre for Social Research, University of Malawi, and UNICEF.

Roe, G., and W. Chilowa
1989 A profile of low-income urban households in Malawi. Centre for Social Research, University of Malawi.

Samu, S.
1992 Background information for a social soundness analysis for the STAFH Project Paper. Prepared for USAID/Malawi.

Spring, A.
1983 Women farmers and women-headed households in Malawi. Unpublished ms.

Srivastava, M.
1990 Demographic implications of child spacing program in Malawi. Paper prepared for the Ministry of Community Services, Government of Malawi.

Srivastava, M., and W. M'manga
1991 Traditional and modern methods of child spacing in Malawi: knowledge, attitude and practice. Demographic Unit, Chancellor College, University of Malawi.

Tembo, K.
1991 Evaluation of source of messages on AIDS by college students. Malawi Medical Journal 7(3):117-118.

Thompson, C.
1991 Report on KAP Baseline Survey. Project HOPE Malawi Child Survival Project.

UNICEF
1987 The situation of women and children in Malawi. GOM and UNICEF, Lilongwe.

1991 Poverty in Malawi: a situation analysis. Draft Report.

WHO/MOH
1990 Report of the household survey. Draft.

526