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DISSEMINATION OF RESEARCH FINDINGS, RECOMMENDATIONS AND STAFH PROJECT EXPERIENCES AND LESSONS LEARNED IN MALAWI.

STAFH PROJECT
Support to AIDS & Family Health

Dissemination Strategy

USAID Contract No. 623-0238-C-00-4058-00, Support to AIDS and Family Health (STAFH) Project 612-023

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April, 1998.

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LIST OF ABBREVIATIONS

ActionAID	*British Charitable Organization*
AIDSEC	*AIDS Secretariat– National AIDS Control Program of Malawi*
BLM	*Banja Lantsogolo*
CBD	*Community Based Distributors*
CHAM	*Christian Health Association of Malawi*
CHANCO	*Chancellor College , a constituent of the University of Malawi*
CMS	*Central Medical Stores*
CONGOMA	*Council of Non governmental Organization of Malawi*
DHO	*District Health Officer*
DNO	*District Nursing Officer*
EC/AIDS	*European Community*
GTZ	*Germany Organization*
HAM	*Healers Association of Malawi*
I.E.F	*International Eye Foundation*
MAM	*Muslim Association of Malawi*
MBC	*Malawi Broadcasting Cooperation*
MC	*Medical Council of Malawi*
MIE	*Management Institute for Education*
MOE	*Ministry of Education*
MOHP	*Ministry of Health and Population*
MOI	*Ministry of Information*
MOWCAS	*Ministry of Women Children Affairs and Social*
MOY	*Ministry of Youth*
NABW	*National Association of Business Women*
NFPC	*National Family Planning Council*
NGOs	*Non governmental Organizations*
PSI	*Population Services International*
RHO	*Regional Health Officer*
RHU	*Reproductive Health Unit of Ministry of Health and Population*
STAFH	*Support to AIDS and Family Health*
UNFA	*United Nations Fund for Population*
UNICEF	*United Nations International and Children's Education Fund*
USAID	*United States Agency for International Development*
WHO	*World Health Organization*

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A. *INTRODUCTION*

Background

Since 1994, JSI-STAFH has conducted several research studies and activities in areas of Family Planning, STD/HIV prevention and control, Integration and Capacity building with partner agencies. As a result, lots of research findings, recommendations, experiences and lessons learned have been generated. The IEC and Research Unit of JSI-STAFH has so far played a key role in dissemination of research findings through "the JSI-STAFH Distribution List" and other channels to agencies, partners and different target groups. Despite the effort, a backlog of research findings remain not disseminated.

In view of this, JSI-STAFH has designed a research dissemination strategy. The aim of the strategy is to strengthen the already existing channels of dissemination and explore the feasibility of using other channels. Thus, the strategy will compile and prioritize all research findings, recommendations, experiences and lessons learned. And identify the appropriate target groups, channels for dissemination, collaborating agencies etc. to ensure smooth dissemination.

It is important to disseminate research findings for the very fact that program planners, policy makers, health administrators, senior health managers and implementors need information, knowledge and data to assist in proper program planning and implementation. Lack of accurate information on needs, possibilities and consequences of recommended actions result in decisions which are based on assumptions and unjustified conclusions and often result in inappropriate policy choices, the consequences of which are only discovered after implementation.

A research dissemination strategy is a JSI-STAFH tool designed to ensure proper dissemination of the research findings, recommendations, experiences and lessons learnt in the four objective teams. It summarizes and prioritizes outstanding research findings, lessons learnt and recommendations for dissemination purposes. It has two main components : a narrative section and tables which summarizes the narrative. The narrative section has the detailed information for each finding, lessons learnt, experiences and recommendations. A table has eight items : (a) serial numbers which corresponds to the narrative numbers (b) research findings/ recommendations (prioritized), (c) target groups (e.g. policy makers, youths, commercial sex workers etc.), (d) channel for dissemination e.g. radio, posters, pamphlets, etc. (e) timing e.g. dates, duration for each activity (f) resource requirements e.g. financial, material and any technical assistance i.e. consultant (g) collaborating agencies for each activity and (h) lead person or agency e.g. a person or an agency which will see to it that an activity has been done. In addition, the table is grouped into eleven topic areas e.g. STD management, CBD, Youths services, NGOs capacity building and development, management, procurement and service provision etc.

B. *OBJECTIVE :* To compile and prioritize JSI-STAFH experiences, research findings, recommendations and lessons learned for the purpose of dissemination.

C. *METHODOLOGY*

In preparation for the research dissemination strategy tool, two key approaches were adopted: by reviewing research reports, other activity extracts and conducting meetings with the Chief of Party, Advisors and Associates in the four Objective Teams. The discussion with the four Objective teams involved identification and prioritizing of the Units outstanding experiences, research findings, lessons learned and recommendations. Prioritization was based on the target groups, impact on the findings and some special consideration as justified by Unit Associates and Advisors. Thereafter, discussions were conducted with partner agencies: the AIDS Secretariat, the National Family Planning Council, the Ministry of Health and Population and the Reproductive Health Unit for their input.

D. RESULTS

SECTION I. NARRATES RESEARCH FINDINGS, RECOMMENDATIONS AND LESSONS LEARNED.

1. QUALITY OF FAMILY PLANNING COMMUNITY-BASED DISTRIBUTION SERVICES IN MALAWI.

Summary of major findings

The CBD projects were basically effective and contributed positively to the contraceptive prevalence rate in Malawi. The CBD agents exercised a major influence on villagers' acceptance of contraceptive use, and on the whole, were well received by their communities.

There were variations in the effectiveness and quality of the different CBD projects mainly due to differences in commitment of the CBD managers, support from the District Health Officer or NGO project managers, the quality of supervision, and sensitivity to specific cultural and geographical characteristics of the CBD catchment areas.

Sustainability continues to be a serious problem as, while the community members were willing to provide moral support, they were not willing to provide material support and had little means to do so. Projects mainly dependent on the government had difficulties because of the limited governmental resources. Those managers who were skilled in proposal writing and practiced efficient planning were able to procure non-governmental grants on a continuous basis and thus ensured the continuity of their projects.

Recommendations

1.1. Consultations are not always conducted in privacy nor is confidentiality assured. There are several weakness in the consultation which can be addressed by training.

- Various types of training activities should be held regularly in order to improve the quality of the consultation. For example, one day or even half day refresher workshops could be held by the project managers every few months which focus on one area of family planning that the CBD agents select themselves. These could be held in the same place as the mobile clinic or monthly meetings. Training workshops should address the following:

  a. The necessity of confidentiality and privacy.
  b. The necessity to tell about all contraceptives, not just the pill a Depo-Provera.

1.2 Supervision of CBD agents is irregular and inadequate due to insufficient material and human resources and/or lack of commitment of some CBD managers, supervisors and District Health Officers.

- When designing a CBD program, sufficient financial, material and human resources must be allocated to cover all supervisory needs of projects.

- Since the effectiveness of the HSA's as supervisor depends on the supervision they receive from the project manager, it is important that the HSA be closely supervised by the CBD manager consistency providing constructive feedback.

1.3 Re-supplying oral contraceptive users was mainly carried out, but not in the most efficient and consistent manner. There was no systematic mechanism to follow-up potential clients who had been visited once but had not accepted contraceptive use on the first visit nor a system to follow-up contraceptive drop-outs.

- CBD managers should establish follow-up systems appropriate for each project and train their CBD agents during the monthly meetings. Through supervision, with adequate feedback, they should ensure that all the CBD agents implement that system. Refresher courses and training workshops for new CBD agents should also address this issue. The follow-up systems should all include a mechanism to register all people visited giving the results of that visit and a plan for revisits.

- As CBD agents often did not find clients home for the revisits, and clients reported preferring appointments, household visiting could be made more efficient if CBD agents made follow-up appointments with their clients which could be written in the client register kept by the CBD agent and on the client card kept by the client.

1.4 Sustainability of CBD projects is greatly hampered because they all depend on external funding and current economic conditions indicate that this dependence is likely to continue. There is no national budget for CBD programs nor supportive resources on the district or local level. Also there is little commitment on the village level to support CBD programs.

- The Ministry of Health should develop national plans for establishment and maintenance of CBD programs based on areas not served by static clinics. The CBD program should be part of the budget allocation and a mechanism for continuously seeking funding should be devised. The private sector should also be encouraged to continue the establishment and maintenance of CBD programs which run parallel to the National Program and follow the National CBD guidelines.
-
- Other village based services such as TBA's and traditional healers for which people are willing and do pay should be studied to identify motivations behind this willingness to pay for the service.

1.5 Although the CBD agents are volunteers their drop-out rate was very low and they expressed as a motivation to continue work their satisfaction and recognition of the importance of increasing contraceptive use among the villagers. However, they tended to slacken the pace of work as time went on and did express the desire for some material incentives as well.

- High quality supervision with much positive feedback and praise from village leaders and other influential people may be key to high level continuous work.

- Experiments in income generating activities for CBD agents themselves or village level cooperatives such as flour mills, chicken breeding, etc. where the profits go to pay the CBD agents could be conducted. Systems using revolving funds shared by NGO's or from the Ministry of Health could be explored.

- The use of other cadres of workers like agricultural extension workers, literacy instructors, community development workers, TBA's to distribute contraceptives on the village level should continue to be explored.

2.0 EVALUATION OF AIDS EDUCATION IN THE CLASSROOM: A NATIONAL SURVEY

Summary of major findings

Teachers' lack of information, since the teachers' Guides are the only source of information accessible to them. Lack of instructional material. Teachers discomfort talking about sexual issues related to AIDS. Confusion over where in the time table and under what subject AIDS education should be included.

Recommendations

2.1 Resource materials need to be produced in the country's main languages, other than Chichewa, for the lower primary level. These include materials in Tumbuka, Yao and Thonga.

2.2 The schools require specific communication and instructions from MOE in relation to AIDS education, and its inclusion in the time table to guide them in carrying out AIDS education Program and activities.

2.3 An external monitoring system should be established by the MOE in order to ensure effective implementation of inclusion of AIDS education in the educational system. This includes a follow-up to see if teachers are adequately sensitized on the subject and if they indeed impart the knowledge to students.

2.4 Since Radio was the main medium in which the students heard about AIDS, it may be advissible to propose to the agencies involved in radio broadcasting, to prepare and broadcast programs that can actually address some of the AIDS issues that are more difficult for the teachers to discuss with their students.

3.0 CULTURAL PRACTICES RELATED TO HIV/AIDS RISK BEHAVIOR: FOCUS GROUP DISCUSSION OF VILLAGE LEADERS IN PHALOMBE.

Summary of major findings

This study suggests that there are many types of behavior and beliefs in the community that could be associated with HIV/AIDS transmission. It also indicates that the village leaders have much knowledge, understanding and insights concerning issues related to HIV/AIDS. These findings confirm the soundness of the project strategy to mobilize the community to develop the project interventions. They will provide the basis for the survey of the population of Phalombe which will identify the practices and beliefs most crucial to change based on their prevalence and correlation with HIV/AIDS transmission or risk behavior.

4.0 HEALTH SEEKING BEHAVIOR AND PARTNER NOTIFICATION BY CLIENTS WITH SEXUALLY TRANSMITTED DISEASES (STD's) IN MALAWI: AN ETHNOGRAPHIC APPROACH.

Summary of major Findings

STD client health seeking behavior

The health seeking behavior surrounding the experience of a sexually transmitted disease involves several steps. The process of going through these steps contributes to delays in seeking treatment. Most clients ask someone for advice when they discover their symptoms, and this advice strongly influences the further activity of the client including the place where first treatment is sought. The experience at the first place of experience, then influences where the clients will go next if the symptoms persist past the time that they expect them to disappear.

There is a greater tendency to switch from hospital to healer than vice-versa. This is mainly because the clients are more satisfied with the explanations given by the healers than those given by the clinic practitioners. The healers give the prognosis of the illness where they inform the clients of a long duration of the symptoms during which time they must continue to take medication. The clinic practitioners tend to neglect explaining a prognosis and the clients leave the STD consultation believing their symptoms will disappear immediately after taking the medication. They expect a difference after taking just one pill which is only part of the required dosage necessary for a complete cure. Thus, when their symptoms have not disappeared as they expected, they seek treatment elsewhere, usually from a traditional healer.

STD client partner notification

Partner notification is one step in the process of health seeking behavior which occurs either at the time the client discovers the symptoms, or after the client has gone for treatment the first or second time. The nature of the relationship to the people with whom the index client has sexual intercourse directly influences whether or not he/she will inform that person of the STD and is strongly mediated by the fear of the perceived consequences of informing that person. Where the fear of marital disruption or another sort of social disruption in the client's life is strong, there is a great tendency not to inform or to postpone informing the particular partner who would cause that disruption. However, if the perception of social disruption is low, then the client has a

greater tendency to inform that sexual partner from whom he could expect cooperation. Fear of the perceived consequences of partner notification is, in turn, mediated by the sexual partner to whom the STD transmission is attributed, which is, in turn mediated by gender and marital status of the sexual partners.

Recommendations

4.1 Since there are important gaps in the communication process of the STD consultation which result in switching from hospital to healer for treatment and which do not necessarily encourage partner notification, the communication process must be strengthened. And those positive aspects of healer-client communication could be adopted by the hospital practitioners.

4.2. Develop community and clinic waiting room based STD messages on symptom recognition, early treatment, partner notification

4.3 recognition of the STD services provided by the healer needs to be made and training on managing STD's could be given to the healers where, if they were not willing to give up on offering their herbal concoctions as medications, they may be willing to refer to hospitals for additional treatment by an antibiotic.

4.4 A system of coordination of referral of the patient from the traditional healer to the hospital could be established where the healer could be trained to recognize STD symptoms and be given some type of incentive to refer clients to the clinic for treatment.

4.5 Since there is a tendency for clients to switch from the hospital to the traditional healer, all of the efforts currently underway in Malawi to strengthen the quality of STD treatment are extremely important and should take priority in programmatic and budgeting considerations.

5.0 FEMALE CONDOM ACCEPTABILITY AMONG FAMILY PLANNING CLIENTS OF BLANTYRE

Summary of major findings

The study suggested three major factors which influenced the low acceptance of female condoms among family planning clients: 1. The current low rate of modern contraceptive prevalence and continuation rates which make it difficult to introduce any new modern contraceptive; 2. The current stigma attached to male condoms which has been attributed to female condoms as well; 3. Male dominance between husbands and wives over sexual matters including contraception which results in the need for the husbands approval for the wife to use the female condom.

While this study indicated a low acceptance rate among urban family planning clients in the largest clinic in Malawi, this is not sufficient evidence to generalize a strong lack of acceptance to family planning clients in the entire country. Also, as there is other evidence of acceptance of female condoms by special populations such as women living with AIDS and commercial sex workers, it would be premature to suggest no further interest in the introduction of the female condom.

As the female condom would add an additional resource for STD/HIV protection were it used, further consideration of its introduction is important, especially noting that before any contraceptive has ever been accepted much public education as well as its availability has been necessary. In addition, it will be necessary to provide female condoms either free and/or at an affordable price for the majority of the population as are the other contraceptives.

Recommendations

5.1. Development of a multifaceted approach to target men for sexual and contraceptive education. To increase male acceptance of contraceptives and of use of condoms with their wives, men should be especially targeted for sexual and contraceptive education which directly addresses the issues of male sexual dominance, the need for female sexual empowerment and the cooperative sharing of such decisions.

5.2 Introduction of female condoms in family planning clinics in conjunction with depots for special populations .To avoid the stigma already associated with condoms, the female condom should be introduced for use in clinics in conjunction with depots targeting other specific users such as people living with AIDS and commercial sex workers. All public health education should emphasize the use of female condoms between married couples so that it would be associated with the family.

6.0 CULTURAL PRACTICES RELATED TO HIV/AIDS RISK BEHAVIOR: COMMUNITY SURVEY IN PHALOMBE, MALAWI.

Summary of major findings

The findings strongly suggest that many of the cultural practices contributing to sexual relations with multiple partners persist throughout the life cycle of an individual and are within the normative system of behavior. Those which contribute the most to multiple sexual partners may be the high divorce and re-marriage rate along with a general acceptance of unmarried adults to have sexual relations. Every time a person marries and remarries, he or she will necessarily have several sexual partners in their life, and, in addition, in-between marriages will also have other acceptable sexual relations. It is not clear why the divorce and re-marriage rate is so high. On the one hand, receiving advice from traditional instructors and/or marriage advocates and participation in the marriage process were significantly correlated with marital stability. On the other religiosity, attitude toward sexual pleasure, fidelity and perception of risk of HIV were not significantly correlated with marital stability. It may be that the concept of marriage itself does not necessarily involve a strong notion of life -time commitment and advantages of divorce out weigh the continuation of an unsatisfactory marriage. Or, it is a fluid concept . It is not always clear as to just at what point in the marriage process one is definitely "married". This concept needs to be further understood from the perception of the villagers' themselves before it is clear as to what sorts of change are necessary that would promote less risky behavior.

The data strongly suggests that the importance of sexuality and the way it is interwoven throughout life experiences contributes to the complexity understanding the motivations for practicing risk behavior even when one is aware of its consequences. Sexuality appears to be a theme that runs throughout the life cycle and functions as a guide to much behavior. This is manifested in terms of various customs revolving around rules for abstinence, substituting a sexual partner for ritualistic reasons, as well as devising ways for sexual enhancement between sexual partners.

Recommendations

6.1 Since participation in the various rites of passage has some positive effects on health seeking behavior, participation should not be discouraged, but rather they should be used as vehicles for HIV/AIDS prevention education as appropriate.

6.2 Since sexual relations for both reproduction and sexual pleasure was reported to be very important by most of the respondents, maintaining sexual pleasure should be included in any education concerning changes in sexual behavior. . Since change in such intimate, personal behavior must originate from within the individual, village level discussion groups may be an effective way to begin the process. Subjects could be discussed such as:

- How to use condoms and maintain sexual pleasure at the same time.
- Abstinence during customary designated periods.
- What should be done about the problem of multiple sexual partners.

6.3 The symptoms and causes attributed to AIDS are confused with those attributed to the two traditionally identified syndromes, *tsempho* and *kanyera*. There is, then, the possibility that a person who suffers from opportunistic illnesses related to HIV are considered to be suffering from *tsempho* or *kanyera*. and therefore are not taken to hospital to be treated for the opportunistic illness. To address this problem:

- AIDS symptom recognition should be enhanced.
- All symptoms should be treated as though they were related to AIDS.

- There should be a focus on preventive measures for the care provider of HIV/AIDS patients.
- Villagers should be made aware of the biological basis of the symptoms associated with *tsempho* and *kanyera*.

7.0 CONDOM USE IN MARRIAGE AMONG FAMILY PLANNING PROVIDERS IN THE CITIES OF BLANTYRE, LILONGWE AND MZUZU.

Summary of major findings

The perception that condoms interfere with sexual pleasure, as well as strong association with extra-marital sex is suggestive that change to using condoms will be slow even among some health care professionals as family planning providers. Family planning providers need to change from using or advising others to use condoms as a back-up to using condoms for STD/HIV protection between husband and wife

Recommendations

7.1. Family planning providers are in a strategic position to promote condom use among the public. Seminars should be conducted for the family planning providers to help them clarify their roles and values in the wake of the AIDS epidemic. Husbands of the family planning providers should also be included in the seminars to assist the spouses to clarify their values on condom use.

7.2 There is a recognition of circumstances under which condoms could be used I marriage, that is, as part of STD treatment: by HIV sero-positive couples; and in cases of suspected infidelity.

Such positive thinking should be encouraged through in-service education and should be included in family planning curriculum.

8.0 CONDOM USE IN MARRIAGE AMONG URBAN WORKERS AND THEIR WIVES.

Summary of major findings

Results of the study show that there was great similarity in views expressed. For the men's groups, there was no difference observed in the views expressed by those husbands in management level and those in skilled and unskilled level position. A similar observation was also made for their spouses, the views of wives whose husbands were in management level position were not different from those whose husbands were in skilled and unskilled level position. There were no differences observed in views expressed by city, religion or ethnic background.

IEC IMPLICATIONS AND RECOMMENDATIONS

8.1. The major reason for strong negative responses to a spouse bringing home condoms or suggestions condoms use is the resultant suspicion that the spouse is unfaithful and promiscuous.
This association should be directly addressed. Husbands and wives should be assisted to find ways to deal with their actual problems or experiences with extra-marital sex. Condoms should also be promoted as protective devices to used between couples who care about each other and as a contraceptive. In group discussion, coupes were asked how they thought this association could be changed. Posters on condoms promotion should illustrate situations where it is obvious that a husband and wife is using a condom as a demonstration of love for each other.

8.2. Although either husband or wife sometimes do suggest condoms in marriage, the husband is a key to acceptance of condom use by the couple and his explicit cooperation is absolutely necessary.
IEC messages should reinforce the responsibility of husbands for the health of their wives and families. Messages which strengthen female negotiations skills befitting such situations should be developed.

8.3. Husbands and wives of higher level of education may have a greater tendency to discuss about sex with each other than those of lower education. It also helps if the level of education of the wife is as high as that of the husband.

Programs to encourage condom use between married couples can start by targeting the more highly educated couples who may be more easily convinced. Once they have accepted condom use, they could be used as agents of change to influence the other couples.

9. TWO YAO INITIATION RITES: JANDO AND NSONDO IN MACHINGA, MANGOCHI AND ZOMBA DISTRICTS.

Recommendations

9.1 The Ngaliba and the Michila need to be taught about the characteristics of HIV/AIDS infection and how it is spread to check bad use of razor blades for circumcision or when shaving of the hair and making incisions on the body of initiates.

9.2 The Nakanga must be persuaded to help I the fight against HIV/AIDS through lessons they give at the Simba in songs. Zitagu, misyungu and straight talks to the initiates.

10. EVALUATION OF STD TRAINING

Summary of major findings

The in-service training of syndromic management of STDs seems to have been reasonably successful in preparing for an adequate management of the syndromic approach in general- but only in pilot sites. The pilot sites performed far much better than non-pilot sites in almost all instances(in terms of history taking, use of flowcharts, accuracy of treatment and communication. The only factor that might explain this difference in performance was constant support and attention in terms of regular and frequent visits and feedback on performance. Other factors such as availability of resources (drugs, equipment, staff, reference materials etc.), previous experience or other training were not different between pilot sites and non-pilot sites.

Recommendations

10.1. Standardization of the Management Information System for the recording of data related to STDs, HIV and AIDS.

11. CONDOM INITIATIVE : (CONDOMS, CONTRACEPTION AND MARRIAGE)

Summary of major findings

The Family Planning Providers have not been positive towards either the condom or counseling about HIV in the family planning clinics. The condom is seen as a method of protection disease protection used outside of marriage not within a stable union. Moreover couples do not communicate about sex , which makes it more difficulty for women to negotiate condoms usage. For the condom to be an effective protection against HIV and pregnancy, it must be used consistently and must be available at the clinics or readily purchased in rural or urban outlets. These issues need to be discussed if necessary , policy changes made to enforce a knew thinking.

Recommendations

11.1 District Health Officer either should not have to pay handling charges for free condoms or portion their budgets should be earmarked for the condoms.

11.2 Establish more efficient monitoring systems to ensure that contraceptives are evenly distributed.

12. LESSONS LEARNED

CAPACITY BUILDING Unit

12.1 NGOs understand and accept weaknesses in their organization and are eager to take corrective action.

12.2 There is a need to assist in development /strengthening of constitutions, mission statement and strategic plans for NGOs. And policies and procedures on personnel, finance ad internal communication and strengthen management systems.

12.3 Capacity of NGOs to generate income both through Income Generating Activity (IGA) and donor support is weak.

12.4 Boards need to be active and consists of appropriate people they need to understand their roles and responsibility.

Logistics Section

13.1 It is important that when designing a Health Project that the Logistics Section is included as a full time functional section and budgeted for. For example, Logistic Section of JSI- STAFH which was not part of the JSI-STAFH-USAID contract, proved to be an important section in support of service delivery (e.g. . designing Management Information Systems, training pharmacy assistant countrywide in handling STD drugs and contraceptives, transporting contraceptives and drugs from warehouses to user points) etc. It is apparent that the Logistics Section played a substantial operative role for the Units.

14. Community Services Unit

14.1 The majority of the participants at Kasungu Flue Cured Tobacco Authority (KFCTA) were not conversant with English instructional materials which had been prepared. As such lessons were taught in Chichewa. There is an urgent need to translate the material from English to Chichewa.

14.2. Some companies have shown commitment to introduce STD/HIV & FP interventions in their work place. For example, ESCOM, B&C and OILCOM have financial support staff to attend private sector work shops on STD/HIV/FP and they have in-service training programs. However, some companies have refused outright to allow such programs.

14.3. There is inadequate STD/HIV/FP Information Education Counseling appropriate materials at work place. For example, posters, pamphlets, leaflets, videos which could enhance the awareness and/or understanding problems associated with STDs and HIV.

15. FAMILY PLANNING UNIT

15.1 All training centers that were visited did not have learner material for STD and CDMIS and most FP clinics trainees are not getting adequate experience in managing STD problems using the syndromic approach.

15.2 Infection prevention is poor in most clinics because there is inadequate supply of chlorine and gloves. FP trainees learn about infection control but do not have an opportunity to practice what they learned in the clinics.

15.3 Family Planning providers who were trained as preceptors are not usually available to work with the FP trainees. All the coaching in the clinical area is let to the trainers.

15.4 Space for FP service is a big problem in most of the service delivery areas so much so that FP equipment provided by JSI-STAFH Project is not being used in some clinics because there is no space to put it.

16. STD/HIV UNIT

It appears lessons learned in the STD/HIV Unit have been were reflected in the STD Training Evaluation findings and recommendations.

17. IEC UNIT

17.1 Ensure that distribution channels work and that materials do no sit at the Regional or District Health Offices or Health Center cupboards and not get to the targeted audience. Training of service providers is effective use of IEC materials imperative

18. YOUTHS

18.1 Youth organizations in Malawi need to equip Youth with adequate knowledge on STD/HIV/AIDS and FP, if Youths are to understand the HIV epidemic and value the importance of FP Programs. There is a need to the Youths in capacity building in order to run their institutions properly. Youths must take leadership in advocating for the prevention and control of the HIV epidemic. In addition radio programs should intensify educating the youths in STD/HIV/AIDS and Family Planning.

19. SERVICE PROVISION AREA: MANAGEMENT, PROCUREMENT AND DISTRIBUTION.

Experiences and lessons learned in areas of medical equipment, computer, vehicle procurement and clinic upgrades will be shared.

SECTION II : TABLES SUMMARIZE RESEARCH FINDINGS, RECOMMENDATIONS AND LESSONS LEARNED IN SECTION I.

Note: The serial numbers in the tables corresponds to the narrative numbers in section I.

TABLE 1. TRAINING, SUPERVISION AND OPERATION OF CBDs

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April, 98. 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
1.1	Consultations are not always conducted in privacy nor is confidentiality assured.	CBD Program Managers, Supervisors,	Briefing workshop			x							RHU, NFPC, STAFH	NFPC	NFPC Chilongozi
1.2	Supervision of CBD agents is irregular and inadequate due to insufficient material and human resources and/or lack of commitment of some CBD managers, supervisors and District Health Officers.	CBD Program Managers, Supervisors,	Briefing workshop			x							RHU, NFPC, STAFH	NFPC	NFPC Chilongozi,
1.3	There is inconsistency in re-supplying oral contraceptive to users.	CBD Program Managers, Supervisors,	Briefing Workshop			x							RHU, NFPC, STAFH	NFPC	NFPC Chilongozi,
1.4	Sustainability of CBD projects is greatly hampered because they all depend on external funding. There is no national budget for CBD programs nor supportive resources on the district or local level.	Policy Makers CBD Managers	Briefing Workshop								x		NFPC, MOHP, RHU, NABW, STAFH	NFPC	NFPC Chilongozi,
1.5	CBD agents are volunteers their drop-out rate was very low and they expressed as a motivation to continue work. However, they tended to slacken the pace of work as time went on and did express the desire for some material incentives as well.	Policy Makers CBD Managers	Briefing Workshop								x		MOHP, RHU, NGOs, NFPC, NABW, CHAM, STAFH	NFPC	NFPC . Chilongozi,

TABLE 2. WORKING WITH YOUTH-SERVING ORGANIZATIONS TO PROMOTE BEHAVIOR CHANGE OF REPRODUCTIVE HEALTH ISSUES AMONG YOUTH.

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April, 98. 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
2.1	Revise AIDS Education materials and need to be produced in Tumbuka, Yao and Tonga for lower primary level.	Policy Makers (MOE)	Briefing workshop,								x		MOH, MOE, MIE, STAFH	A. Domatob, Consultant	AIDSEC Chilongozi
2.2	Schools require specific communication and instructions from MOE in relation to AIDS education, and its inclusion in the time table to guide them in carrying out AIDS education Program and activities.	Policy Makers (MOE)	Briefing Workshop,								x		AIDSEC, STAFH, MOE	A. Domatob, Consultant	AIDSEC Chilongozi.
2.3	An external monitoring system should be established by the MOE in order to ensure effective implementation of inclusion of AIDS education in the educational system.	AIDS Education Desk Officer (MOE), Senior Officers (MOE)	Briefing Workshop								x		MOE, UNICEF	A. Domatob, Consultant	AIDSEC Chilongozi
2.4	Propose to the agencies involved in radio broadcasting, to prepare and broadcast programs that can actually address some of the AIDS issues that are more difficult for the teachers to discuss with their students.	MASO, Youth Arm	Briefing Workshop							x			MOE, MBC, MASO, STAFH	A. Domatob, MASO	AIDSEC Chilongozi
18.1	Youths programs in STD/HIV/FP needs institutional capacity building.	MOY, Youth Arm, Senior Managers	Briefing Workshop							x			UNIEF, UNFPA	K. Sklaw	MOY Chilongozi

TABLE 3. SET-UP, ACCESSIBILITY AND UTILIZATION OF STD SYNDROMIC CASE MANAGEMENT SERVICES (diagnosis, treatment and prevention).

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April, 98. 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
4.1	Strengthen the communication process of the STD consultation in the hospital to reduce switching of clients from hospital to healer for treatment	STD Managers, Supervisors, Tutors Medical Institutions, STD Trainers	Briefing Workshop			x							MOHP, STAFH, CHAM, BLM, RHU	Chilongozi,	Chilongozi, AIDSEC
4.2	Develop community based and clinic waiting room based messages on STDs in Chichewa, Yao, Tumbuka and Tonga	STD Trainers, Managers, IEC Managers	Workshop				x						AIDSEC, HAM , NFPC, EC/AIDS, MC, CHAM Medical Institutions	Chilongozi Consultant	AIDSEC Chilongozi,
4.3	STD services provided by the healers need to be recognized and healers trained in management of STD.	Policy Markers (MOHP)	Briefing Workshop			x					x		"	Chilongozi, Consultant	AIDSEC Chilongozi,
4.4	A system of coordination of referral of the patient from the traditional healer to the hospital could be established..	Senior Hospital Managers, Policy Makers, HAM.	Briefing Workshop								x		"	Chilongozi Consultant	AIDSEC Chilongozi,

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April, 98. 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
4.5	STD clients seek treatment from both healers and clinical practitioners for the same episode. And there is a great tendency for clients to switch from the hospital to the traditional healer.	Policy Makers, Senior Health Managers	Briefing Workshop			x							"	Chilongozi	AIDSEC Chilongozi,
10.1	Standardization of the management Information Systems for the recording of data related to STDs, HIV and AIDS	STD Managers, Policy Makers	Briefing workshop								x		CHSU, RHU, AIDSEC	C. Kachiza	AIDSEC Chilongozi, RHU

TABLE 4. CONDOM PROMOTION, SALE/, DISTRIBUTION AND USE.

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April, 98. 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
5.1.	Development of a multifaceted approach to target men for sexual and contraceptive education	Private Sector, BLM Officers,	Briefing Workshop			x							NFPC, BLM RHU, PSI	D. Namate, Consultant	NFPC, Chilongozi, AIDSEC
5.2.	Introduction of female condoms in family planning clinics in conjunction with depots for special populations	F P Managers, Tutor Medical Institutions	Briefing workshop			x							BLM, NFPC, CHAM, RHU, PSI	D. Namate,	NFPC, Chilongozi, AIDSEC
7.1	Family planning providers are in a strategic position to promote condom use among the public. As husbands and wives have a greater tendency to listen to messages about condoms from FP providers and other health care providers	F P Managers, Tutor Medical Institutions	Briefing workshop			x							MOHP, RHU, STAFH, BLM, PSI, CHAM	D. Namate,	NFPC, Chilongozi, AIDSEC
7.2	There is a recognition of circumstances under which condoms could be used in marriage, that is, as part of STD treatment: by HIV sero-positive couples; for family planning and in cases of suspected infidelity.	FP Managers, Tutor Medical Institutions	Briefing workshop			x							MOHP, RHU, BLM, CHAM, STAFH, PSI,	D. Namate,	NFPC, Chilongozi, AIDSEC

TABLE 4. CONDOM PROMOTION, SALE/, DISTRIBUTION AND USE.

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April,98.									Collaborating agencies	Resource requirements	Lead person / Agency
				4	5	6	7	8	9	10	11	12			
8.1.	The major reason for strong negative responses to a spouse bringing home condoms or suggesting condoms use is the resultant suspicion that the spouse is unfaithful and promiscuous.	FP Managers & Supervisors	Briefing workshop			x							Churches, NABW, MOWCAS	D. Namate,	NFPC, Chilongozi, AIDSEC
8.2	Although either husband or wife sometimes do suggest condoms in marriage, the husband is a key to acceptance of condom use by the couple and his explicit cooperation is absolutely necessary	F P Managers, Supervisors	Briefing workshop			x							Churches, NABW, MOWCAS	D. Namate,	NFPC Chilongozi, AIDSEC
8.3.	Husbands and wives of higher level of education may have a greater tendency to discuss about sex with each other than those of lower education.	F P Managers, Supervisors	Briefing workshop			x							Churches, NGOs, NABW, MOCAS	D. Namate,	NFPC, Chilongozi, AIDSEC
11.1	District Health Officer either should not have to pay handling charges for free condoms or a portion of their budgets should be earmarked for the condoms	Logistic Staff Committee, DHOs, CMS	Briefing workshop			x							CMS, MOHP, CHAM, BLM	R. Msowoya	AIDSEC, Chilongozi, NFPC

TABLE 5. ADDRESSING HARMFUL CULTURAL PRACTICES AFFECTING STD/HIV TRANSMISSION.

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time Frame Quarters 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
6.1	Participation in various rites of passage has some positive effects on health seeking behavior, participation should not be discouraged, but rather they should be used as vehicles for HIV/AIDS prevention education messages could be given at each step where possible.	NGO Office & Field Officers from Collaborating Agencies	Briefing workshop						x				Salvation Army, Project Hope, Action AID, STAFH, AIDSEC	D. Namate, Consultant	NFPC, Chilongozi, AIDSEC
6.2	Couples who received advice from traditional marriage counselors, (*anchoswe*) and instructors (*anakungwi*) had a greater tendency toward marriage stability than those who did not.	NGO Office & Field Officers from Collaborating Agencies	Briefing workshop						x				"	D. Namate,	NFPC, Chilongozi, AIDSEC
6.3	Since sexual relations for both reproduction and sexual pleasure was reported to be very important by most of the respondents, maintaining sexual pleasure should be included in any education concerning changes in sexual behavior.	NGO Officers from Collaborating Agencies	Briefing workshop						x				Salvation Army, Project Hope, Action AID, STAFH, AIDSEC, CSR	D. Namate, Consultant	Chilongozi, NFPC, ADISEC

TABLE 5. ADDRESSING HARMFUL CULTURAL PRACTICES AFFECTING STD/HIV TRANSMISSION.

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April,98. 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
6.4	The symptoms and causes attributed to AIDS are confused with those attributed to the two traditionally identified syndromes, *tsempho* and *kanyera*. There is, then, the possibility that a person who suffers from opportunistic illnesses related to HIV are considered to be suffering from *tsempho* or *kanyera*. and therefore are not taken to hospital to be treated for the opportunistic illness.	NGO Officers from Collaborating Agencies	Briefing workshop						x				"	D. Namate,	Chilongozi, NFPC, AIDSEC
9.1	The Ngaliba and the Michila need to be taught HIV/AIDS risk free practices in handling blood and blood products.	MAM Office	Briefing workshop						x				"	Kamongera	MAM Chilongozi,
9.2	The Nakanga must be persuaded to incorporate HIV/AIDS lessons at the Simba in songs and straight talks to the initiates.	MAM Office	Briefing workshop pamphlet						x				"	Kamongera	MAM Chilongozi,

TABLE 6. INTRODUCING OR EXPANDING FP, STD AND HIV/AIDS PROGRAMS IN THE PRIVATE SECTOR WORKPLACE.

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April, 98. 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
14.1	Most workers in farms and estates are unable to read IEC materials in English- there is urgent need of translation into vernacular languages	Workplace Task Force	Briefing, workshop pamphlets translated in vernacular								x		PSI, AIDSEC, STAFH	C. Nyirenda	Chilongozi Private Sector
14.2	Some companies such as B &C, ESCOM and Limbe Leaf have introduced STD/HIV/FP interventions at workplace.	Workplace Task Force	Briefing workshop								x		PSI, AIDSEC, STAFH, B&C, ESCOM	C. Nyirenda	, Chilongozi Private Sector
14.3	Companies have inadequate IEC materials in STD/HIV/FP	Workplace Task Force	Briefing, workshop pamphlets translated in vernacular								x		PSI, AIDSEC, STAFH	C. Nyirenda	Workplace Task Force, Chilongozi

TABLE 7. NGO PROGRAM DEVELOPMENT, IMPLEMENTATION AND MANAGEMENT

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April, 98. 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
12.1	There is a need to assist in development /strengthening of constitutions, mission statement and strategic plans for NGOs. And policies and procedures on personnel, finance ad internal communication	Policy makers	Briefing workshop							x			MOHP, USAID, UNFPA, UNAIDS, WHO CONGOMA, STAFH, DfID,	K. Sklaw	CONGOMA, Chilongozi,
12.4	Capacity of NGOs to generate income both through IGA and donor support is weak.	NGO donors	Briefing workshop							x			"	K. Sklaw	CONGOMA, Chilongozi,
13.1	Health Projects design must include Logistics as a full time functional unit and be budgeted for.	Donors, Policy Makers	Briefing workshop							x			Donors, NGOs MOHP	R. Msowoya	MOHP, R. Msowoya

TABLE 8. BUILDING PUBLIC AND NGO MANAGEMENT CAPACITY FOR FAMILY PLANNING AND STD/HIV/ AIDS.

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April,98. 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
12.5	Boards need to be active and consists of appropriate people they need to understand their roles and responsibility.	NGO donors	Briefing workshop							x			MOHP, USAID, UNFPA, UNAIDS, WHO CONGOMA, STAFH, DfID,	K. Sklaw	CONGOMA, Chilongozi,
12. 1	NGOs understand and accept weaknesses in their organization and are eager to take corrective action.	NGO donors	Briefing workshop							x			"	K. Sklaw	CONGOMA, Chilongozi
15.1	Some centers that were visited did not have learner material for STD and CDMIS and most FP clinics trainees are not getting adequate experience in managing STD problems using the syndromic approach.	FP Managers	Briefing workshop							x			RHU, NFPC, STAFH, DHOs	M. Mchombo	NFPC, Chilongozi
15.2	Infection prevention is poor in most clinics because there is inadequate supply of chlorine and gloves. FP trainees learn about infection control but do not have an opportunity to practice what they learned in the clinics.	FP Supervisor, FP Managers	Briefing workshop guidelines on infection control			x							RHU, NFPC, STAFH, DHOs	M. Mchombo	NFPC, Chilongozi,

TABLE 9. TRAINING , SUPERVISION AND SUPPORTING SERVICES PROVIDERS (FAMILY AND STDs SERVICES).

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April, 98. 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
15.3	Family Planning providers who were trained as preceptors are not usually available to work with the FP trainees. All the coaching in the clinical area is let to the trainers.	FP Supervisor, FP Managers	Briefing workshop			x							RHU, NFPC, STAFH DHOs	M. Mchombo	NFPC Chilongozi,

TABLE 10. SET- UP, ACCESSIBILITY AND UTILIZATION OF FAMILY PLANNING SERVICES (CORE AND COMPREHENSIVE SERVICES).

11.2	Establish more efficient monitoring systems to ensure that contraceptives are evenly distributed.	Policy Makers FP Managers, FP Supervisor	Briefing Workshop			x							CMS, RHOs, RHU, NFPC	M. Mchombo	NFPC Chilongozi,
15.4	Space for FP service is a big problem in most of the service delivery areas so much so that FP equipment provided by JSI-STAFH Project is not being used in some clinics because there is no space to put it.	Policy makers FP Supervisor, FP Managers	Briefing workshop			x							RHU, NFPC, STAFH	M. Mchombo	NFPC Chilongozi
17.1	Ensure that distribution channels work and that materials do no sit at the Regional or District Health Offices or Health Center cupboards and not getting to the targeted audience. Training of service providers in effective use of IEC materials is imperative	RHOs, DHOs IEC Program Officers	Briefing workshop				x						AIDSEC, CHAM, NFPC	A. Domatob	NFPC, AIDSEC

TABLE 11. SERVICE PROVISION AREA: MANAGEMENT, PROCUREMENT AND DISTRIBUTION

Serial #s	Research findings, recommendations (prioritized)	Target Groups	Dissemination channels	Time frame Months from April, 98. 4	5	6	7	8	9	10	11	12	Collaborating agencies	Resource requirements	Lead person / Agency
19.1	Procurement experiences: • Medical equipment & distribution • Vehicle procurement • Computer procurement	Senior Planning Officers MOHP, Program Managers/ Directors, USAID	Briefing workshop					x					MOHP, NPFC, AIDSEC, BLM, RHU	P. Killick/ R. Msowoya	NPFC, AIDSEC Chilongozi
19.2	Clinic upgrades	Senior Planning Officers MOHP, Program Managers/ Directors, USAID	Briefing workshop					x					MOHP, NPFC, AIDSEC, BLM, RHU	P. Killick/JR Nyirenda	NPFC, AIDSEC, Chilongozi

E. *TURNING THE DISSEMINATION STRATEGY INTO ACTION.*

For ease of implementation of the Research Dissemination Strategy it has been grouped into eight activity groups, namely: (a) Issues Involving Supervisors and Trainers, (b) Issues of NGO Implementation (c) Issues of IEC material development (d) Service: Management, procurement & distribution (e) Issues of NGOs working with communities where harmful cultural practices leading to HIV transmission are practiced (f) Issues of Private Sector Involvement (g) Issues of NGO capacity building and development and (h) Issues of Advocacy and Policy. These groupings will translate into briefing seminars, for example, Issues of Advocacy and Policy, Table 1, 2, 3, 9 and 10 have predominately policy issues. This means that experiences, research findings, lessons learned and recommendations related to policy issues will be presented at one seminar to decision makers and policy makers etc. The principle will apply to the rest of the groupings.

However, Table 1, 2, 3, 9 and 10 may have both policy and none policy issues. In this case, none policy issues will be switched to any of the eight groups and be presented at appropriate sessions. Hence on the research dissemination strategy some activities have been earmarked for more than one session on column of "time frame". The tallying on the "time frame" reflects the above mentioned principle.

With this approach eight half day briefing workshops/seminars have been planned from June, 1 through November, 1998. A proposed work plan is as follows:

A. Work plan

Seminar #s	Groups of issues	Month of conducting seminar
1.	Issues Involving Trainers & Supervisors	June 1, 1998
2.	Issues of NGO Implementation -Lisa Krift	June 29, 1998
3.	Issues of IEC material development in STD/HIV/FP	July, 1998
4.	Service Provision: Management, procurement & distribution	August, 1998
5.	Issues of NGOs working with communities where harmful cultural practices are practiced leading to HIV transmission.	September, 1998
6.	Issues of Private Sector Involvement	October, 1998

Seminar #s	Groups of issues	Month of conducting seminar
7.	Issues of NGO Capacity Building and development	October, 1998
8.	Issues of Advocacy & Policy	November, 1998

B. MATCHING GROUPS AND TOPIC AREAS

Seminar 1 : Issues Involving Trainers & Supervisors

Table 1
Table 3
Table 4
Table 5
Table 9

Seminar 2 : Issues of NGO Implementation

Seminar 3 : Issues of IEC material development in STD/HIV/FP

Table 10 & cuts across all topic areas

Seminar 4 : Service Provision: Management, procurement & distribution

Table 11.

Seminar 5 : Issues of NGOs working with communities where harmful cultural practices are practiced leading to HIV transmission.

Table 5
Table 3

Seminar 6 :	**Issues of Private Sector Involvement** Table 6

Seminar 7 :	**Issues of NGO Capacity Building and development**
Table 2	
Table 7	
Table 8	
Table 11	

Seminar 8 :	**Issues of Advocacy and Policy**
Table 1	
Table 2	
Table 3	
Table 9	

F. CONCLUSION

There is no doubt that substantial amount of JSI-STAFH experiences, research findings, lessons learned and recommendations have not been adequately disseminated. The Research Dissemination Strategy is an ideal dissemination tool to supplement the existing channels of dissemination. It appears that the time frame of six months may not be sufficient to adequately accomplish the dissemination work. Bearing in mind that partner agencies have their own work plans for the year. However, with good planning and adequate resources (e.g. budget and personnel) and cooperation from partner agencies a lot could be achieved.

As most of the dissemination work requires development of IEC materials and translation in vernacular languages (e.g. Tonga, Tumbuka, Chewa and Yao), there is a need to engage a local consultant to assist in some aspects of dissemination work. Since JSI-STAFH contract is ending shortly some activities which require continuity in dissemination could be transferred to the relevant partner agencies.

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Other extracts i.e. wall charts.