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SUPPORT TO AIDS AND FAMILY HEALTH PROJECT

Contract No. 623-C-00-94-00058-00 MALAWI

FINAL REPORT

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STAFH PROJECT
Support to AIDS & Family Health

JSI

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LIST OF ACRONYMS

ADMARC	-	Agricultural Development and Marketing Corporation
AIDS	-	Acquired Immune Deficiency Syndrome
AIDSEC	-	National AIDS Control Program Secretariat
AVSC	-	Access to Voluntary and Safe Contraception
B&C	-	Brown and Clapperton
BLM	-	Banja La Mtsogolo
CBD	-	Community-Based Distribution
CBDA	-	Community-Based Distribution Agent
CDLMIS	-	Contraceptive Distribution and Logistics Management Information System
CHAM	-	Christian Health Association of Malawi
CHAPS	-	Community Health Partnerships
CHSU	-	Community Health Sciences Unit
CO	-	Clinical Officer
CONGOMA	-	Council of Non-Governmental Organizations of Malawi
CQI	-	Continuous Quality Improvement
DfID	-	Department for International Development
DHMT	-	District Health Management Team
DHO	-	District Health Office
ECAM	-	Employers Consultative Association of Malawi
ENM	-	Enrolled Nurse-Midwife
EU	-	European Union
FBCQI	-	Facility-Based Continuous Quality Improvement
FGD	-	Focus Group Discussion
FHI	-	Family Health International
FP	-	Family Planning
FPLM	-	Family Planning Logistics Management
GOM	-	Government of Malawi
GTZ	-	German Technical Cooperation Agency
GUD	-	Genital Ulcer Disease
HIV	-	Human Immunodeficiency Virus
HPN	-	Health, Population and Nutrition
IC	-	Institutional Contractor
ICPD	-	International Conference on Population and Development
IEC	-	Information, Education and Communication
IEF	-	International Eye Foundation
IUCD	-	Intra-Uterine Contraceptive Device
IPCC	-	Interpersonal Communication and Counseling
JICA	-	Japan International Cooperation Agency
JSI	-	John Snow, Incorporated
KCN	-	Kamuzu College of Nursing
LCH	-	Lilongwe Central Hospital

LSE	-	Life Skills Education
LTPC	-	Long-Term and Permanent Contraception
MA	-	Medical Assistant
MASO	-	Media and AIDS Society in Malawi
MBC	-	Malawi Broadcasting Corporation
MCHS	-	Malawi College of Health Sciences
MIS	-	Management Information System
ML/LA	-	Minilaparatomy under Local Anaesthesia
MOHP	-	Ministry of Health and Population
MOLG	-	Ministry of Local Government
NACP	-	National AIDS Control Program
NFPC	-	National Family Planning Council
NFWC	-	National Family Welfare Council
NGO	-	Non-Governmental Organization
NTF	-	New Transcentury Foundation
PA	-	Program Assistant
PATH	-	Program of Appropriate Technology for Health
PSI	-	Population Services International
QECH	-	Queen Elizabeth Central Hospital
PVO	-	Private Voluntary Organization
RCO	-	Regional Contracting Office
RH	-	Reproductive Health
RHMSTF	-	Reproductive Health Management Strengthening Task Force
RHO	-	Regional Health Office
RHU	-	Reproductive Health Unit
RN	-	Registered Nurse
SCF-US	-	Save the Children Federation-United State
STAFH	-	Support to AIDS and Family Health
STD	-	Sexually Transmitted Disease
TA	-	Technical Assistance
TBA	-	Traditional Birth Attendant
TOT	-	Training of Trainers
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

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EXECUTIVE SUMMARY

This is the final report on the four-year (1994-1998) JSI-STAFH Malawi contract. The report presents and discusses the interventions and activities undertaken, the accomplishments, key lessons learned and recommendations. The report on the STAFH Transition Conference held in Lilongwe on 30 September, 1998 is a companion of and an annex to this report.

The goal of the six-year (1992-1998) USAID-funded Government of Malawi Support to AIDS and Family Health (STAFH) Project is to reduce sexually transmitted HIV and to lower the fertility rate. Following a competitive bidding process, JSI was selected as the Institutional Contractor, to work with and assist the Ministry of Health and Population, the National Family Planning Council and the National AIDS Control Program to implement the project. JSI personnel arrived in Malawi in October of 1994 to begin implementation of the contract, joining the other national and international partners involved with the project. JSI was assigned seven main responsibilities:

- Provision of technical assistance;
- Procurement of commodities and medical supplies;
- Development and implementation of a training plan, workshops, mass media campaigns and other IEC activities;
- Research;
- Monitoring project activities and the end-use of project resources;
- Development of management information systems; and,
- Development and management of grants to local NGOs to support community-based expansion, quality assurance activities and operations research for family planning and AIDS.

In implementing the contract, JSI built and managed a team of eight expatriate advisors and 12 senior Malawian associates. They combined technical knowledge, experience and skills in family planning promotion and services, STD/HIV prevention and control, behavioral research, reproductive health communications, community- and workplace-based FP and STD/HIV/AIDS programs, and NGO and management capacity building. Working closely and in collaboration with the MOHP and other partners, the JSI-STAFH personnel, supported by JSI subcontractors (URC, PATH, WLI, and NTF) and consultants served as a multidisciplinary source of technical assistance, bringing strategic and innovative approaches to the development of FP and STD/HIV policy,programs and management.

The focus of activities was on building and strengthening capacity, particularly institutional capacity, in the public, private and NGO sectors, for planning, implementing, managing and evaluating quality and integrated programs and services to reduce fertility and transmission of STD/HIV. JSI conducted needs assessments to establish the basis for action, developed a variety of training curricula and materials for training FP, STD/HIV and other personnel, developed strategies and implementation plans to direct and guide action, produced a variety of education and communication materials, procured and distributed clinic, audio-visual, training and office

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equipment, renovated FP service facilities and disseminated the findings of research conducted or supported by JSI-STAFH.

As a result of the contract implementation, a number of major accomplishments were realized in pursuance of STAFH project objectives and targets:

Increased knowledge about FP, STD and HIV/AIDS as well as the factors affecting them. JSI conducted or supported 17 socio-cultural, bio-medical and other research studies, and assisted with the production and distribution of a wide variety of information and education materials for targeted groups and for the general public.

Expanded and strengthened the physical and material infrastructure for FP and STD service provision. Twenty three FP facilities were renovated to provide additional space or to improve the audio and visual privacy. Equipment and furniture were delivered to 228 FP and 79 STD facilities throughout the country.

Increased number of trained FP and STD personnel, including managers, trainers, supervisors and service providers. In the STD area, JSI assisted in training or retraining 44 trainers and 1,200 health care workers. In FP, 408 FP service providers were trained in IPCC, in addition to training of other personnel for core and comprehensive services.

Expanded the involvement and strengthened the capacity of the NGO and private sectors to participate more actively and effectively in FP, STD and HIV/AIDS programs. JSI developed and administerd 24 NGO grants, and worked directly with 15 private, estate and parastatal companies. In the private sector, 130 managers were oriented to FP, STD and HIV/AIDS issues, and 370 workers were trained in peer education. As a result, JSI-assisted programs reached over 70,000 workers. Through the NGO grants, 447 CBDAs were deployed to disseminate integrated FP and HIV/AIDS information, and 79 clinical sites were able to provide clinic-based services.

Development and testing of strategic directions in RH. The STD syndromic case management approach was tested, leading to its introduction into the health care system by the MOHP as the standard approach. The strategy for expanding long-term and permanent methods of contraception was developed. A model for facility-based continuous quality improvement was tested in six facilities. This is a low-cost approach requiring minimal resources other than regular supervision and technical assistance.

Strengthened communication and coordination among RH participting institutions. Through three annual STAFH coordination meetings, JSI brought together the main players to review and learn from experience, discuss common concerns and objectives, and attempt to harmonize plans. JSI also facilitated and hosted a large number of task forces and working groups that promoted coordination and collaboration.

Although the host country situation was generally positive and supportive, a number of specific obstacles and constraints nevertheless affected the pace and outcome of contract implementation in some areas. They include: the continuing shortage of personnel in two of the three key partner

agencies, with consequences for timely actions and decisions; limited production and printing capacity for IEC materials; young and weak NGOs; limited research capacity; certain USAID regulations affecting utilization of the services of third country nationals, and JSI interactions with construction contractors; and the currency (Kwacha) devaluation and its implications on staff salaries and morale.

Important lessons and recommendations relate to factors affecting successful TA efforts; the need for balance in the technical support and implementation roles of the institutional contractor; factors affecting the success of NGO and private sector programs; balancing the demands of contract deliverables with meeting other needs; the scale and budget of the facility renovation activity; and the comparative effectiveness of locating JSI-STAFH outside the Government.

I. INTRODUCTION

This report presents and discusses the interventions and activities undertaken during the four-year (October, 1994 to October, 1998) JSI-STAFH contract and the contract accomplishments, against the background of the STAFH Project and the JSI-STAFH contract deliverables. The key lessons from the experience of the contract implementation, and recommendations for future action are also presented.

Record keeping on and reporting of activities, progress, accomplishments and constraints have been an ongoing aspect of contract implementation. The original program goal, purpose, strategy and outputs as established in the contract were converted to annual workplans which were approved by USAID and became the annual basis for action, and for monitoring progress and assessing performance and accomplishments. On a routine ongoing basis, records were meticulously kept on activities and decisions. Briefing memos, memos to files, minutes of internal and external meetings, scopes of work, weekly reviews (of program and management activities), trip reports and reports on training courses and workshops were used to document the contract implementation experience.

On a quarterly basis, the information was synthesized and consolidated to form the quarterly progress reports: thirteen of these were prepared and submitted to USAID. Three annual reports (for 1994-1995, 1995-1996, and 1996-1997) were prepared highlighting activities, progress, and accomplishments, as well as issues, problems and constraints, and lessons. To establish the status of activities and accomplishments at the close of the contract, a STAFH transition conference was held and the report on it provides a comprehensive documentation on the program accomplishments.

The workplans, quarterly and annual reports and the transition conference report outline in greater detail what JSI set out to do in fulfillment of the STAFH contract, what was actually done and the outputs, the lessons and recommendations from the experience, and the proposed activities for the future with recommended responsible organizations. These are all intended to compliment this final report which will therefore focus on the key lessons and recommendations. In addition, a large body of research, consultancy and other reports provide supplementary information on the contract implementation experience and outcomes.

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II. BACKGROUND

A. STAFH Project Setting

The six-year USAID-funded Government of Malawi (GOM) Support to AIDS and Family Health (STAFH) Project was initiated in 1992 at a cost of $45 million. Implementation of the project coincided with the introduction of the multiparty system, following nearly thrity years of the one-party system. With the new political dispensation came a more liberal and enabling environment, allowing for a more open debate and discussion of national issues, including issues partaining to reproductive health, particularly family planning and AIDS.

The health and demographic indicators for Malawi at the beginning of the 1990s are outlined in the STAFH Project paper. The population census of 1988. revealed that contrary to the popular belief in Government at the time, the population was growing at the much higher rate of 3.3% per annum. The population size of nine million revealed by the census was also of concern, showing as it did that the population had more than doubled from four million at independence in 1964. Other indicators, such as the infant and maternal mortality rates were not any more encouraging. At the same time, the new national openness had began to reveal the extent of the HIV/AIDS pandemic in the country, and the urgent need for responsive action. For example, seroprevalence among one sample of reproductive-age urban women rose from 2% in 1985 to 30% by mid-1993. An estimated HIV seroprevalence of 11% among adults in 1993 suggested that some 700,000 were infected.

These developments, and the implications and demands arising from them, spurred Government action in approving the creation of two important national structures in the early 1990s. Under an Act of Parliament in 1992, the National Family Welfare Council (NFWC, now National Family Planning Council - NFPC) was created as a parastatal in the Ministry of Women, Children Affairs and Community Services (now Ministry of Women, Youuth and Community Services) to spearhead family planning advocacy, and coordination of and support to FP implemnting agencies. The National AIDS Control Program was also organized under the umbrella of the Ministry of Health which, later on, took over the added responsibility for population, thus becoming the Ministry of Health and Population.

The donor support for reproductive health programs was active and strong. UNFPA, UNICEF, The World Bank, WHO, the European Community, JICA, GTZ and the then British Overseas Development Administration (ODA, now Department for International Development - DfID), along with USAID had been active in the health and population sector through funding for various projects and activities, and had been encouraging and assisting the GOM to take the necessary actions. With USAID, the donor support for FP and HIV/AIDS became organized in the form of the STAFH Project, along with other activities.

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B. Constraints to be Addressed

The setting of the STAFH Project was characterized by eleven specific constraints which the GOM and USAID had identified in the project paper. The constraints were:

- Insufficient Funding of Primary Health Care
- Insufficient MOH Providers
- Not Enough MOH Staff Time
- Limited MOH Implementation Capacity
- Limited Supply of AIDS Control and Child Spacing Services
- Weak Distribution System for Contraceptives and Pharmaceuticals
- Poor Training Provided CS Providers and Their Supervisors
- Incomplete Knowledge of Contraceptive Options and the Perceived Value of More, Rather than Fewer, Children
- AIDS Policies Progressive But Slow to be Implemented
- Incomplete Knowledge of AIDS
- Impact of AIDS Control Strategies Uncertain

C. The STAFH Project Framework

The goal of the STAFH Project is to decrease sexually transmitted HIV and to lower the fertility rate. The project's purpose is to increase the contraceptive prevalence rate and to promote behavioral change to reduce the prevalence of STDs and HIV/AIDS. The goal and purpose were to be accomplished by increasing condom use, the prevalence of safe sexual practices, the quantity and quality of STD treatment services and the use of modern methods of contraception. The project's strategy to attain its goal and purpose include:

- Increasing the supply of services by increasing the number of fixed facilities staffed and equipped to provide child spacing (family planning) and AIDS services, and extending services to new communities through community-based distribution programs;

- Emphasizing the delivery of services through the private sector;

- Improving knowledge of how to prevent AIDS, how to plan families and where to get AIDS and child spacing information and services;

- Increasing contraceptive use by broadening the choice of contraceptive options and making services more convenient;

- Strengthening two national leadership organizations, the AIDS Secretariat (AIDSEC) 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

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effectiveness of care given by service providers; and

- Promoting an integrated approach to reducing fertility and STD/HIV/AIDS transmission which targets many of the same populations; focusses on the importance of behavioral change by strengthening information, education and communication (IEC) activities; and utilizes efficiently and effectively the limited resources (staff and facilities) which are available.

The NFWC, AIDSEC and a competitively selected Institutional Contractor were identified for implementation of the project. The USAID Mission was to provide additional TA through buy-ins to centrally managed projects, and provide complementary grants to US-based PVOs for their programs in Malawi.

Project outputs were stated in two categories: child spacing (family planning) and AIDS control. The child spacing component has one output measure of achievement: increased access to child spacing information and services. The outputs of the AIDS control program are: increased access to condoms and condom education services; increased access to high quality STD drugs and appropriate 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 bar girls) and the general population. Indicators were established to monitor progress during the course of project implementation.

III. THE JSI-STAFH CONTRACT

The original JSI-STAFH contract was for a four-year period, beginning from July 14, 1994. The budget, exclusive of fee, was $12, 447, 618. The fee was fixed at $580,000.

JSI officially arrived in Malawi in October, 1994 to join other national and international organizations as a participant and partner in the STAFH project. With respect to the HIV/AIDS component of the contract, there was a brief overlap with Family Health International while it wound up its contract with USAID. Centrally managed Cooperating Agencies/projects which were to play key roles in STAFH included AVSC, FPLM and MACRO (RAPID). These did not have field presence in Malawi.

The key USAID contact persons at the time were Chris McDermot, HPN Officer; Laura Kearns, STAFH Project Manager; and Nem Chakhame, Assistant STAFH Project Manager. The principal contracting officers at the Regional Contracting Office in Nairobi were Kimberly Kester and Richard Webber. The main GOM contact persons were Dr Mukiwa, Secretary for Health and Population, and Mr Odala, Principal Secretary (2) both in the MOHP.

The specific work to be undertaken by JSI was set against the background of the country setting,

family planning and STD/HIV constraints, and the STAFH project framework outlined above.

A. JSI Responsibilities and Deliverables

As specified in the STAFH project paper, the responsibilities of JSI as the institutional contractor were to be as follows:

- Provision of technical assistance;
- Procurement of commodities and medical supplies;
- Development and implementation of a training plan, workshops, mass media campaigns and other IEC activities;
- Research;
- Monitoring project activities and the end-use of project resources;
- Development of management information systems; and
- Development and management of grants to local NGOs to support community-based expansion, quality assurance activities, and operations research for family planning and AIDS.

The specific project outputs for which JSI was held accountable as the institutional contractor were:

1/ Family Planning

-- number of MOH and CHAM hospitals providing comprehensive child spacing services increases from 3 to 25, 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, 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) increases from 68,000 to 280,000 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.

2/ AIDS Control

-- percent of MOH and CHAM 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 bar girls, STD patients, out of school youth, and other at risk men and women;

-- 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 NACP increases from 3.0 per year to 10.0 million per year by 1998; and

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

B. Changes and Contract Modifications

As contract implementation was initiated and progressed, some important changes and contract modifications were made to parts of the original expectations of JSI in light of the actual situation on the ground with regard to the programs and activities of other organizations. The changes and modifications, most of which were later formalized through contract modifications, explicit USAID Mission approval letters and USAID and GOM approved action memos from JSI, included the following:

- The number of FP sites to be renovated was reduced from 266 to 35;
- Funds for FP facility renovation previously allocated through the MOHP were transferred to JSI which was to undertake all the renovations;
- Instead of JSI, USAID was to award and manage the PVO grants. JSI was to deal only with the NGO grants;
- As the EU AIDS Project was already working with bar girls, JSI was to collaborate in producing IEC materials and not initiate any other new activities;

- Through its direct PVO grant from USAID, PSI was to handle the social marketing of condoms and pills; and

- As the supply of STD drugs from USAID greatly exceeded the consumption requirements, distribution of the drugs was to be extended beyond the STD pilot sites.

In the HPN Office at USAID, Chris McDermot was replaced in October, 1996 by Joan LaRosa(as Health and Population Team Leader, following the USAID re-engineering). Although Laura Kearns also left that year, her replacement in the form of a personal services contractor did not arrive in Malawi until early July, 1997. She was Linda Andrews who assumed the title of STAFH Team Leader. At the RCO, Maureen Shauket became the principal contact, replacing Jeff Bell. However, other contracting officers, including Gala Willoughby-Specht continued to be involved with the JSI contract particularly following the medical evacuation of Maureen Shauket from the RCO.

With JSI, the major staff changes involved replacement of Jerry Russell, the first Chief of Party, by Marc Okunnu in late 1996. Dr. Russell left in October, and Mr. Okunnu arrived in Lilongwe on 18 November. Roger Swartz was appointed as the JSI home-office program manager, with Stephannie Silk serving as program associate. Richard Moore initially served as the senior technical officer, providing overall technical oversight and back-up. During the third and fourth years he was replaced by Ken Olivola and Patrick Dougherty, although he continued to provide Senior level support for the contract.

C. Implementation

1. Implementation Strategy

As intended in the STAFH project design, JSI's implementation strategy focussed on the planning and provision of technical and material assistance, funding for related activities, the NGO grants, and the private sector program development. Planning and providing TA constituted the major portion of the program work undertaken.

Planning, Delivery and Evaluation of Technical Assistance

The planning, delivery, reporting and evaluation of TA consumed the major portion of the time and expertise of the eight full-time advisors (two phased out in 1997), and ten senior Malawian associates. To supplement and complement the in-house expertise and time of advisors and associates, the services of JSI home office staff, personnel of JSI subcontractors, and other national and international consultants and resource persons were utilized. Working with JSI-STAFH personnel, they helped to:

- formulate and develop strategies (e.g. IEC and LTPC strategies, and strategic plans for NGOs and the NFPC);
- conduct evaluations and prepare case studies (NGO program development and management, private sector programs);
- design and conduct research;
- plan, facilitate and report certain important events (e.g. staff retreat, annual STAFH coordination meetings); or
- fill in temporary staff positions (STD/HIV Advisor, NGO Management Associate).

The focus of TA was on three key areas:

- improving and expanding knowledge about FP and HIV/AIDS prevention;
- planning, implementing and evaluating training for FP and STD service provision, including development of trainer and learner materials; and
- building or strengthening public, NGO and private sector capacity for FP, STD and HIV/AIDS programs.

As TA was a major preoccupation, it was important to structure and document the processes. To this end, a system for identifying, utilizing and evaluating consultants and resource persons, and for guiding the process of TA in general was developed and implemented. The elements of the system were as follows although for various reasons some elements may have been missed with some consultants and TA activities:

- soliciting and reviewing curriculum vitae from potential consultants;
- development and updating of the consultant register, including advertized requests for new or revised CVs from interested individuals and institutions (consultant register with about 60 names on national and international persons);
- preparation of consultant scope of work, stating the objectives, activities and outputs from each consultancy as well as the terms of reference for individual consultants (format designed);
- circulation and publicity of scopes of work and related information (e.g. to JSI-STAFH personnel, USAID HPN staff, JSI-Boston, partners and donors), in building understanding of and consensus for the planned activities and in identifying prospective candidates;

- short-listing and interviewing of candidates, as appropriate;
- contracting (agreement, scope of work, and time sheet);
- periodic review of progress in undertaking assignment and achieving objectives, and providing feedback (informal sessions);
- preparation and review of TA (or consultancy) report (guidelines provided); and
- evaluation of services rendered (special form designed for the purpose, for consultants).

The Role of JSI Subcontractors

JSI managed a team of four US-based *subcontractors* who assisted in implementing various aspects of the contract. Without establishing any field offices, the subcontractors provided field-based personnel, consultants and/or other administrative, technical or logistical inputs. In the field (Malawi) the subcontractors and their corresponding inputs were:

- University Research Corporation (one Research Advisor and one Quality Assurance Advisor; design and implementation of socio-cultural and behavioral research; and design and pilot testing of facility-based continuous quality improvement techniques, including training of coaches and participating facility personnel);
- PATH (one IEC Advisor; development and implementation of a multi-media IEC strategy);
- World Learning, Inc. (one PVO/NGO Advisor; development and administration of a program of NGO grants);
- and New Transcentury Foundation (off-shore procurement of vehicles, commodities and medical supplies).

Coordinating and Working with Partners

In order to promote a holistic, integrated and *coordinated approach*, emphasis was placed on planning and working closely together with the key GOM implementing agencies (the NFPC, AIDSEC and the Reproductive Health Unit of the MOHP), other USAID-supported STAFH participants (centrally managed projects and PVOs), other national and international organizations active in Malawi (e.g. BLM), and other health and population donor organizations (UNFPA, UNICEF, DfID, The World Bank, EU-AIDS and WHO).

"Planning and working closely together" was intended to promote, enhance and strengthen joint

national ownership of plans, activities and outcomes; *inclusiveness in decision making*, and mutual agreement on individual and joint *responsibility for identified actions*. Planning and working closely together, in spite of various limitations and constraints, also provided opportunities for discussing common concerns, shared objectives, and issues of common interest as well as attempting to harmonize activities and plans.

The mechanisms for planning and working closely together included:

- annual JSI-STAFH planning retreats;
- bilateral quarterly coordination meetings with the key GOM implementing agencies;
- JSI-facilitated annual coordination meetings of STAFH project participants and partners;
- quarterly NGO exchange of experience meetings;
- participation in JSI-supported or other agency facilitated task forces, committees and working groups; and
- participation in other agency activities (e.g. UNFPA tripartite review meetings, UN Youth Theme Group meetings, and the Regional Health Office (South) quarterly coordination meetings with national and international organizations active in the region).

Through the combination of these mechanisms, JSI was able to remain up to date on changing circumstances and priorities, and to accommodate the important needs and requirements of the three GOM implementing agencies in its annual workplans. As required, four annual workplans were produced and approved by USAID. It was also possible to harmonize the scheduling of some activities with the NFPC, AIDSEC and the RHU-MOHP, and plan joint activities, such as conceptualization, development and pre-testing of the national FP logo project with them. As USAID also participated in the planning retreats, it was possible to reflect the concerns, priorities and perspectives of the Mission in the workplans.

2. Management and Administration

Staffing and Personnel Management

As planned, the services of eight advisors were utilized, four (Chief of Party, Community Services Advisor, Communications Advisor, and Finance Manager) through the four-year contract period, and three (Quality Assurance Advisor, STD/HIV Advisor, and Research Advisor) through the third year. The eighth position (NGO/PVO Advisor) was originally planned for phase-out at the end of the third year. However, with USAID approval, it was extended through the fourth year. The research advisor position was also extended for three months with USAID approval.

The local hire, long-term positions filled were also more or less in line with plans, except that no District Community Officers were hired. At its peak (around July, 1997), the total JSI staff strength was 44, organized into seven technical and administrative units dealing with FP (one Advisor and three Associates), STD/HIV (one Advisor, one Associate and one Program Assistant), Community Services (one Advisor, one Associate and one PA), NGO Programs (one Advisor, three Associates and two Financial Analysts), Research (one Advisor, one Associate and one Data Entry Clerk), IEC (one Advisor and one Associate), and Finance and Administration (one Advisor and one Associate - senior administrator). Altogether, about 61 persons worked with JSI for at least three months during the life of the contract.

Building and Maintaining the Administrative Infrastructure

The main office was established in Lilongwe, in the Central Region (where USAID, other donors, and most Government Ministries are based). The office facility (increased with the acquisition of an annex in 1996) was adequate to accommodate all staff members in one location. However, for 18 months, a sub-office was operated in Blantyre in the Southern Region, to facilitate the development phase of the NGO program as most of the NGO grantees were located in the Southern Region.

A motor pool of 12 vehicles enabled fairly easy movement by staff within Lilongwe and to the field for official assignments. Air and coach travel were utilized from time to time to supplement the internal transportation facilities for inter-city travel.

Development of Partnerships and Linkages

This took the form of JSI personnel linking up with existing working groups, or working with partners to set up new groups that were needed. As at the end of the contract, JSI had facilitated or participated in at least 15 working groups as listed below:

- Proposal Review and Approval Committee (for the NGO grants program)
- Syphilis Laboratory and Quality Control Working Group
- STD Technical Advisory Working Group
- National population Research Committee
- National Youth Sexual Health and HIV/AIDS Coordinating Committee
- Work Place Task ForceFacility Upgrading Committee
- Continuous Quality Improvement Task Force
- VSC Task Force
- Tinkanena Review Committee
- National Family Planning Logo Development Task Force
- IEC Material Pre-Testing and Users Guide Working Groups
- Media and Health Task Force
- Reproductive Health Management Strengthening Task Force

In a number of the groups, such as the Work Place Task Force, JSI served as the Secretariat, convening and hosting meetings, consulting with partners to agree upon meeting agendas, and preparing and circulating minutes of meetings.

3. Program Activities

The program activities were implemented under four program objectives:

Family Planning Promotion and Services:

The main objective of the family planning component of the STAFH Project is to improve knowledge about and attitudes towards family planning, as well as access to and use of quality FP services. Over the contract period, JSI supported the realization of the objective by supporting measures to increase the number of service delivery points, training of FP service providers, and pilot-testing simple low-cost techniques for improving the quality of FP services.

Expansion of FP services was planned to be effected at the three levels of the FP service delivery system, namely:

- Comprehensive FP services which encompass the provision of all core FP methods - oral contraceptive pills, injectables, intra-uterine devices, condoms and spermicides, plus minilaparatomy under local anaesthesia, Norplant insertion and removal, and vasectomy services in a select number of facilities;

- Core FP services which include provision of all FP methods except ML/LA, Norplant and Vasectomy; and

- Community-based FP services. This level includes the provision of pills, condoms and spermicides by CBD Agents.

With respect to quality improvement, interpersonal communication and counseling was to receive a special focus in order to improve the quality of provider-client interactions. In fulfilling and meeting these expectations, JSI planned and implemented a number of specific support and other activities as follows.

Renovation of service delivery facilities

The renovation activity was intended to provide space, or improve audio and visual privacy for both core and comprehensive FP services. A total of 23 sites were renovated. Facility renovation was a major activity involving:

- identification and selection of sites; assessment of renovation needs in each site;

- preparation of site plans;
- competitive selection and engagement of contractors;
- technical supervision and quality control of renovation works; and handing-over of completed sites to the MOHP.

Procurement and distribution of clinic equipment and furniture.

In order to enable hospitals, health centers and other health facilities to introduce, expand or strengthen provision of core and/or comprehensive FP services, the STAFH Project provided for the procurement and distribution of clinical equipment and furniture. Based on needs assessed with the MOHP and CHAM, an order was placed with NTF for 270 sets of clinic equipment. Specialized VSC and theatre equipment for the planned comprehensive service facilities were also to be procured off-shore. Furniture was to be procured locally.

The 270 sets of equipment were procured and a total of 228 FP service delivery facilities received clinic equipment and/or furniture. The balance was awaiting delivery to private sector and private practitioner facilities. Equipment procurement and distribution was also a major activity. It involved:

- identification and selection of facilities to receive equipment;
- assessment of the specific equipment needs in each facility, both for core and for comprehensive services as the individual cases warranted;
- placement of the order with New Transcentury Foundation (NTF), the procurement subcontractor, or directly with approved suppliers (or manufacturer, in the case of furniture);
- receipt and storage of the equipment; and
- transportation and delivery of the equipment to the selected sites.

At the time of delivery, to facilitate rapid utilization of the equipment, JSI staff assisted to assemble and install the equipment (e.g. examination couches). JSI also trained the staff at the receiving facility that needed training to use certain equipment (e.g. the autoclave).

Designing, piloting and monitoring a facility-based continuous quality improvement

The FBCQI model was tested in six sites in two regions under the direction of an interagency task force composed of the MOHP, the NFPC, CHAM, Medical Council, Nurses and Midwives Council, the Central and Southern Regional FP Coordinators and JSI-STAFH. The pilot testing process involved seven key steps, as follows:

- Development of plans for the activity by the interagency task force;

- Selection of the six pilot sites. Among others, two major selection criteria were used: district where no other donor activities were taking place; and representation of different levels of service delivery to enable comparisons in performance and experience, given the variations in the staffing patterns. The sites selected were: Mchinji District Hospital; Kochilira Rural Hospital; and Nkhwazi Health Center all in the Central Region; and Chiradzulu District Hospital; Namitambo Rural Hospital; and Namadzi Health Center all in the Southern Region;

- Development of the CQI curriculum and data gathering tools;

- Training of personnel. Ten CQI coaches drawn from the participating RHOs and Districts, and JSI-STAFH were trained to provide supervision and coaching. Two rounds of training was conducted for 24 personnel from the pilot sites. The first training introduced the concepts of CQI, data collection and team work. The second training was on problem solving approaches and skills;

- Implementation of the model in the pilot sites. Personnel in each site worked in teams composed of Nurse, Clinical Officer, Administrative staff, Health Surveillance Assistant and Ward Attendant. As the teams worked to identify and solve their problems, personnel from JSI and the RHOs conducted six visits to each site to provide continuous monitoring, supervision and technical assistance. Team experiences were documented as each site worked on its problem-solving exercises. The problems selected included long waiting time for clients, and inadequate knowledge of facility personnel on types and availability of FP services;

- Documentation of the entire activity and dissemination of experience and lessons from the pilot sites. The dissemination workshop was jointly organized and co-funded by JSI-STAFH and the Medical Council in September, 1997; and

- Follow-up monitoring, supervision and TA visits to the pilot sites after the dissemination workshop. These visits (two rounds) were undertaken by JSI personnel for monitoring and supervision of activities and provision of technical assistance.

In the course of implementing the CQI activities in the pilot sites, the task force members who had been specially oriented and trained to provide support were most of the time not available to provide the required assistance, due to other demands. In spite of the training, some also seemed to lack the confidence to undertake the support and supervision role. As a result, most of the follow-up and supervision was provided by the JSI staff member.

Training of personnel

As envisaged in the STAFH Project, the role of training is critical in increasing FP information and services, and improving the quality of services. However, funding for training was to be disbursed directly by USAID to the MOHP, which was to be responsible for organizing and conducting the training. Thus, apart from LTPC, JSI was not given a direct role in training of FP personnel. JSI was to develop and monitor a training MIS, and provide technical support to the MOHP.

The actual JSI role involved significant work in curriculum development, pre-testing and revision; training of core provider trainers; training in interpersonal communication and counseling; and training of core FP service providers using the three-day curriculum.

Training in core FP service provision: In collaboration with the NFPC, RHU-MOHP, CHAM, BLM and the FP training centers, the three-day curriculum was developed. After pre-testing and revising it, the curriculum was used to train 52 health care personnel in core FP service provision. This was a bridging training to enable health care workers who had not undertaken the 4 or 6 weeks FP course to provide core FP services. In addition to the number trained with JSI assistance, another 317 health workers in the Northern Region were trained with other donor support, monitored by JSI.

Training in IPCC was intended to contribute towards the provision of quality core and comprehensive services, and make services more user-friendly. The process for developing and delivering the training went as follows:

- Curriculum development for the six-day training, in collaboration with the NFPC, RHU-MOHP, HEU-MOHP, CHAM, Malawi College of Health Sciences and FP trainers;
- Pre-testing of the curriculum with a group of core FP trainers whose feedback were used to revise and finalize the curriculum;
- Planning and organization of a two-week TOT in January, 1997. A total of 27 trainers were trained, drawn from each of the 24 districts (2 each) and the RHOs (one each);
- Planning, scheduling and conduct of IPCC training, in collaboration with the NFPC. Four rounds of training were implemented, two funded by NFPC with other donor resources.

On the whole, JSI supported the training of 408 FP service providers in IPCC. However, the resources of other donors enabled training of a total of 921 providers as at the end of October, 1998. The achievement compares to the STAFH Project target of 600 trained personnel.

Training in CDLMIS: In addressing the constraint of weak distribution system for contraceptives,

JSI worked closely with FPLM, the RHU-MOHP and NFPC to design, conduct and evaluate a training program. Approximately 1,000 regional, district, health facility and community-level FP service providers, supervisors and managers received training in contraceptive distribution and logistics management information system (CDLMIS). In all cases, a training needs assessment was conducted; the training curriculum was designed or adapted; logistical and administrative arrangements were planned and implemented; and training was evaluated. Subsequently in 1997, JSI supported a workshop to incorporate the CDLMIS curriculum into the FP training curriculum, and to train the FP trainers to teach the course.

Training Support to the MOHP: The MOHP is responsible for training 576 FP practitioners, and running contraceptive technology update courses for 200 providers, using funds disbursed directly from USAID. The training is conducted through three training centers supported by USAID. The role of JSI in this activity was limited to monitoring the progress of training, and assisting to facilitate the flow of USAID funds.

The start of the activity was delayed due to an earlier requirement by USAID that the MOHP funds the training and seek reimbursement of costs. This arrangement was not feasible and USAID eventually agreed to provide an advance, to be reimbursed upon satisfactory accounting. The new arrangement allowed 137 FP practitioners to be trained as at the end of the JSI contract. As funding for each round of training has to be separately requested by the MOHP and advanced by USAID, the arrangement is very slow, accounting for the low number of trained personnel compared to the target of 576.

Development, production and distribution of IEC materials and channels.

Although no specific FP IEC outputs are stated in the STAFH Project paper, the document calls for the "Design and implementation of a comprehensive IEC program to:

- increase knowledge of contraceptive options, and dispel rumors, fears and misconceptions about contraception; and
- counter the large family planning bias in the society."

At the commencement of the JSI contract, the country setting underscored a compelling need for the development of an IEC strategy. The strategy was seen as important to identify the appropriate niche for JSI, given the activities and plans of the various partners, to enhance complementarity of JSI-STAFH IEC interventions, and to promote overall effectiveness and efficiency in IEC work. Development of an IEC strategy was thus the first step, preceded by a comprehensive IEC needs assessment. The needs assessment revealed that there was:

- a wide gap between FP (and HIV/AIDS) awareness and knowledge, and practice;
- high unmet need for FP;
- poor quality and depth of FP (and HIV/AIDS) information;

- no match between awareness creation and services;
- little or no pre-testing of IEC materials; and
- no evaluation of IEC materials and interventions.

Against the background of the findings of the needs assessment and the goal and objectives of STAFH, the IEC strategy was formulated to focus on four strategic thrusts:

- Condom promotion, through the Condom First or Condom Plus Initiative;
- Linking women who want FP to services;
- Using every opportunity to prevent sexually transmitted diseases; and
- Maximizing resources through collaboration.

In line with the vision and objectives of the IEC strategy, a range of print and other materials and channels were developed and put into use. They include:

- six FP method-specific leaflets (condom, pills, injectables, IUCD, vasectomy and TL);
- flier and leaflet on the "Role of Men";
- wall chart on available contraceptive options in Malawione jingle and ten FP radio spot messages on FP methods, and rumors and misconceptions: the jingle and three of the spots were aired on MBC Radio 2 while the remaining seven were awaiting final production;
- the national FP logo was developed, pretested, revised and launched;
- four bill boards with FP messages were designed and erected in strategic locations; and
- T-shirts, Chitenjes, car stickers and other publicity materials were produced as part of the support materials for launching the national FP logo.

In addition, JSI worked with media personnel (managers, journalists and reporters) to increase their knowledge, understanding and conviction on matters of reproductive health. The aim of this contact was to increase and improve the coverage of RH issues (features and news stories) in the electronic and print media. Given the necessary attention and resources, the Media and Health Task Force which resulted from the contact with the media could play a vital role in further increasing knowledge about FP and STD/HIV among newspaper readers and radio listeners.

Design, implementation and dissemination of research.

Although the STAFH Project paper calls for behavioral and operations research, no specific research outputs are stated, apart from the development of a national population research agenda. To shape the work of JSI in the research area, JSI personnel interviewed various partners (GOM organizations, NGOs, donors, etc) to ascertain research needs, and to establish the research capacity. The findings from this investigation suggested or confirmed three areas of need for JSI attention:

- technical assistance to develop a population research agenda;

- general technical assistance for conducting research on behavior change; and
- technical assistance to USAID for its evaluation needs.

JSI-STAFH personnel played an active role in the development of the national population research agenda, a role that was later formally acknowledged by the Center for Social Research. On an ongoing basis, JSI staff provided technical advise and guidance to various organizations on the design and implementation of research; built or enhanced research capacity among personnel such as enumerators and supervisors, and NFPC and NACP research staff, and provided on-the-job training to NGO research personnel on subjects such as research tool design. In addition, JSI itself conducted or supported other partners to conduct research resulting in the following reports:

- Family Planning in Malawi: An Annotated Bibliography;
- Quality of Family Planning Community-Based Distribution Services in Malawi;
- Condom Use Among Family Planning Providers in the Cities of Blantyre, Lilongwe and Mzuzu;
- Male and Female Involvement in Contraceptive Decision-making, Use and Discontinuation in Rural Malawi; and
- Female Condom Acceptability Among FP Clients in Blantyre City.

JSI developed a mailing list of FP implementing, donor and other agencies, and educational and research institutions for distributing copies of all the research and evaluation reports. During the fourth year of contract implementation in addition to distributing copies of research reports, JSI planned and executed a workshop-based research dissemination strategy, to discuss research findings and contract implementation experience and lessons with partners. The purpose of the activity was to bring important information to the attention of partners, and to discuss the implications of such information in effecting necessary changes to current interventions or planning future ones. Three such dissemination workshops were held, dealing with training and supervision of CBDAs, IEC experience and lessons, and FP and STD service provision.

STD and HIV/AIDS Prevention and Control:

In line with the strategy of HIV prevention adopted under the STAFH Project, and as the reduced incidence of STDs is expected to lead to reduction in HIV transmission, expanding the availability and improving the quality of comprehensive STD services were the main focal points for action in the STD/HIV component. In operational terms, these objectives necessitated a number of activities: support for policy development; biomedical research to inform policy and program development; training of health care workers in each district in STD management; piloting STD activities in 3 to 6 sites throughout the country and replicating the experience in other areas; and community education on HIV/AIDS prevention, early health care seeking for STDs, and sources of STD treatment services.

Piloting of STD syndromic case management services.

Building on work done by AIDSCAP and in collaboration with the NACP and the MOHP, five sites (initially QECH, LCH and Mzuzu Health Center, with Mangochi and Nkhata Bay District Hospitals added later) were identified, assessed and assisted to set-up syndromic management services. Where necessary, support for renovations and furnishing of rooms was provided to enhance client privacy and drug security. Provider and client reference materials, such as desk reference cards for providers; and set of male and female flipcharts, STD leaflets and demonstration penis for clients, were provided.

Another five expansion sites (Chikwawa, Mulanje, Thyolo, Mchinji, and Ntchue District Hospitals) were added later. All sites were monitored and supervised regularly (quarterly) and supplied STD drugs (Gentamicin, Erythromycin, Doxycycline,Metronidazole, and Benzathine Penicilin), as available. A MIS on the treatments and other services, accomplishments and clients of the sites was established and updated regularly. The 5 pilot sites serve approximately 2, 500 clients monthly.

Procurement and distribution of clinic equipment.

Although on a smaller scale, this activity was similar to that undertaken under family planning. Provision of the equipment was intended to help the service providers to examine and diagnose accurately using sterile equipment. Facilities to receive equipment were selected, equipment needs for each were assessed, and orders placed with NTF. Upon their receipt in-country, the equipment were stored in the JSI warehouse and later gradually distributed to 19 CHAM Hospitals, 22 MOHP District Hospitals, 15 Rural Hospitals, and 60 Health Centres, in addition to the pilot sites. and 79 NGO STD service facilities throughout the country.

Training of personnel

Based on the recommendations from the STD baseline survey conducted in 1994, the antibiotic efficacy studies and the STD treatment guidelines developed in collaboration with the National AIDS Control Program, curricula for in-service training of STD trainers and service providers were developed. In 1994, a national training of trainers workshop was held involving 18 participants drawn from MOHP FP training centers, BLM, Project Hope and NFPC. In September, 1996, the 18 trainers were refreshed, and another batch of 23 trainers were trained.

The trainers together trained 1,200 service providers and 26 Health Educators. The courses lasted 3-4 days, held within the districts for health care workers in Health Centers. There were no practicals but each participant was supplied a reference manual. In June/July, 1997, JSI-STAFH supported an evaluation of the STD training. The purpose was to evaluate the extent to which the trained STD service providers were correctly implementing the syndromic approach to STD management throughout the country. The evaluation revealed deficits in diagnosing, treatment

and supervision.

Based on the findings, the curricula were revamped in a process extending between September, 1997 to February, 1998. A new one for training trainers of supervisors was also developed. The new set of handbooks:

- incorporate pertinent and relevant research recommendations, in addition to the recommendations of the training evaluation itself;
- will help to prepare service providers to review the context in which they work, including their role in the community;
- bring in a humanistic approach to STD service delivery;
- empower the service provider to communicate more effectively with clients. and assist the clients with negotiation skills for introducing safer sex.

The new set of four handbooks were pre-tested and used to retrain trainers (38), supervisors (11) and service providers (105). In trying to improve the quality of care in STD service provision, an in-build graduate and program monitoring and evaluation system was established through the development of 2 supervisory handbooks, one each for trainers of supervisors, and supervisors of service providers.

Building on the STD pilot site and training activities undertaken, and to provide guidelines for systematically and firmly establishing the syndromic case management approach, JSI developed the following strategy framework:

- orientation of DHMTs on STD client management and training to promote ownership and support;
- development of District/hospital STD workplans;
- training of STD trainers for two weeks;
- training of trainers of supervisors of STD services for one week;
- training of service supervisors for one week;
- training of service providers for two weeks;
- in-service education to maids and servants on symptom recognition and sources of STD services on the job; and
- promotion of community participation in STD information and education activities.

To cater to the needs in the pre-service area, separate curriculum materials were also developed for MCHS, KCN and Enrolled Nurse-Midwifery Technical Schools. These materials are currently in use. However, the tutors and lecturers require training in STD syndromic management.

Development, production and distribution of IEC materials.

The IEC needs assessment and strategy development process described above in relation to the FP component also covered STD and HIV/AIDS issues.

In line with the findings of the needs assessment and the strategy, a range of materials on STD and HIV/AIDS prevention and control were produced, including:

- posters (nine, addressed to the following target groups: STD patients, general public, bar girls, youth, sexually active youth, and participants in youth initiation ceremonies);
- leaflets (two, addressed to sexually active people, and the general public);
- picture codes (four, addressed to youth and bar girls);
- laminated desk reference cards (for use by service providers);
- partner notification slips flip charts.

These materials, developed for the general public, STD patients, men, and STD service providers, address issues of:

- STD prevention;
- early symptom recognition and the importance of partner notification;
- importance of completing STD treatments;
- treatment guidelines; and sources of treatment.

As with the FP IEC materials, the development and production process involved audience and message research, initial and follow-up pre-testing, and work with graphic artists and printers to design and print the materials.

A major activity undertaken under the STD/HIV component was the school AIDS education program. This was the main thrust of the objective to increase awareness and knowledge about HIV/AIDS among the school going population with the following results:

- 16,000 primary and 450 secondary school teachers were oriented to teaching AIDS education in the classroom, utilizing the AIDSCOM teacher's guide and learner's handbook: this activity reached 98.5% of primary schools in Malawi;

- worked with the Malawi National Examination Board to make AIDS education a testable subject in public school examinations; and

- conducted an evaluation of the schools AIDS education effort in 1996-1997: a report outlining the way forward was produced and disseminated.

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Design, implementation and dissemination of research.

As under the FP component, no specific research outputs are stated for AIDS control in the STAFH Project paper. Most of the research work done under the JSI-STAFH contract was with respect to STD and AIDS. Research dealt with behavioral and socio-cultural factors, investigating issues such as initiation rites and HIV transmission, STD partner notification, and male and female condom use. A number of bio-medical studies (on GUD, drug efficacy, and HIV in semen) were completed and reported.

Work began with the compilation of an annotated bibliography on AIDS in Malawi. Apart from ongoing research capacity building with partners similar to those reported in the FP component above, JSI supported or directly undertook bio-medical and socio-cultural research as well as evaluation studies which produced the following research reports:

- Evaluation of AIDS Education in the Classroom: A National Survey;
- Cultural Practices Related to HIV/AIDS Risk Behavior: Focus Group Discussion of Village Leaders in Phalombe District;
- Cultural Practices Related to HIV/AIDS Risk Behavior: Community Survey in Phalombe, Malawi;
- Health Seeking Behavior and Partner Notification by Clients with Sexually Transmitted Diseases (STDs) in Malawi: an Ethnographic Approach;
- The Role of Traditional Healers in the Management of Sexually Transmitted Diseases (STDs) in Malawi: A Case Study of Lilongwe, Ntchisi and Nkhata Bay Districts;
- Adolescent Commercial Sex Workers in Malawi: A Case Study of Mzuzu and Salima;
- Initiation Rites Among Yao Muslims In the Southern Region of Malawi: *Jando and Nsondo* From Machinga, Mangochi and Zomba;
- Effects of HIV in Semen: Treatment of Urethritis Reduces the Concentration of HIV-1 in Semen; and
- Susceptibility of *Neisseria Gonorrhoeae* to Gentamicin in Malawi, 1998.

As with the FP component, JSI utilized a comprehensive mailing list to distribute copies of the various research reports.

Integration

The STAFH project consists of two distinct activity and output areas in FP and STD/HIV. All the same, the project is emphatic about the need for integrated FP and STD/HIV information and services. The ultimate aim is to have all health facilities providing access to integrated services. Another integration objective was with respect to the involvement of non-health organizations in the provision of FP and STD/HIV information and services. This objective was partly at the base of the NGO grants and the private sector support programs.

Integration of FP, STD and HIV/AIDS information in various curricula and manuals.

Integration of FP promotion and STD/HIV prevention education and services is an important objective of the STAFH Project. To address the objective, JSI supported the development or expansion of integrated information, education and messages in various documents as follow:

- CBD curriculum, guidelines and handbooks (set of five);
- Life planning skills manual;
- FP practitioner training curriculum;
- IPCC curriculum;Peer education training manual;
- STD training handbooks (set of four);
- and"Tinkanena", the youth-targeted radio soap opera.

Integration of FP, STD and HIV/AIDS into the programs of NGOs: development, administration and supervision of *NGO grants.*

The NGO grants program component of the STAFH Project was intended to facilitate and expedite the effective participation of NGOs in FP, STD and HIV/AIDS activities and services in order to expand the overall range and geographic coverage of the activities. The program was also aimed at strengthening the capacity of Malawian organizations to design, implement, account for, monitor and evaluate effective FP, STD and HIV/AIDS promotion, prevention and service delivery activities.

JSI planned and implemented a three-step strategy in its work with NGOs. In the first (grant development) stage, JSI worked with CONGOMA, CHAM, other NGOs and USAID to develop a set of criteria for identifying the NGOs that had the potential to design and implement projects in FP, STD and HIV/AIDS IEC, training, service delivery and research. Twenty-four NGOs were identified, and assisted to plan and develop projects to introduce, expand or strengthen various FP, STD and HIV education, service delivery or research projects into their regular activities.

To ensure linkages with public sector programs for technical assistance and other support, the NGOs were required to discuss their planned activities with the respective District Health Offices, and to obtain letters of support from them. JSI organized a Project Review and Approval

Committee with the membership of the NACP, CONGOMA, NFPC, MOHP and USAID, along with JSI-STAFH, to provide guidance and approval.

In the second (grant implementation) stage, JSI assisted and supervised the 24 NGOs to implement their range of activities. The activities implemented included:

- clinic-based provision of FP education, counseling and contraceptive services as well as referrals;
- Community-based provision of integrated FP promotion and STD/HIV prevention education, counseling and services as well as referrals;Social marketing of "Chishango" condoms;
- Clinic-based STD diagnosis and treatment, and STD and HIV/AIDS prevention education;Socio-cultural research;
- Development of IEC materials; and
- Peer education, including training of peer educators.

In supporting, supervising and administering the NGO grants, JSI undertook five main activities, as follows:

- Provision of technical assistance, both directly by the NGO Program Unit and by JSI personnel in other Units. TA consisted of advice, guidance and direction on issues such as set-up, operation and management of clinic- and community-based services; FP quality assurance; development and production of IEC materials; design and implementation of research as well as research report writing; commodity logistics; financial management; and program and financial record keeping and reporting.
- Provision of training, in CBD, STD services, CDLMIS, project management, production of IEC materials, and financial management.
- Procurement and distribution of office, audio-visual, clinical and other supporting equipment. These included desk-top computer sets, photocopiers, audio-visual sets, and FP and STD clinic equipment sets.
- Facilitation of exchange/transfer of experience. This involved the quarterly NGO exchange of experience meetings; an international study/observation tour to Uganda; sponsorship of participation in/presentation of papers at national and international conferences.
- Tracking, monitoring and supervision of office and field activities, to ensure compliance

with the terms and conditions of grants, and to identify TA and other support needs. Monitoring and supervision of field was undertaken on a quarterly basis.

Of the 24 NGOs approved to receive grants (ranging between $23,000 and $136,000), a number, including ECAM, Scripture Union, Youth Arm Organization, MASO and Phwezi, were non-health. However, they were still able to integrate and undertake FP, STD and HIV/AIDS activities as part of their programs. Ongoing monitoring of grant activities revealed no unusual problems: for most grantees project implementation was generally on course throughout their grant durations (18-30 months). However, two NGOs (AFROB and ECAM) were terminated, for financial irregularities and inadequate performance, respectively. For all the NGOs, a mid-term audit was arranged and conducted.

The third and final (close-out) stage involved working with the NGOs to plan (at the last NGO exchange of experience meeting) and implement the close-out activities. The original latest terminating date for all grants was previously set at 30 June, 1998. The date was deliberately set to allow three months (July to September) for JSI to close-out the grants before close-out of the main contract. For 11 grantees, this schedule was adhered to. However, in view of the one month extension to the main contract and to provide a bridge as close as possible to the STAFH extension grants were extended for three (nine) to four (two) months. Thus the final termination date for two grants was 31 October, 1998. For all grants, close-out involved the submission of a final report by the grantee, and a close-out audit arranged by JSI.

Integration of FP, STD and HIV/AIDS into the activities of the private sector: private sector program support.

The purpose of the private sector program was to increase the participation and strengthen the institutionalized capacity of private, estate and parastatal companies, as well as private medical practitioners in the development and management of FP, STD and HIV/AIDS programs. The emphases were on companies with 300 or more employees, employed males and establishment of systematic HIV/AIDS prevention education programs.

Private, estate and parastatal companies were assisted to introduce, expand or strengthen their own FP, STD and HIV/AIDS programs. JSI worked directly with 15 companies with a combined work force of 70,641 or 23% of Malawi's estimated total private sector work force of 380,000. A private sector program strategy setting out specific objectives and activities was developed to guide the JSI action. JSI support involved:

- sensitization of management, to mobilize support and resources;
- development and distribution of a set of six private sector motivation and program support materials;

- training of peer educators and their trainers;training of STD service providers;
- technical advise and guidance in the set-up, monitoring and supervision of peer education programs and STD service delivery; and
- procurement of clinic equipment.

To facilitate and expedite development of the private sector programs, JSI worked with the NACP and the NFPC to establish the Work Place Task Force. The WPTF is co-chaired by the NACP and the NFPC while JSI served as the Secretariat. JSI's secretariat functions included convening meetings of the task force (approximately four meetings were held per year); preparing and circulating minutes of meetings; and maintaining and updating a computerized database on the number, activities and accomplishments of companies.

JSI also assisted two companies (B&C and Makndi Estates) to analyze the cost-benefits of AIDS programs in their companies. The report on the two analyses were distributed to other companies through the WPTF.

Although the private sector programs took longer to develop than had been planned, the momentum for rapid growth has been created and an increasing number of companies (e.g. Air Malawi and the Reserve Bank) has began to request assistance for various activities (e.g. peer education and training of STD service providers). Experience has also shown that the companies are willing to meet the cost of programs: this is very important to ensure sustainability of programs.

Institutional Capacity Building

Capacity building tends to be considered in terms of structured and formal activities, usually in the form of technical assistance and training. However, equally and some times more important is the capacity building that occurs informally through routine interactions with counterparts and their exposure to JSI management and program implementation processes. Throughout the life of the contract, JSI-STAFH personnel and consultants provided informal coaching, mentoring and on-the-job training that enhanced individual and institutional capacity among personnel of STAFH Project participants and partners.

An illustrative example can be cited. As a result of his invited participation in a JSI staff recruitment exercise, a senior partner official became exposed to a set of JSI personnel recruitment guidelines and formats. The set included a form for short listing candidates; an interview score sheet showing specific factors for scoring candidates; a written test exercise; and the outline for preparing the report of the interview panel. The partner official found the set to be more complete, and sought (and received) permission to adapt and use the set in the partner organization.

Whether in the processes of designing and implementing research, and presenting research reports, the processes of developing and producing IEC materials, or in the set-up, delivery and supervision of services, JSI personnel routinely provided advice, guidance and training to STAFH participating and partner agency staff at different levels, to improve their knowledge, skills and proficiency.

The following are the more structured and formal instances of JSI-STAFH capacity building activities.

NGO management capacity building.

A special program of NGO management capacity building was designed and implemented for eight of the NGO grantees. This was based on the lesson that program capacity is enhanced when management capacity is also strengthened. However, in view of time and resource constraints, only the selected group could be assisted. The selection criteria developed by JSI emphasized NGO interest and willingness to participate in the program, and the potential of the NGO to absorb and utilize the assistance (as judged by JSI).

The program involved three sequential steps for each of the participating NGOs: institutional assessment; development of five-year strategic plan; and implementation of tailor-made management development initiatives, based on needs identified from the strategic planning exercise. The management development initiatives included: review of constitution, training for Board and staff members on their respective roles and responsibilities, preparation of job descriptions, development of and training in financial management systems, and training in project planning and proposal writing. For the institutional assessments, JSI went into a partnership with Concern Universal which was then in the process of being established in Malawi. The partnership provided JSI with a pool of management human resources to assist the JSI NGO Management Associate, while affording hands-on training and experience gathering for the CU personnel.

Whereas the strategic plans were developed for all the 8 NGO participants in the capacity building program, implementation of the management development phase did not occur uniformly, with some NGOs moving further along than others, depending on their respective strengths and needs. For example, only St Anne's and Ekwendeni Hospitals were able to receive project planning and proposal writing training which both hospitals had identified as a priority need. MACRO, on its part, identified assistance for review of its constitution as its initial priority. Others wanted and received assistance to review or develop their financial management systems.

Support for public sector strategic planning.

This was part of the effort and process of assisting to strengthen the institutional capacity of two public sector organizations (RHU-MOHP and NFPC) that are in the forefront of reproductive health policy and program development, management and coordination. The focus of attention

was on clarifying institutional roles and responsibilities, and supporting the development of specific sustainable structures and mechanisms for ensuring effective strategic leadership, oversight and coordination of RH activities.

Technical and financial assistance to the NFPC consisted of the services of two consultants (one international and one national), and funding for three workshops and meetings to develop a five-year (1998-2002) strategic plan. The consultants undertook the NFPC environmental and institutional analyses, facilitated workshops with NFPC Board and staff members to review and re-formulate the Council's vision, goals and objectives; and assisted the Council to present the draft strategic plan outline to clients, partners, and donors at a one-day consultative meeting. However, the final stages of the process (finalizing the plan, presenting it to the NFPC Board for formal approval, and printing and distributing copies) were disrupted with the announcement of Government defunding of the Council. With the Council's uncertain future, JSI focussed on assistance with strategic thinking/planning for survival, and examining various options for enhancing sustainability of the Council and its services.

Institution strengthening support to the RHU-MOHP consisted of technical assistance to develop a five-year RH program strategic plan. This was less elaborate, involving JSI participation in a series of three workshops/retreat to plan, draft, and revise the strategic plan. The JSI technical assistance complemented similar support from the WHO through its Chief Technical Advisor based in the RHU-MOHP.

In view of the problems with the number and stability of NACP staff, it was less possible to undertake any major capacity building activity with the organization. At the inception of the JSI contract in 1994, there was no full-time NACP program manager, nor senior staff such as evaluation officer. The staffing situation did not improve until late in 1995. In 1997, JSI support for a strategic thinking/planning exercise similar to that offered to the NFPC (but not for a national AIDS control program which was receiving support from UNDP and other donors) was discussed with the NACP program manager. However, the uncertainties surrounding the future of the AIDSEC and the departure of the program manager held back any action.

However, JSI provided partial support for office equipment, assisted with transportation (loan of STAFH vehicles as and when needed), and supported a masters program for the STD officer. On an annual basis throughout the life of the contract, JSI also assisted with sustaining the NACP capacity to monitor seroprevalence in 19 sentinel sites through financing for the purchase of the needed supplies, and the field travel of the responsible staff.

Reproductive Health Management Strengthening Technical Assistance.

Assistance was given to the MOHP to establish the reproductive health management strengthening task force (RHMSTF) in an effort to improve and strengthen the overall strategic planning and management of RH activities, and cooperation and coordination among RH

organizations. The task force, with membership by the nine key public and NGO sector organizations active in RH, was set up in February, 1998, with JSI assisting with its secratariat needs and functions during its first five months.

To support the work of the task force, JSI provided the services of three consultants (two international and one national), and financing for a series of consultative workshops. The consultants planned and conducted a needs assessment/situation analysis; and planned and facilitated three consultative workshops to present their proposals for discussion and approval. The final report, incorporating all comments and suggestions for improvement received, was submitted to the MOHP for formal approval.

Interagency Coordination and Collaboration

Annual coordination meetings of STAFH participants and partners.

As original envisaged in the STAFH project paper, annual coordination meetings were to bring the project participants together to review progress, discuss implementation issues, and coordinate activities and plans. Over the contract implementation period, the meetings assumed greater significance and bigger dimensions, filling the vacuum of a greatly needed national forum for RH dialogue by all players and take holders.

JSI organized and coordinated the planning and hosting of three such annual meetings, each lasting one-two days. On each occasion, a planning committee was set up, involving the MOHP, NACP, NFPC, BLM, UNFPA and USAID. Each meeting brought together about 40 national and international RH implementing and donor organizations (about 70-90 individual participants on each occasion) to review progress, discuss common concerns and objectives, and attempt to harmonize activities and plans.

As documented in the evaluation section in the reports on the last two meetings (1997 and 1998), the meetings assumed acknowledged significance in promoting interagency communication, consultation, cooperation, coordination and collaboration among RH institutions. Although some participants felt that many of the issues discussed were "old" ones whose resolution was being apparently unnecessarily delayed, most felt that the meetings were still useful for exchange of experience and lessons learned. In view of their acknowledged usefulness, many participants called for measures to ensure their continuation after the JSI contract.

Set-up, facilitation or participation in various task forces, working groups and committees.

As mentioned earlier, JSI organized or participated in the meetings and activities of 14 such groups, and served as secretariat for a number of them.

Bilateral coordination meetings with key partners.

For JSI, this involved convening, participating in and minuting quarterly coordination meetings with key partners (NFPC, AIDSEC, RHU-MOHP, and CHAM) to review progress and issues in joint activities, and to harmonize plans and activities. The meetings were clearly useful and beneficial in reviewing, assessing and planning joint activities. However, scheduling of meetings proved very difficult due to other demands on staff time and availability on both sides. It is also possible that as JSI was in routine contact with its partners, issues and concerns were routinely discussed as they arose, leaving only major issues and those requiring the involvement of several people at the same time for the bilateral meetings. In effect, instead of the desired and planned quarterly meetings, actually meetings were less regular and tended to be held when there were pressing and substantive issues for discussion and decision.

The report on the STAFH Transition Conference held on 30 September, 1998 provides further details on the program activities undertaken. As mentioned earlier, the report is meant to be an annex to this final report.

IV. BARRIERS AND CONSTRAINTS

JSI's arrival in Malawi to participate in the STAFH Project coincided with the change from one-party to the multi-party system. With the new political dispensation came a more liberal and permissive environment, allowing for a more open debate and discussion of national issues, including RH particularly FP and HIV/AIDS. The new liberal environment also permitted expansion of the NGO sector and its larger participation in health, population and AIDS programs.

JSI is grateful to USAID and the GOM for the opportunity to be part of the STAFH Project, and for the cooperation, support and assistance received in the implementation of the STAFH contract. JSI is particularly grateful to the Government and people of Malawi who welcomed the presence of JSI and generally cooperated with and assisted us in our work without undue let or hindrance.

While the overall national environment was generally conducive to and supportive of the work of JSI, there were, nevertheless, some specific areas or issues which in one way or another constituted barriers or constraints to fuller or more rapid contract implementation.

A. Staffing of Counterpart Organizations

JSI worked with three key national level Governmental or semi-governmental organizations: the MOHP (particularly the offices of the Principal Secretaries, the Controller of preventive health Services, and the Reproductive Health Unit (previously Family Health Unit); the NACP,

particularly the AIDSEC; and the NFPC. JSI personnel were also in frequent and close contact with Regional and District Health Offices. In addition, JSI established important partnership and working linkages with many other RH organizations and donors.

The STAFH Project was signed in 1992, under a different Government and different personnel in the Ministry. Prerequisite to starting the JSI-STAFH contract was to be the formation of a STAFH Project Steering Committee, and a STAFH project desk officer at the MOHP. Neither of these were put in place. Moreover, as USAID forbade JSI meetings with the high level MOHP officials (PS or Chief of Health Services), those we were able to meet were not the ones who approved the STAFH project (and the JSI contract), did not understand it, and were not as cooperative as could be expected. The situation was compounded by difficulties in the direct transfer of funds from USAID to the MOHP (until late in 1996). This had implications on the appropriate points for as well as the pace of decision making, and the commencement of some STAFH project activities, such as training of FP providers and the facility upgrading/renovation effort.

JSI was expected to assist in building the capacity of the NACP, along with the NFPC and the MOHP. However, in 1994, the NACP did not have a full-time program manager, no program office and an evaluation officer, and none of the existing positions were confirmed. There were really no counterparts to work with. It was not until late in 1995 that the NACP became mostly staffed. However, funding for the staff was of a short-term nature and was to finish by June of 1997. In terms of staffing, the NFPC was better placed, with most of its established staff positions filled. The NFPC was also more articulate with regard to its institutional capacity building needs. This centered around the development of a five-year strategic plan which JSI was able to assist with. However, the final stages of the planning was thrown into disarray when the Council lost (at least temporarily) its funding from Government.

Staffing of the RHU was also less than desired, in view of the units massive workload. For long periods of time, too, even the established staff positions were not filled, further stretching the workload of those at post. The net result was extensive delays in decision making or in carrying out activities. The notable examples here are related to the logo development and approval process, approval of the LTPC expansion strategy, and approvals for the facility renovations to proceed.

B. Unclear Roles and Responsibilities of Counterpart Agencies

The counterpart agencies did not have clearly defined roles or channels of communication, creating misunderstanding not only among themselves but also with JSI. For example, who should be contacted first on a FP issue, the RHU or the NFPC ? How could this be done without stepping on toes or creating disunity ? Initially, communication with the NFPC was rather difficult since JSI did not know who was responsible for what in FP and RH. Our experience showed that where the correct channels were not adhered to then activities tended to be stalled and no

progress was made. Through the annual coordination meetings and the RH management strengthening TA, the issue of unclear roles and responsibilities was significantly addressed although not before it had constrained some initial contract start-up activities.

C. Limited Capacity for Production and Printing of IEC Materials

This significantly delayed the availability of IEC materials. In some cases, printing facilities had to be obtained from Zimbabwe and South Africa. The extended delay in the finalization of educational materials for bar girls was caused by this constraint. One of the NGOs (ADRA/Cobbe Barracks) had to procure T-shirts from abroad. Similarly, electronic production facilities are limited. Although ten radio spots on FP were developed, only three of them could be produced due to the production short fall.

D. Relative Youth and Weakness of NGOs

Most NGOs are new and are only just getting themselves established. In their relative youth and inexperience they are also weak. Most lack the basic infrastructure for operation. Most of the 24 NGOs identified by JSI for the grants program had to be assisted to develop proposals. Extensive amounts of time were spent on this, reducing from the time available for grant implementation.

V. ACCOMPLISHMENTS

A. Preamble

The work and accomplishments of JSI under the STAFH project must be seen as part of the continuing effort in strengthening reproductive health in Malawi. Apart from USAID and its various assistance mechanisms in the health sector, other donors continue to be active in Malawi, supporting a wide variety of RH initiatives and programs. Even within the USAID assistance, STAFH is only one of the group of health sector interventions, along with others such as CHAPS. STAFH itself involves the inputs of a number of national and international players. For example, the STD/HIV component of STAFH was previously handled by FHI under a cooperative agreement.

As a participant and partner in STAFH, JSI sought to play a strategic support role to advance the coverage and strengthen the sustainable impact of reproductive health in Malawi, focusing on FP promotion and services, the prevention and treatment of sexually transmitted diseases, and HIV/AIDS prevention education. As is well known, the range of RH needs is wide and complex. JSI's contribution (enabled by USAID) can therefore be seen only as supplementary and complementary to the total efforts of all the RH players.

In RH as in development in general, four years is a short time to talk about impact. Furthermore,

no external evaluation of the work of JSI was done during the contract period to assess its short- as well as long-term effectiveness. Against the background of these preambles, the accomplishments discussed in this section should, therefore, be assessed more in relation to their strategic significance in building strong foundations for sustainable RH programs.

B. Deliverables

1. Increased Access to Family Planning Information and Services

Access to information and services has been significantly increased. According to CHSU, 154,088 new clients were registered in 1997 (the last year of complete records). In the same year, there were 377,400 revisits, making for a total of 531,488 users of modern FP services during the year. This represents a 79% increase over the corresponding figure for 1994, and a 22% increase over the STAFH target of 437,000 for 1998. A crude estimate of the CPR based on the user figure would suggest a current CPR of about 24%.

The methods stated in the CHSU records are: pills, IUCDs, injectables (depo provera), condoms, foaming tablets, and surgical methods. Overall, the injectable is the first method of choice followed by the pill. The number of users of surgical methods has increased from 3,052 in 1994 to 6,931 in 1997. The use of IUCDs seems to be declining (between 1990 and 1994) but the figure of 5,258 users in 1997 represents an increase of about 25% over the figure for 1994.

Core Family Planning Services

Information from the RHU-MOHP shows that the number of clinics providing core services has increased from 326 in 1994 to 455 as at the end of the JSI contract. The STAFH target for 1998 is 593 which is 138 more than the actual. However, in addition to these static facilities, a growing number of outreach clinics has also been recorded. Statistics from the Central and Southern Regional FP Coordinators show that 419 outreach clinics provide core services. Ownership of the outreach clinics breaks down as follows: MOHP, 325; MOLG, 17; CHAM, 57; and private, 20. Thus, although the increase in the number of static core facilities was below the target, there are now more outreach services reaching more locations with increased frequency.

Comprehensive Family Planning Services

The number of MOHP hospitals providing comprehensive services (including ML/LA but excluding vasectomy and Norplant) increased from the baseline of three in 1994 to 13, following training of 12 Clinical Officer/Nurse teams. Instead of 24, only six MOHP hospitals provide Norplant, and two rather than five provide vasectomy services. The STAFH target is 24 hospitals providing comprehensive services including ML/LA and Norplant.

One cause of the shortfall is the delay in implementation of the LTPC strategy which was to be

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completed in September, 1997. In addition, there was a significant delay in replacing the former LTPC coordinator in the RHU who retired in 1997. In the absence of the coordinator to "push" it, the LTPC strategy was not approved by the MOHP until early 1998. This set back plans for training more trainers and service providers, and for launching district-based campaigns for strengthening demand. Anyhow, JSI spent time in April and May working with the RHU-MOHP to assist District Health Offices to develop their respective first year LTPC implementation plans.

Five teams of LTPC trainers were trained in July in collaboration with AVSC (the technical partner), and arrangements were made to conduct two rounds of training for ML/LA service providers in September. As equipment for new ML/LA sites were already available in the country, the September training would have permitted initiation of ML/LA services in 12 more MOHP hospitals. However, the training had to be postponed for two reasons: delay in deciding which approach to adopt - facility-based or centralized; and uncertainties about the availability of funding from AVSC to meet its consultant costs. In the end, the training had to be abandoned in view of the contract close-out in October.

The number of non-Catholic CHAM hospitals able to provide comprehensive modern FP services (including ML/LA and Norplant) increased from the baseline of five in 1994 to nine in 1998. Eight CO/Nurse teams were trained to enable the expansion of services.

In both core and comprehensive services, "access" began to be significantly increased in qualitative terms, too, as a result of the personnel training, facility renovation and clinic equipping activities. With the training provided in core and comprehensive services as well as IPCC, there has been an increased number of trained service providers able and more confident to dispense a wider range of contraceptives, including ML/LA and Norplant. The delivery of clinic equipment and furniture to 228 facilities boosted the capacity for and the quality of services. Similarly, as the facility renovation effort progressed, additional space and privacy were provided, enhancing the quality of the infrastructure for service delivery. Moreover, in six health centers, implementation of a simple model for low-cost, facility-based continuous quality improvement significantly cut down on client waiting time thereby enabling more clients to receive services, and demonstrated how similar techniques can be employed in other facilities.

Access to Family Planning Information

Access to information was greatly increased. Although development and production of IEC materials (posters, leaflets, radio spots, etc) inevitably took some time (due to the need for careful audience and message research, initial and follow-up pre-testing, and the limited printing capacity in the country), the large scale availability of the materials had started to occur by 1996. In 1997 and 1998, a total of 702,000 copies of posters, leaflets and wall charts on the benefits and methods of FP and sources of services were distributed.

A jingle and ten radio spots also on the benefits of FP and countering rumors and misconceptions

were produced, with three of them aired for three months on MBC Radio 2. The new environment of open discussion meant that more information could be made available, through both interpersonal as well as mass media channels. In addition, a mix of marketing, publicity and promotional materials and channels were used to popularize and desensitize FP among the general public, women, men, sexually active youth and community leaders. The materials and channels included bill boards, car door stickers, banners, songs, drama and dance as well as bus painting.

Through increased and structured contacts with the print and electronic media, it was also possible to increase the coverage and depth of FP (and other RH) issues in those media. Although the print media is limited in its readership, it does reach significant sections of the educated and reading population. The radio is much more accessible and has a much wider coverage among the rural residents.

The contacts took the form of a consultation with senior media managers, and a workshop for reporters, journalists and producers. As a result of the contact with the media, coverage of RH issues in the print and electronic media shot up dramatically. For example, during the October-December quarter of 1997, 21 stories and features on FP appeared in the media, compared to nine during the previous quarter. To ensure sustainability of the expanded coverage, JSI worked with the NFPC, the MOHP and UNFPA to facilitate the formation of a media and health task force, with JSI and UNFPA serving as its secretariat. Compose of senior personnel from both sides, the task force is intended to facilitate contact between the two sides and thereby enhance regular and timely availability of accurate and up to date media for publication.

The Role of Community-Level Workers

The contribution of CBDAs (and other community-level workers such as HSAs and TBAs) in disseminating information and education and dispensing non-prescriptive methods, sometimes in remote areas previously not served, is also important in assessing access to information and services. Apart from disseminating information and education, these community workers are also an important and trusted source of referrals for other services.

According to data from the NFPC, there were 2,305 CBDAs as at the end of the JSI contract. Of the number, 447 were trained under STAFH grants to nine NGOs with community-based distribution activities. In addition, 239 CBD supervisors were trained, including 102 trained under STAFH NGO grants. Also through the NGO grants, 870 CBDAs received refresher three-four rounds of training, each. The accomplishment with number of CBDAs exceeds the STAFH target of 1,800 CBDAs by 1998.

Social Marketing of Oral Contraceptive Pills

The target for social marketing of pills was an increase from nil to 1.4 million cycles in 1998. USAID was to work directly with PSI on this activity.

2. Increased Access to Condoms and Condom Education Services

Social Marketing of Condoms

Social marketing of condoms is another activity assigned to PSI. Unlike pills, the condom social marketing project was initiated and has progressed well although sales now appear to be reaching a platueau. According to PSI's quarterly report for January to March, 1998, sale of Chishango condoms through social marketing has surpassed the projections under STAFH. The sales figures and the corresponding years are as follow:

1994: 992,411
1995: 4,645,998
1996: 5,816,785
1997: 5,751,689

To support the condom social marketing effort, JSI gave an NGO grant to PSI/Malawi to work with 12 other STAFH NGO grantees to undertake Chishango condom social marketing activities: publicity, promotion and sales.

Public Sector Condom Distribution

The public sector condom distribution program has been less successful. According to information from the Central Medical Stores, only 3.0-4.5 million condoms, instead of the STAFH target of 6 million, are distributed annually through public sector channels - District Pharmacies, Health Centres, NGOs, and District AIDS Coordinators (for AIDS campaigns and in Bottle Stores). The issue is not availability of condoms. There is, in fact an over-supply of the item. The issue is transportation to move stocks through the supply pipeline. However, in addition to transportation, there is also the need for a more vigorous condom education and promotion program to counter the present apparent dislike of the product.

3. Increased Access to High Quality STD Drugs and Appropriate STD Case Management Services

Comprehensive STD Services

There are 44 MOHP and CHAM central, district and rural hospitals. As at the end of the JSI contract, 32 of the hospitals or 73% were providing STD services. This represents a 23% increase over the projected STAFH target of 50%. In addition, 42 health centers also provide STD services. The definition of "STD services" is based on the syndromic case management approach which JSI supported the NACP and the MOHP to pilot-test in five sites. The usual services include provision of information and some counseling, diagnosis and treatment services, and availability of drugs, from a designated location in the hospital manned by a trained health

care provider (usually a Clinical Officer).

To make the provision of information and services possible, 1200 health care workers and 44 trainers were trained between 1996 and 1997. Categories of HCWs trained included MD, CO, Medical Assistant, Registered Nurse, and Enrolled Nurse-Midwife. Approximately 40 HCWs were drawn from each of the 24 districts. In addition, 26 Health Educators were also trained. STD clinic equipment was supplied to 19 hospitals and 60 health centers. An evaluation of the first round of training was conducted in 1997 and the findings and recommendations of the evaluation were used to revamp the training curricula and to revise the approach to training and service provision. The set of four handbooks resulting from the review exercise were pre-tested and began to be used to retrain trainers, supervisors and service providers.

4. Increased Access to Counseling, Education and AIDS Prevention Materials Among High Risk Groups

Increased Access to Information and Education

Based on the findings of the IEC needs assessment and strategy, a variety of materials and channels were produced and utilized to expand the availability of information and education on STD and HIV/AIDS. Most of the print materials (posters and leaflets) are in local languages - Chichewa and Tumbuka. The posters and leaflets were targeted at STD patients, youth in general and sexually active youth in particular, bar girls and the general public. In addition, picture codes dealing with peer pressure and condom negotiation skills were produced, targeted at youth and bar girls, respectively. In all a combined total of 240,000 copies of the materials were distributed to hospitals, health centers, dispensaries, youth organizations, Regional and district health offices, and through partner organizations such as PSI, Project Hope, SCF-US, IEF and EU-AIDS.

Access to information and education through interpersonal channels was also made possible through training for various cadres of public, NGO and private sector personnel. As a result of their training, COs, MAs, RNs, ENMs, FP service providers, CBDAs, youth leaders and Peer Educators were enabled and empowered to disseminate STD and HIV/AIDS prevention and control education. The same information is provided in the various manuals and handbooks developed by JSI as trainer or learner materials: STD and CBD handbooks, and the Life Planning Skills, IPCC and Peer Education manuals.

Private Sector Program

JSI collaborated and worked with partners in the Work Place task Force to reach 80% of Malawi's estimated private sector labor force of 380,000, employed by the largest companies (300+ employees). The number of individual companies reached is 103 out of the target of 186. However, the momentum for rapid program development has been created. JSI directly and through the Work Place Task Force worked with some of the companies with the largest number

adapted from other curricula materials. This resource was used to train 100 youth leaders and workers throughout the country in adolescent reproductive health. The trainees were drawn from Lilongwe, Mangochi, Mchinji, Blantyre, Kasungu, Thyolo and Chitipa districts.

JSI worked very closely with and supported the NFPC and the Scripture Union (a STAFH NGO grantee) which were the lead agencies in the initiative. However, other organizations were involved, including the Ministry of Women, Youth and Community Services, NACP, Project HOPE, Youth Arm, the Catholic Secretariat, Islamic Center, BLM, Youth clubs (Edzi Toto and Pamodzi), Inter-Aide, CPAR, EU-AIDS and UNICEF.

JSI-STAFH also entered into a collaborative arrangement with UNICEF to co-fund "Tinkanena", the Chichewa local radio soap opera communicating integrated FP, STD and HIV/AIDS prevention and positive behavior messages to the youth. The program was originally intended for the out-of school youth but all youth and older listeners benefit from it. As at the end of the JSI-STAFH contract, "Tinkanena" had run 207 weekly episodes (each episode is repeated), and had won three consecutive annual awards as the best produced program on MBC. A multi-sectoral review committee, a creative writer, and an MBC Producer successfully ran the show for four years.

Other Accomplishments:

- *Increased knowledge about FP, STD and HIV/AIDS as well as the factors affecting them.* JSI conducted or supported 17 socio-cultural, bio-medical and other research and studies, and assisted with the production and distribution of a wide variety of information and education materials for targeted groups and the general population.

- *Expanded and strengthened the physical and material infrastructure for FP and STD service provision.* Twenty-three FP facilities were renovated to provide additional space or to improve the audio and visual privacy. FP and STD clinical equipment and furniture were delivered to over 230 health facilities throughout the country.

- *Increased number of trained FP and STD personnel, including managers, trainers, supervisors and service providers.* In the STD area, JSI assisted in training or retraining more than 40 trainers and over 1,000 health care workers. In the FP area, over 400 FP service providers received training in IPCC with JSI support.

- *Expanded involvement and strengthened capacity of the NGO and private sectors to participate more actively and effectively in FP, STD and HIV/AIDS programs.* JSI developed and administered 24 NGO grants, and worked directly with 15 private, estate and parastatal companies. In the private sector, 130 managers were oriented to FP, STD and HIV/AIDS issues, and 370 workers were trained in peer education. Through the NGO grants, over 70 sites through out the country are able to provide clinic- or

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community-based integrated FP, STD and HIV/AIDS education and or services.

- *Development and testing of strategic directions in RH.* The syndromic approach to STD treatment was tested, leading to its introduction into the health care system by the MOHP as the standard approach. A model for facility-based continuous quality improvement was also tested in six facilities. This is a low-cost approach requiring minimal resources other than regular supervision and technical assistance. Working with several partners, JSI also developed the strategy for expanding long-term and permanent contraception services.

- *Strengthened communication and coordination among RH participating institutions.* Through three annual STAFH coordination meetings, JSI brought together the main players to review and learn from experience, discuss common concerns and objectives, and attempt to harmonize plans.

Important Products and Processes:

A large number of reports, publications, other documents and IEC materials were produced under the contract. They include the following:

- STD handbooks (set of 4) for in-service training
- STD handbooks (set of 3) for pre-service training
- Private sector program resource materials
- CBD guidelines, curriculum and handbooks
- IPCC training manualLife planning skills manual
- LTPC expansion strategy
- Food handler policy (in collaboration with AIDSEC)
- Socio-cultural and bio-medical research reports
- Case studies (e.g. on private sector programs) and evaluation reports (e.g. on the quality of CBD services)
- Framework for planning, implementing and evaluating coordination of RH activities

A full and comprehensive list of all the reports, publications and other documents produced appears in the report on the STAFH Transition Conference.

VI. KEY FINDINGS, LESSONS LEARNED AND RECOMMENDATIONS

Reference has been made to the STAFH Transition Conference report which serves as an important compliment to this final report. The report provides details on lessons learned and recommendations in all the major areas of program implementation. The facility renovation activity report also lists and discusses a number of specific lessons and recommendations related to that activity. The lessons and recommendations discussed in the following sections are,

therefore, largely of a general nature and are intended to reinforce or expand on those stated in the other documents.

A. Technical Support and Implementation

Throughout the contract implementation period but more at the initial stages, there was the distinct challenge in achieving a balance between direct hands-on implementation and focussing more on the technical assistance and support role. Given the responsibilities of the IC, both roles were appropriate. However, doing "implementation" tended towards establishing JSI-STAFH as a parallel body for undertaking FP and STD/HIV activities, a body that could not be sustainable and whose activities and accomplishments could easily be lost.

Thus, from the point of view of continuity and sustainability, the support role was more appropriate and desirable, to build and enhance local capacity. The role would involve tieing JSI personnel and activities to those of the key partners, jointly formulating, planning and implementing activities. In effect, this was essentially the approach that was used. Although JSI-STAFH personnel did not physically sit with counterparts, there was close and ongoing contact as well as routine consultation with national counterparts and other personnel. This was achieved through the various working groups and task forces, joint field visits, and JSI participation in partner activities. The facility renovation activity, the national logo development project, and the development of NGO grants are examples of the support mode of action.

On the other hand, the inclusion of activities such as "mass media and other IEC campaigns, training and workshops, and research" in the IC's responsibilities meant that an implementation role could not be entirely ruled out. These are activities that required some hands-on involvement, particularly given the shortage of personnel and the generally limited implementation capacity which continued throughout the contract period. In research, for example, it was possible to utilize some of the NGO grants (Salvation Army and Muslim Association) to design and conduct socio-cultural research, with advice and guidance from JSI. However, the need to meet the large demand for FP and AIDS information and knowledge required that JSI staff themselves be more directly involved in designing and implementing research, and disseminating the findings. That this was done in collaboration with the NACP and the NFPC meant that the support mode was also applicable to some extent, thus limiting the direct implementation mode.

B. Planning, Delivery and Evaluation of Technical Assistance

Technical Assistance was a major area of planned and actual work. Through TA, JSI brought to bear on the national FP and STD/HIV aspirations a combination of strategy, technology and process to provide direction, guidance and basis for concerted action. As the largest single source of multi-disciplinary FP and STD/HIV TA in Malawi over the last fours years, JSI-STAFH was able to cover a wide range of TA needs, and to learn extensively from the experience. In particular, we identified six important factors that account for successful TA:

- participatory approach, involving all concerned government, community, donor and other stake-holding organizations;
- shared vision, focussed and clearly defined needs, goals and objectives;
- receptivity on both sides (giver and receiver) to the needs and objectives;
- flexibility with approaches and processes;
- acknowledged expertise in the person(s) assigned to provide the TA;
- availability of the required resources to undertake the TA.

JSI's ability to provide complementary financial and material assistance was also important in enhancing the overall acceptability and effectiveness of TA.

C. Balancing Contract Deliverables with Meeting other Needs

The STAFH Project was designed and implemented before the USAID re-engineering, and the International Conference on Population and Development in 1994. The project outputs and the JSI contract deliverables were stated using the former USAID approach, and outputs are specific in FP and AIDS control, although STAFH places a strong emphasis on integration. ICPD emphasizes integrated approaches under the concept of reproductive health, including concerns for adolescent and women's health.

In attempting to be responsive to this re-orientation, JSI placed a major priority on integrated information and messages in all IEC and training materials. The curricula for training CBDAs, and FP and STD service providers integrate FP and STD/HIV information, education and skills. They also incorporate the concept of condom first/condom plus, although the MOHP did not warm up to the initiative. The RH program strategic plan developed by the RHU-MOHP also emphasizes FP promotion and practices that recognize the HIV/AIDS epidemic. However, more and intensified measures should be taken in advocacy, training and supervision, to keep the issues alive and in the front with service providers.

The original STAFH plans emphasized the provision of program and technical capacity building. The NGO grants program was particular important in this regard, in order to increase FP and AIDS control services. However, in both the public and the NGO sectors the experience has shown that management capacity building is equally important in order to build overall capacity. While donors have been traditionally not averse to providing program and technical resources, support for management and institutional capacity building has tended to be less readily available, and limited.

For example, whereas substantial resources were allocated by STAFH for equipment procurement, facility renovation and training of personnel, there were hardly any explicitly allocated resources for management capacity building, in spite of the many references to capacity building with the AIDSEC and NFPC. The JSI support for strategic planning and other management strengthening assistance in both the public and NGO sectors were based on this

need.

D. A Flexible Support and Funding Mechanism

The JSI-STAFH contract provides for specific outputs and indicators. However, at the same time, the statement of work, in touching on various issues and needs, allows considerable flexibility for JSI action in pursuance of the overall goal and purpose of the project. Not only was it possible for JSI, in working closely with partners, able to respond flexibly to their resource needs that supported progress towards STAFH goals. In most cases, these were low-cost activities which, however, entailed significant results. For example, during the 1996 and 1997 World AIDS Day, JSI collaborated with BLM to provide free STD treatment services, including media and other forms of publicity of the services. In both years, the occasions provided significant opportunity for far reaching public campaigns on the dangers of STDs, prevention and symptom recognition as well as the availability, safety and sources of treatment.

Also, the JSI flexibility could be extended to USAID where the Mission itself could not act due to various constraints. Thus, JSI staff were able to assist USAID with the design of the evaluation plan for STAFH, evaluation of the female condom in Malawi, and funding for the FGDs, workshop and other aspects of the STAFH review process.

E. Training

Both in FP and STD case management, training has been a major area of JSI work. Much of the work done has been with respect to in-service training, although curricula were developed for pre-service training as well. Clearly, the in-service training programs would benefit from the availability of at least purposefully established (if not purposefully built) training centers. Most of the present seven facilities described as FP training centers really do not qualify as such. The center in Lilongwe, one of the three supported by USAID, is somewhat an exception. Although not purpose-built, the building is owned by the MOHP, and it provides hostel facilities with a kitchen, and has been supplied with some important training equipment. However, it does not have classroom facilities, clinic for practicals nor library and offices for trainers. The other "centers" (hostel and classrooms) are rented during training courses, with trainers based in RHOs or DHOs when training is not in session.

There has been a protracted discussion about the benefits of one national or three regional FP training centers (built, bought or rented) that can be properly set-up, complete with all the necessary facilities. With the efforts at pre-service training, the need for in-service training should be reduced over time, to focus on periodic refreshers and updating of health care personnel that would have received pre-service training. The need would not necessitate seven training centers, and depending on the numbers to be trained and the training logistics, may not even require three centers.

In a situation where health care personnel have already received appropriate pre-service FP and STD training, a spacious well-established and managed center can conduct a number of different courses annually to suit different needs, thereby meeting the needs for refresher and update training. It is easier to adequately fund, staff and manage one center. With time, full clinic equipment and client load can be built to support practical training needs. In selecting the site for a national training center, two existing facilities can be considered: the Lilongwe center described above, and QECH in Blantyre. The latter has the requisite client load (both FP and STD), could combine training in core and comprehensive services, can exploit its resources as the apical national medical and health training facility in the country, and could forge useful links in pre- and in-service training. However, it seeks a purpose-built facility. The Lilongwe center will also need renovations and extensions to effectively serve as a national training institution.

F. NGO Program

Given the relative youth of NGOs in Malawi, the desire to utilize their existing physical and staff infrastructure to introduce or expand FP, STD and HIV/AIDS programs will often not work since these facilities are often virtually non-existent or at best very weak. Many of the NGOs are only a few years in age. In most cases, their weaknesses are exhibited in the NGO governance (membership participation, role of Board, constitution), lack of basic management systems (planning, staff roles and responsibilities and terms and conditions, accounting), and project activity monitoring and supervision.

In the beginning, JSI was seeking already well-established NGOs that could more quickly begin project implementation and manage systems. The reality among most NGOs was that human resources were not at the expected levels, either because the NGOs were short-staffed or lacked the needed skills for the project implementation and grant management.

Although the imperatives of sustainability will discourage large scale support for administrative and staff infrastructure, the JSI-STAFH experience clearly compels some support, failing which some programs cannot be initiated or expanded. Worse still, many NGOs with potential for future development and success would lose the breathing space that such temporary staff and infra structural support could provide. In all the 24 NGOs that received STAFH grants, none could have implemented its project without some grant support for program and/or administrative personnel. In addition, most of the NGOs had to be provided with basic office equipment: desk-top computer set, photocopier, etc.

The life of the NGO grants (18-30 months) was too short. A two-year time-frame is not sufficient as a two-year grant actually means one year at full capacity. With most of the grants, it took six months to a year to really gear up to full capacity. Further, two years are not enough for the NGOs to begin thinking about sustainability as the projects are just getting moving when they end. A longer grant cycle, perhaps four to five years, would make implementation more successful and sustainability more likely.

Due to their relative youth and inexperience with fund raising, the financial status of most NGOs is tenuous, at best, with most relying almost totally on donor funds. It is, therefore, very difficult for NGOs to support overhead costs on their own. For the same reason, the capacity of NGOs to meet donor matches is questionable. The NGOs have little or no money of their own to reach their project matches. Donors should consider supporting some overhead costs, or at least be aware of the implications of not supporting such costs. Donors should also be realistic when setting a match.

Transport proved to be a limiting factor in NGO success. There was no NGO which was not limited by lack of or insufficient transport. This is an issue which must be understood by donors before they fund NGOs. The promise of an NGO to provide transport for project activities is often just provided so that donors will fund their projects, and during implementation does not materialize. NGOs need to be honest with donors and donors have to encourage this honesty from NGOs so that the issues and their implications to the implementation of the project are at least understood if not addressed up-front.

It should be clear from the beginning that the projects belong to the NGOs and that the donor is just providing funds to allow the NGOs to implement their projects. This means that each NGO should set terms for salaries, benefits, allowances, etc, based on the organization's policies and procedures, and the grant should be written accordingly. Further, if the donor is to pay salary for any NGO staff, they should also include items such as leave grants and a 13th month salary if it is the NGO policy. The donor cannot be seen to be contradictory in that they cannot say this is the NGO's project but not allow the NGO to implement their normal policies and procedures.

With Malawian NGOs generally young and weak as they are, a good deal of assistance is needed in order for them to be able to implement their grants as anticipated and successfully. In the case of the STAFH NGO grantees, the assistance needed was both technical and administrative, including financial. The implications are many, and are points that donors should seriously consider:

- the number of NGOs to be funded: as they will need a good deal of assistance, a smaller number may be more appropriate;

- the type of financial assistance to be provided: is the interest to implement grants or to create viable institutions, or both ? Obviously, the answer to this question should drive the type of support;

- the type and amount of technical support to be provided: the JSI-STAFH NGO unit was severely under-staffed for the task to be undertaken, and the task envisioned was not clear at the beginning. With clarity on the two points above, the issue of staffing could then be more appropriately addressed, based on experience with other NGO support programs.

JSI found that NGOs understand and accept their weaknesses, and are eager to take the necessary corrective actions. However, they need support and assistance to devise the programs that allow them to address the weaknesses. These can include partnering stronger NGOs with weaker ones, periodic activities to help strengthen NGOs on specific issues (the quarterly exchange of experience meetings conducted by JSI were intended to address issues such as financial management, grant administration, and evaluations), ensuring that quarterly monitoring visits cover capacity building aspects (e.g. by providing on-the-job training to project coordinators in supervision and financial managers on bookkeeping), and by developing a capacity building program.

G. Private Sector Program

JSI worked directly with 15 private, estate and parastatal companies and supported the conduct of an evaluative case study of the FP, STD and HIV/AIDS programs of three of the companies. The case study report very well summarizes the lessons learned by and the "best practices" gleaned from the three companies studied as well as the implications for private sector support groups such as JSI-STAFH. The following lessons are partly extracted from the report on the case study.

1. Program Funding

The private sector is willing to meet the cost of their FP, STD and HIV/AIDS programs and services. This stems from the realization of company Boards and senior managements that "investment in preventive health has economic gains for the company, staff, their families and ultimately to the nation." The companies that JSI worked directly with, such as Portland Cement, ADMARC, and Southern Bottlers, were willing and able to meet the cost of training their peer educators and STD service providers. However, adequate and sustained levels of program resources do not necessarily come naturally or easily and require continuous advocacy with management..

2. Successful Programs

The interventions likely to receive adequate and sustained funding and therefore likely to succeed, are those that are well thought-out, stating specific and precise goals and objectives to be achieved over given time frame, activities to be undertaken and expected outcomes, resource requirements, and monitoring and evaluation systems. Systematic and coordinated linkages with technical support groups, such as the District Health Offices, PSI, and BLM, afford access to the needed technical assistance and other supports. "Building and strengthening partnerships between the private sector and members of the Work Place Task Force ensure that the companies benefit from the expertise, knowledge, experience and material resources available from these organizations."

In addition, "continuous (internal) advocacy is even more vital to ensure continued (management)

support, allocation of the necessary resources, review of strategies and expansion of the projects". While these remain essentially aims, actions and decisions to be taken internally by each company, the technical assistance, guidance and support provided by JSI (and other workplace program support groups) were found to be of critical enabling importance.

H. Capacity Building

Capacity building is a huge, complex and long-term endeavor requiring careful initial conceptualization, planning, phasing and implementation. Although it involves technical assistance and training, other less formal or structured approaches in coaching, mentoring, team building and routine on-the-job training are also important. Although they overlap and affect one another, three areas of "capacity" for building or strengthening can be separately identified for attention: they are program, technical and management.

"Program" involves creating or increasing the availability of the physical and material resources as well as financing required for activities. "Technical" is concerned with the particular knowledge and skills required among personnel as well as the methodology and technology for action. "Management" involves needs in governance, leadership and oversight, and systems and procedures for planning and getting the work done, documented and reported, including those related to financial accountability.

Given the overriding concern to get started with initiating new or expanding existing services, JSI focussed initial action in capacity building on the program and technical areas: the facility upgrading/renovation activity; procurement for clinic equipping; training of FP and STD service personnel; and identifying and assisting NGOs to develop project proposals. These were critical and essential activities that needed to receive earlier rather than latter attention particularly as they are time consuming activities. By the beginning of 1997 (roughly two years into the contract), most of these program and technical capacity building activities had been successfully initiated with significant progress made, e.g. with respect to training of personnel for FP and STD services, and in the initiation of NGO grants.

At this stage it became increasingly evident that attention needed also to be given to management capacity building, to enhance program and technical capacity. This need was more evident among some of the NGO grantees. However, similar needs were expressed by the NFPC (at the JSI-STAFH retreat in January, 1997), and by the RHU-MOHP later in the same year. With essential initial program resources provided or on order and personnel trained, the time was appropriate to introduce or strengthen systems for planning and administration. The last two years of the contract therefore gave more attention to management capacity building.

Absorption and sustainability were the two biggest challenges to the capacity building objective and process, in both the public and NGO sectors. In terms of technical capacity, "absorption" is in relation to the number of personnel available, and their ability to receive, retain and utilize

knowledge and skills imparted to them. Except on a limited scale with the NGO grants, JSI could not support the creation and funding of new positions. The absorptive capacity challenge for JSI was thus in relation to existing personnel. With the acute shortage of personnel or under staffing particularly in the NGO sector, there are simply not enough people whose technical capacity can be built or strengthened.

In the public sector, the numbers seem large however the same personnel are expected to perform multiple preventive and curative health care functions which limit their time and attention to issues of FP and STD/HIV. With internal and external transfers, absorptive capacity may be further affected where personnel are not able to utilize FP and STD/HIV knowledge and skills in the new positions. In addition to a systematic program of continuous training and retraining, regular and structured supervision that includes on-the-job training and updating is critical in this situation. For the NGO sector, the challenge is less easy to deal with, without donors being receptive to some form of short-term personnel supports while the NGOs are assisted to implement longer-term measures to cover their personnel needs.

Sustainability applies to both program and management capacity. With regard to program capacity, the sustainability questions is related to the institutional ability to maintain and replace program resources. For maintenance, it is easy to advise organizations to budget for the necessary costs. In some instances, this is all that may be needed. However, where the very budget is dependent on restricted donor funds the advice is not too useful. In the short-run (and how short is short is open to question), sustainability cannot be a priority and donor resources should include provision for maintaining and replacing program resources. In the longer-run, the concern with sustainability should emphasize assistance to organizations to design and implement strategies to promote self-reliance: fundraising, income generation, project planning and management skills development, etc.

I. Procurement and Distribution of Equipment

Off-shore procurement is obviously time consuming and should be employed only as needed. Procurement from the US was particularly slow due to the need to comply with various contractual and other requirements. The time span is further lengthened where specifications are not complete or accurate, necessitating additional communication or the supply of inappropriate items.

The large volume and multiple recipients of equipment meant that they could not be consigned and delivered to the individual sites. The equipment had to be received and stored first by JSI. The regular JSI warehouse in Lilongwe was inadequate and additional commercial warehouse space had to be rented in Lilongwe and in the other Regions to facilitate the logistics of distribution.

Distribution was a big learning experience too. While some small items could be distributed during JSI staff travel to the field, a more appropriate transportation arrangement was necessary.

The cost of utilizing commercial transportation proved prohibitive. But the rental of a truck from SHARED, a USAID-funded project, also came with its own problems: frequent break-downs, cost of replacing parts, and controversy over the rental fee, in view of the expenses incurred by JSI-STAFH. With USAID approval, a truck was purchased and, although rather late in the life of the contract, it considerably eased the equipment distribution process.

J. Facility Renovation

Five important lessons were learned with respect to the facility renovation activity. For a four year contract, and given the low construction capacity and slow pace of work, the target of facilities for renovation was far too ambitious, even with the later cut in the targeted number from the original 266 to 35. The original budget of $2,000 per facility was also inadequate.

Although the MOHP, through the Planning Department, was a member of and actively participated in the renovation task force particularly at the initial stages, overall involvement of the ministry was inadequate. This may have resulted from the leading and controlling role played by JSI in ensuring compliance with its contract requirements and obligations. Perhaps the management and control of such a program in future should be placed within the MOHP with professional staff even if of a temporary nature.

Some of the biggest difficulties were with respect to dealing with contractors. In spite of the JSI mandate to renovate buildings, JSI was prohibited by USAID regulations from directly engaging contractors. By issuing a grant to an intermediary, JSI in effect added a layer of unwelcome complexity to the whole process, resulting in difficulty in communication and decision making. To further complicate and delay the process, the initial group of larger contractors (selected because of their stronger resource and logistical capabilities) soon lost interest, due to the small contract amounts and profit margins. When the two that dropped-out were replaced by smaller, locally-based contractors, performance improved along with the pace of work.

Another lesson is related to inflation and devaluation. During the period of the renovation activity, the Kwacha exchange rate fell from 15.5 to over 43.1 to the US Dollar. As the contract prices were fixed to the Dollar, JSI did not really benefit substantially from the devaluations. However, there was a consequence related to the valuation of work done and the amount owed the contractors. Inflation affected builders profits and probably their commitment to the activity. Three recommendations may be considered when building in inflationary times: import materials directly, if possible; be prepared to make large advances to the contractors so that they buy all their materials up front; and make provision for price adjustments to the contract.

K. Continuity and Sustainability of Activities

The most important recommendation is for measures to promote and ensure sustainability of the variety of activities undertaken and to build on the accomplishments. That the STAFH Project will

continue for another three years should make this possible, in spite of the re-design. The STAFH transition conference was an important initial move in this direction. By establishing the status of activities and actions, the proposed next logical steps, and the most appropriate GOM agencies or other organizations to take over the responsibilities, the conference set the stage for continuity and sustainability in the main project component areas. These include the LTPC training and service provision, the STD syndromic management training and services, and the NGO and private sector capacity building.

In each of these areas, a number of foundation laying steps were taken which can well constitute the starting points for the next stages of action. For example, the LTPC strategy developed through a collaborative effort with a number of partners in 1997 is adequate to guide and direct most activities in the area, including the related advocacy and IEC; set-up, delivery and supervision of services; training and development of personnel; coordinated review and planning of activities by all the participating organizations; and the collection and exchange of information on accomplishments and challenges. Focussed and sustained implementation of the strategy is important to achieve the desired sustainable impact on fertility.

Another important recommendation is continuation of the various structures established for ensuring participatory and partnership approaches which are very important to sustain coordination, national ownership, and inclusiveness in decision making. This is not to say that the mechanisms (e.g. annual or biennial general coordination meetings, periodic technical coordination/working group meetings, and ad hoc committees, task forces and working groups) should become ends in themselves. Recognizing that convening, attending, minuting and circulating records of the meetings and activities of these structures can be overly time consuming, it is important to be clear in the needs and objectives for each structure and to stay focussed on those needs and objectives. Moreover, a conscious effort must be made not to slow down the decision making process through the use of the structures. However, the benefits are clear and compelling particularly where pragmatism rather than dogma drives the decisions/actions.