REPORT ON

STAFH TRANSITION CONFERENCE
Capital Hotel, Lilongwe
30 September, 1998

JSI-STAFH, Lilongwe
5 October, 1998

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LIST OF ACRONYMS

USAID	-	United States Agency for International Development
AIDS	-	Acquired Immune Deficiency Syndrome
STAFH	-	Support to AIDS and Family Health
GOM	-	Government of Malawi
JSI	-	John Snow, Incorporated
STD	-	Sexually Transmitted Disease
NGOs	-	Non-Governmental Organizations
IEC	-	Information, Education and Communication
HIV	-	Human Immuno deficiency Virus
PVO	-	Private Voluntary Organization
MOHP	-	Ministry of Health & Population
FHI	-	Family Health International
FP	-	Family Planning
CBD	-	Community Based Distribution
CBDA	-	Community Based Distribution Agent
TA	-	Technical Assistance
DFID	-	Department for International Development (British)
UNFPA	-	United Nations Population Fund
HSA	-	Health Surveillance Assistant
IPCC	-	Interpersonal Communication and Counselling
RH	-	Reproductive Health
NFPC	-	National Family Planning Council
UNAIDS	-	Joint United Nations Program on HIV/AIDS
LTPC	-	Long Term and Permanent Contraception
RHU	-	Regional Health Unit
AVSC	-	Access to Voluntary and Safe Contraception
FBCQI	-	Facility-Based Continuous Quality Improvement
BLM	-	Banja La Mtsogolo
AIDSEC	-	AIDS Secretariat
NACP	-	National AIDS Control Program

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WPTF	-	Work Place Task Force
PRAC	-	Project Review and Approval Committee
BCC	-	Blantyre Christian Centre
YAO	-	Youth Arm Organization
NAPHAM	-	National Association of People Living with HIV/AIDS in Malawi
MACRO	-	Malawi AIDS Counselling and Resource Organization
MASO	-	Media and AIDS Society in Malawi
AHS	-	Adventist Health Services
EU	-	European Union
WHO	-	World Health Organization

REPORT ON THE
STAFH TRANSITION CONFERENCE
Viphya Suite, Capital Hotel, Lilongwe

I. Background

The initial phase (1992-1998) of the USAID-funded Government of Malawi Support to AIDS and Family Health (STAFH) Project was due to end on 30 September, 1998. With agreement reached between the GOM and USAID, STAFH was to be extended for three years (1998-2001). Based on the experience and lessons of the initial phase and the changing circumstances and needs in the country setting, the STAFH project was re-designed for the extension period.

As the Institutional Contractor, John Snow, Incorporated (JSI) has been involved in implementation of the STAFH project since its four year contract was awarded in September, 1994. The JSI contract was due to end on 30 September, 1998. JSI was, therefore, planning for close-out (31 October, in view of the USAID-approved one month extension) at a time when preparations were also underway to initiate implementation of the re-designed STAFH project.

Against this background, the STAFH Transition Conference was planned and held on schedule on 30 September, 1998 at the Viphya Suite of the Capital Hotel in Lilongwe. For JSI, it was the main concluding event of the four-year STAFH contract.

The purpose of the conference was to introduce the re-designed STAFH project and review the transition to it from the JSI contribution. The specific conference objectives were:

1. To review the current status and terminating point of JSI activities in key areas of the STAFH project;
2. To identify transitional activities from JSI and agree the organizations that will take over the responsibilities; and
3. To introduce the interventions and the corresponding responsible organizations in the re-design phase of the STAFH project.

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The conference lasted approximately eight hours (8.00 am to 4.00 pm), including coffee (thirty minutes) and lunch (one hour) breaks. The conference program (Appendix 1) provided for four panel presentations (on Family planning, STD/HIV, NGO and Private Sector, and Advocacy and IEC), followed by time for questions and discussion.

Conference participants, numbering 55 (Appendix 1A), were drawn from GOM, NGOs and US PVOs participating in the STAFH project as well as national and international reproductive health partner agencies and donors, including USAID.

II. Proceedings

The conference was chaired by Dr. Wilfred Nkhoma, Controller, Preventive Health Services in the Ministry of Health and Population. The formal opening began with welcome remarks (Appendix 2) by Mr. Marc A. Okunnu, Sr., Chief of Party, JSI-STAFH. This was followed by "greetings" by the Principal Secretary (2), Mr. George Mkondiwa in the MOHP. Ms Joan LaRosa, Health and Population Team Leader at USAID, then made opening remarks on behalf of USAID.

In her remarks, Ms LaRosa gave a brief background to the STAFH project, including the initial work done by FHI which was an earlier contractor. She singled out integration as one major area of JSI accomplishment, citing various examples of integration that have been effected: FP and AIDS information in the CBD training curriculum and handbook for CBDAs; FP, STD and HIV/AIDS messages in IEC materials, particularly those addressed to youth; and services in FP and STD clinics. Ms LaRosa remarked that JSI provided "timely and high quality TA", noting that the renovation of facilities and distribution of equipment could not have been accomplished by USAID without the "high expertise" of JSI.

Presentations began with an *Overview of JSI-STAFH, 1994-1998* (Appendix 3), made by Mr. Okunnu. This was followed by panel presentations. There were four panels, respectively on Family Planning (five panelists), STD/HIV (two panelists, out of the three invited), NGO and Private Sector (four panelists out of five invited), and Advocacy and IEC (two panelists out of three invited). Eight (Appendices 4-11) out of the 13 panel presentations

made were available as handouts in the conference folders. Two other handouts on facility renovations, and equipment distribution (Appendices 12-13) were available in the folders although not formally presented.

In each panel, JSI staff (one or two) began the presentations with a JSI status report, concluding with proposed transitional actions and the recommended responsible organizations. This was then followed by a presentation by a GOM or collaborating donor official outlining planned interventions and activities during the STAFH extension period. Within the FP and STD/HIV panels, UNFPA and DFID, respectively, made presentations on planned activities complementing those of GOM-USAID under STAFH.

Time (30-40 minutes) was made available for questions and discussion after each set of panel presentations. These periods were used to obtain further clarifications or additional information on the status or other aspects of the work of JSI, activities during the STAFH extension, and the planned interventions of the two other donors present: UNFPA and DFID. Some "old" issues re-surfaced: e.g. incentives in CBD programs, the use of Health Surveillance Assistants (HSAs) to dispense injectable contraceptives, and the duration of training for FP providers (4 versus 6 weeks).

Other questions and issues raised and/or discussed were:

- Integration of IPCC training into the curriculum for the FP practitioner course
- The continuing urgent need for FP and STD training materials
- Provision of refresher training for CBDAs
- The consolidation of the current number of seven FP training sites into three (planned by the MOHP) or one (recommended by JSI)
- The cost of expired STD drugs and measures to prevent such losses in future
- The need for some action on unsafe abortion while recognizing that abortion is illegal in Malawi
- Funding for producing and printing more training materials, and for retraining of STD service providers
- The role of the NFPC in coordinating RH activities, including organizing and convening meetings of a RH technical working group similar to the HIV/AIDS group facilitated by UNAIDS.

In summary, the conference noted the following status and plans with respect to some of the key areas of JSI's work:

Family Planning:

- A LTPC strategy has been developed and, based on it, training was started for trainers and service providers. The RHU and AVSC are to continue the activities.
- FBCQI has been piloted in six sites. The Medical Council is taking forward the broader area of quality assurance. However, the RHU needs to focus on the smaller FP aspect, through replication of the FBCQI approach.
- A set of CBD guidelines and handbooks have been produced and printed. Decisions need to be made (RHU-MOHP and NFPC) regarding further translations beyond Chichewa.
- Renovation work on 29 FP sites (out of the 35 planned) have been started, are in progress, or have been completed. Work on six sites (including two where the authorities declined the renovations) did not start. All renovations are expected to be completed by 31 October.
- FP equipment and/or furniture have been delivered to 228 sites and further distributions were ongoing. JSI will hand-over the remaining items to the MOHP.

STD/HIV:

- The syndromic approach has been pilot-tested in five pilot sites.
- STD training curricula and materials have been developed and used to train approximately 1200 health care workers and trainers.
- An evaluation of the training has been completed and, based on its findings and recommendations, the curricula and materials have been revised and are now being used for retraining the previously trained health care workers.
- DFID proposes to take this area forward under a five-year, $40m project with the MOHP.

Private Sector:

- JSI did not initiate work in this area: NFPC, BLM, AIDSEC and others had been active. However, JSI has worked directly with eight private

sector companies, on sensitization of management, training of peer educators and their trainers, and training of STD service providers.

A Work Place Task Force has been established co-chaired by the NACP and NFPC, and JSI-STAFH had been the Secretariat which has been transferred to the NFPC.

- Within the framework of the WPTF, JSI-STAFH has supported two important studies (a private sector needs assessment, and a case study of the FP, STD, and HIV/AIDS programs in three private sector companies) which will help to shape and guide the strategic development and management of private sector programs.
- The WPTF Secretariat, transferred to the NFPC from JSI-STAFH, will be the focal point for organizing and coordinating work place activities, and for supporting such programs.

NGO Grants:

- JSI, working with the Project Review and Approval Committee (PRAC), developed and administered 24 18-30 months NGO grants, most of which ended on 30 June, 1998.
- The grants have initiated or expanded a variety of FP, STD and HIV/AIDS activities, including clinic- and community-based education and services, HIV testing and counseling, and socio-cultural research on factors affecting FP and HIV/AIDS.
- Eleven (11) of the grants were extended for three-four months (July-September/October).
- Nine (9) grants (with BCC, YAO, NAPHAM, MACRO, MASO, Malamulo, Ekwendeni, St. Anne's, and AHS) were recommended to USAID and have been accepted for funding during the STAFH extension, even though for seven of them there will be a funding gap.

Advocacy and IEC

- In collaboration with the MOHP, NFPC and NACP, an IEC strategy with emphasis on linking services with demand was developed and has guided planning of IEC programs.

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- Based on the IEC strategy, a large variety of print and other IEC materials on FP, STD and HIV/AIDS have been produced to support programs with FP and STD clients, youth in- and out-of-school, men, bar girls, and the general public.
- To emphasize and focus on behavior change, USAID will support the placement of a Behavior Change Specialist in the NACP (accessible to other organizations) during the STAFH extension

Further details, and information on other aspects of the status of JSI's work are provided in Appendices 3-13. Although not formally presented at the conference, a list of reports, publications and other documents produced by JSI-STAFH is attached as Appendix 14.

The Chairperson, Dr. Nkhoma summarized the day's proceeding at the wrap-up session, and then requested Ms Linda Andrews, STAFH Team Leader at USAID, to make her closing remarks. Ms Andrews commended and thanked JSI for meeting its deliverables in spite of the various difficulties. She reviewed her positive experiences working with JSI staff in the field and elsewhere, noting their dedication, hard work, enthusiasm, and technical knowledge. She commended the long hours worked by staff, and their openness and receptivity to USAID requests.

The JSI-STAFH Chief of Party, Mr. Okunnu was invited to make closing remarks (Appendix 15). He expressed satisfaction and pleasure at some of the conclusions reached by the conference regarding continuation, improvement and expansion of some of the work done by JSI under the STAFH project. He expressed appreciation and gratitude to various people and JSI's partners for their cooperation, support and assistance in the work of JSI in Malawi in general, and for their help with planning and organization of the transition conference.

In closing the conference on behalf of the MOHP, the Chairperson, Dr. Nkhoma thanked JSI for its work and accomplishments in Malawi. He drew attention to how the work of JSI under the STAFH project (e.g. in capacity building, facility renovations, and development and production of various documents and materials) is contributing to one of the six strategies of the MOHP: strengthening basic health programs, including FP and STD/HIV

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within the RH package. He commended JSI for the innovation it brought, and Chief of Party Mr. Okunnu, for the "new participatory approach" he introduced to the functioning of JSI-STAFH.

III. Related Events

As part of the conference resources, an exhibition of IEC materials, reports, documents and publications produced by JSI and its partners under the STAFH project was mounted. Pictures depicting various aspects of the work of JSI, and the reaction of a cross section of partners and recipients of assistance were also on display.

In the evening a two-hour farewell reception was held also at the Viphya Suite, Capital Hotel. About 100 guests, comprising partners from the MOHP and other Government ministries, the National Family Planning Council, NGOs, US PVOs, USAID and other donor organizations (EU, WHO, UNFPA) attended the function. The occasion was used by JSI to present merit awards to deserving JSI staff.

The USAID Mission Director, Dr. Kiertisak Toh, kindly attended and presented the merit awards. Three general awards were made to Messrs. Alfred Mwase (Office Cleaner), McDonald Mhone (Accountant), and Alex M'Manja (General Services Officer). The special Chief of Party awards were presented to Mrs. Chifundo Kachiza (STD/HIV Associate), Ms Anne Domatob (IEC Advisor), and Mr. Peter Killick (Finance Manager).

Dr. Toh and the Secretary for Health and Population, Dr. Wes Sangala, both made closing remarks in which they commended, thanked and congratulated JSI for the good work done. The JSI-STAFH Chief of Party thanked all guests for coming to the reception (Appendix 16). He conveyed appreciation and gratitude to the Government and people of Malawi for allowing JSI to work in the country. He paid tribute to a number of partners and professional colleagues for their support and assistance to him personally and to JSI in general.

IV. Appendices

All the 16 Appendices are attached, in the following pages.

STAFH TRANSITION CONFERENCE

Viphya Suite, Capital Hotel, Lilongwe
30 September, 1998, from 8.00 am - 3.30 pm

Program

ARRIVAL AND REGISTRATION: 7.30 - 8.00 AM

FIRST MORNING SESSION: 8.00 - 10.00 AM

1. Formal Opening: (8.00 - 8.30)

    - Welcome and Introductions (Marc A Okunnu, Sr., Chief of Party, JSI-STAFH)
    - Opening Remarks (Ms Joan LaRosa, Health and Population Team Leader, USAID)
    - Conference Overview (Marc A. Okunnu, Sr.)

2. Family Planning Panel: (8.30 - 10.00)

    2.1 Panel Presentations

    - FP Training, Quality Assurance, and Long-Term and Permanent Contraception: A Status Report (Mrs Mellina Mchombo, Training and Service Delivery Associate, JSI-STAFH)
    - Community-Based Distribution Training and Services: A Status Report (Mrs Jane Banda, NGO Associate, JSI-STAFH)
    - Pre-Service Training and Long-Term and Permanent Contraception Training and Services: Future Plans (Mrs Jane Namasasu, Assistant Controller, Preventive Health Services, RHU)
    - Community-Based Training and Services: Future Plans (Mrs Prisca Masepuka, Family Health Officer, Reproductive Health Unit, MOHP)
    - UNFPA-Supported District Reproductive Health Program: Current Activities and Future Plans (Dr Ann Phoya, National Safe Motherhood Coordinator, RHU)

    2.2 Questions and Discussion

Coffee Break (10.00 - 10.30)

SECOND MORNING SESSION: 10.30 AM - 1.00 PM

3. STD/HIV Panel (10.30 - 11.30)

3.1 Panel Presentations

- STD and HIV/AIDS Prevention Education and Services: A Status Report (Mrs Chifundo Kachiza, STD/HIV Associate. JSI-STAFH)
- HIV/AIDS Control: Future Plans (Dr Owen Kalua, Acting Program Manager, National AIDS Control Program)
- STD Syndromic Management Training and Services: Future Plans (Ms Jenny Allan, Department for International Development)

3.2 Questions and Discussion

4. NGO and Private Sector Panel

4.1 Panel Presentations

- Building NGO Capacity for Expanded FP, STD and HIV/AIDS Programs: A Status Report (Mrs Ellen Chirambo, NGO Team Leader, JSI-STAFH)
- FP, STD and HIV/AIDS Programs in the Private Sector: A Status Report (Mr Cuthbert Nyirenda, Community Services Associate, JSI-STAFH)
- FP, STD and HIV/AIDS Programs in the Work Place: Future Plans (Mrs Effie Pelekamoyo, Deputy Director/Service Delivery, National Family Planning Council)
- HIV/AIDS Prevention and Control Activities in the Work Place: Future Plans (Dr Owen Kalua, Acting Program Manager, NACP)
- Strengthening NGO HIV/AIDS Prevention and Control Programs: Future Plans (Ms Elizabeth Marum, USAID or Ms Linda Andrews, STAFH Team Leader, USAID)

4.2 Questions and Discussion

Lunch Break (1.00 - 2.00 pm)

AFTERNOON SESSION: 2.00 - 3.30

5. Advocacy and IEC Panel (2.00 - 3.00)

5.1 Panel Presentations

- FP, STD and HIV/AIDS Information and Education: A Status Report (Ms Anne Domatob, IEC Advisor, JSI-STAFH)
- Sustaining an Enabling Environment for Reproductive Health through Advocacy: Future Plans (Mr Bob Ngaiyaye, Deputy Director/IEC, NFPC)
- HIV/AIDS Behaviour Change Communication: Future Plans (Dr Owen Kalua, Acting Program Manager, NACP)

5.2 Questions and Discussion

6. Wrap-Up and Closing (3.00 - 3.30)

- Closing Remarks (Ms Linda Andrews, STAFH Team Leader, USAID)
- Thank You and Closing Remarks (Mr Marc A. Okunnu, Sr.)
- Formal Closing (Mr George Mkondiwa, Principal Secretary, Ministry of Health and Population)

APPENDIX 1A

JSI-STAFH PROJECT
PARTIPATION REGISTRATION FORM

SECTION : Administration
TITLE : STAFH Transion Conference
DURATION : 1 Day
VENUE : Captial Hotel
DATE : 30 September, 1998

NO	NAME	ORGANIZATION	CONTACT ADDRESS AND TEL. NUMBER	TITLE
1.	Dr. Ann Phoya	USAID/Malawi	P.O. Box 30455, LILONGWE 3	Mission Director
2.	Ms. Joan LaRosa	USAID/Malawi	P.O. Box 30455, Lilongwe 3	Health and Population Leader
3.	Ms. Linda Andrews	USAID/Malawi	P.O. Box 30455, Lilongwe 3	STAFH Team Leader
4.	Ms. Jenny Allan	DfID	P.O. Box 30042, Lilongwe 3	Health and Population
5.	Mrs E. Pelekamoyo	NFPC	P/Bag 308, Lilongwe 3	Executive Director
6.	Ms. Angela Trenton-Mbonde	UNAIDS	P.O. Box 30135, Lilongwe 3	Country Program Advisor
7.	Dr. W.O.O. Sangala	MOH&P	P.O. Box 30377, Lilongwe 3	Principal Secretary
8.	Mr. G. Mkondiwa	MOH&P	P.O. Box 30377, Lilongwe 3	Principal Secretary III
9.	Dr. W. Nkhoma	MOHP	P.O. Box 30377, Lilongwe 3	Controlle, PHS
10.	Mrs. J. Namasasu	MOH&P	P.O. Box 30377, Lilongwe 3	Assti Contoller, PHS
11.	Dr. F. Ebanyat	RHU/MOHP	P.O. Box 30377, Lilongwe 3	
12.	R. Ngaiyaye	NFPC	P/Bag 308, Lilongwe 3	

NO.	NAME	ORAGNIZATION	CONTACT ADDRESS AND TEL. NUMBER	TITLE
13	Mr. Chris Moyo	PHRDU		Director, Population Services
14	Mr. D. Nyirenda	CMS		P.O. Box 30377, Lilongwe 3
15	Mrs. J. Nyasulu	RHU-MOH&P	P.O. Box 30377, LL 3	Senior Family Health Officer
16	Dr. M. Palamuleni	NFPC		Executive Director
17.	Mrs. P. Masepuka	RHU-MOH&P	P.O. Box 30377, LL. 3	National CBD Coordinator
18.	Mr. J.G. Malewezi	RHU-MOHP	P.O. Box 30377, LL. 3	
19.	Dr. S. Ayalew	World Bank	P.O. Box	
20.	Mrs. N. Chando	NFPC		Deputy Director, Training
21.	Mr. A. Goddia	ECM	P.O. Box 30384, Lilongwe 3	
22.	Mr. B. Banda	RHU/MOHP	P.O. Box 30377, Lilongwe 3	Logistics Officer
23.	Mr. Kennedy Warren	National Youth Council		Youth Liaison Officer
24.	Mrs. Rashid	RHO		
25.	Mr. G. Kadewele	MOHP	P.O. Box 30377, LL. 3	Controller, Tech Services
26.	Mrs. E. Kumdana	STAFH Project	P.O. Box 30377, Lilongwe 3	
27.	Dr. B. Chawani	CHAM		Executive Director
28.	Dr. E. Kruyt	CHAM		Health Coordinator
29.	Mr. Nem Chakhame	USAID	P.O. Box 30455, Lilongwe 3	

NO.	NAME	ORAGNIZATION	CONTACT ADDRESS AND TEL. NUMBER	TITLE
30	Mr. T. Masache	MCHS		Principal
31.	Mrs. C. Nyirenda	Nursing & Midsifery Council		Asst. Registrar
32.	Mr. E. Kajawo	RHO (S)	P.O. Box 3, Blantyre	Registrar
33.	Mr. S. Konyani	Centre for Social Research		Director
34.	Dr. Chiphangwi	College of Medicine		Principal
35.	Mr. Tom Krift	SFC-US		Director
36.	Mr. E. Chiumia	IEF		
37.	Mr. J. Katangwe	PSI	P.O. Box 529, Blantyre	Marketing Manager
38.	Mr. Jonathan Nkhoma	MASO		President
39.	Mr. Katawa Msowoya	MACRO		Acting Director
40.	Mr. D. Kolondo	NAPHAM		Administrator
41	Mr. J. Maleka	Youth Arm Organization		
42.	Mr. J. Pidini	Malamulo Hospital		
43.	Dr. M. Young	Ekwendeni Hospital	P.O. Box 19, Ekwendeni	
44.	Mr. Chibambo	Ekwendeni Hospital	P.O. Box 19, Ekwendeni	
45.	Mr. R.J. Njoka	St. Annes Hospital		
46.	Mr. C. Bacon	BCC		

NO.	NAME	ORAGNIZATION	CONTACT ADDRESS AND TEL. NUMBER	TITLE
47.	Mr. M. Okunnu, Sr.	JSI-STAFH Project	P.O. Box 1011, Lilongwe	Chief of Party
48.	Mr. P. Killick	JSI-STAFH Project	P.O. Box 1011, Lilongwe	Finance Manager
49.	Mrs. M. Mchombo	JSI-STAFH Project	P.O. Box 1011, Lilongwe	QA Associate
50.	Mrs. C. Kachiza	JSI-STAFH Project	P.O. Box 1011, Lilongwe	STD/HIV Associate
51.	Mrs. J. Banda	JSI-STAFH Project	P.O. Box 1011, Lilongwe	NGO Associate
52.	Mrs. Ellen Chirambo	JSI-STAFH Project	P.O. Box 1011, Lilongwe	NGO Associate
53.	Mrs. M. Ndalama	"	"	MGT. Associate
54.	Ms. A. Domatob	"	"	IEC Advisor
55.	Mr. C.Q. Nyirenda	"	"	Community Services Associate
56.	J.R. Nyirenda	"	"	CM Associate
57.	R. Msowoya	"	"	Logistics Associate
58.	C. Kandulu	"	'	Financial Analyst
59	Mr. F. Amadu			
60.	Mr. G. Maulidi			
61	Mrs. Chimwaza	NACP		
62	Mr. P. Makhumula			
63	Mrs. M. Simbota			

64	Mr. Maulidi	NACP	P.O. Box 30622, Lilongwe 32	
65	Mr. O. Chipukunya	NACP	P.O. Box 30622, Lilongwe 3	
66.	Mrs. T. Mwale	WHO	P.O. 30390, Lilongwe 3	
67.	Mrs. D. Ngoma	BLM, Blantyre	P.O. Box 3008, Blantyre	
68.	Dr. J. de Graft-Johnson	SCF-US	P.O. Box 609, Mangochi	Senior Health Program Manager

Welcome Remarks by
Marc A. Okunnu, Sr., Chief of Party, JSI-STAFH
at the STAFH Transition Conference
Viphya Suite, Capital Hotel, Lilongwe
30 September, 1998

Mr George Mkondiwa, Principal Secretary (3), Ministry of Health and Population
Miz. Joan LaRosa, Health and Population Team Leader, USAID
Distinguished Heads of National and International Governmental, Non-Governmental and Multilateral Organizations
Conference participants, and
Colleagues from JSI-STAFH

On behalf of JSI, I would like to warmly and formally welcome all invited guests and particiapnts to this important conference. I would also like to thank you very much for making time available for the conference inspite of its rather short notice and suddenness.

Exactly four years ago in 1994, JSI joined other national and international organizations as a participant and partner in the USAID-funded Government of Malawi Support to AIDS and Family Health (STAFH) Project. The presence and the work of JSI in Malawi have been made possible by USAID through the competitive institutional contracting of JSI under STAFH. JSI is grateful to USAID for the opportunity, and for the strong support, cooperation and encouragement received. JSI is equally much grateful to the Government and people of Malawi who have welcomed our presence, and cooperated with and assisted us in our work, without let or hinderance.

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

From the initial rather unfortunate perception of JSI as another RH implementing agency, paralell to the MOHP, the NFPC, AIDSEC and other RH implementing organizations, but with inadequate "inclusive" and"ownership" linkages to them,

we later settled down, I hope quickly enough, to our intended strategic role: to serve as a multifaceted technical resource, and a flexible funding mechanism. I truly hope that, overall, the other STAFH participants and partners can see us as successful in playing this cardinal role.

Whatever may be your reaction to the role and achievements of JSI, the time is obviously now up for JSI to hand-over the batton to others. I cannot find better words to describe the occasion than a quote from one of William Shakespaer's many plays. I cannot readily recall the particular play but the quote itself is as follows: "The old order changeth yielding place to the new". As the Institutional Contractor, JSI has been a cardinal part of the old order, along with the other international organizations. In its re-designed form, STAFH ushers in a new order. But the new order is not a clean break with the past or a "revolution". More accurately, what we are witnessing is an evolution. An evolution in which many of the players in the old order will continue to be present and active.

At this conference and in many previous fora (including the STAFH review process of late 1997 to early 1998), we can sit back and appraise the "old order", analysing its strengths and weaknesses, and extract lessons from its experiences. My colleagues and I in JSI-STAFH trust that the experience and outcome of the last four years have effectively contributed towards strengthening the foundations for not only STAFH in particular but RH organizations, programs and management in Malawi, in general.

Mr Chairman, please allow me to conclude my remarks by welcoming everyone, once again, to the hotel, to the conference and to the deliberations. I join you in looking forward to open and fruitful discussions.

I thank you very much for your attention.

OVERVIEW:
JSI-STAFH, 1994-1998

JSI-STAFH, Lilongwe
28 September, 1998

OVERVIEW:
JSI-STAFH, 1994-1998

Background

JSI's arrival in Malawi to participate in the USAID-funded Government of Malawi Support to AIDS and Family Health (STAFH) Project coincided with the change from the 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 reproductive health, particularly family planning and AIDS. The new liberal environment also permitted expansion of the NGO sector, and its larger participation in health, population and AIDS programs.

Thus, at the inception of the JSI contract in October, 1994, the country setting, in general, and with respect to RH, in particular, had began becoming more favourable to and supportive of the type of work to be undertaken by JSI. The specific work that JSI was to undertake was set against the background of some very specific constraints, which the GOM and USAID had identified and analyzed in the STAFH project paper. Eleven constraints were identified (T1).

1. Insufficient Funding of Primary Health Care
2. Insufficient MOH (MOHP) Providers
3. Not Enough MOH (MOHP) Staff Time
4. Limited MOH (MOHP) Implementation Capacity
5. Limited Supply of AIDS Control and Child Spacing (FP) Services
6. Weak Distribution System for Contraceptives abd Pharmaceuticals
7. Poor Training Provided CS (FP) Providers and their Supervisors
8. Incomplete Knowledge of Contraceptive Options and the Perceived Value of More, Rather than Fewer, Children
9. AIDS Policies Progressive but Slow to be Implemented
10. Incomplete Knowledge of AIDS
11. Impact of AIDS Control Strategies Uncertain.

JSI was not expected to address all the constraints as some of them, such as the first two, were clearly beyond the mandate of JSI as the institutional contractor. However, the outcome of the JSI contract was expected to contribute to the resolution of the constraints. In this regard, some specific outputs were identified for child spacing (family planning) and HIV/AIDS, as joint responsibility for JSI and USAID. These are attached as appendices 1 and 2 (T2, T3).

JSI Implementation Strategy

As intended in the STAFH project paper, JSI has sought to provide technical and material support, as well as funding for related activities. As subcontractors, four other organizations have assisted JSI in providing the TA. The TA has focussed on three key areas (T4).

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

The aim has been to build or strengthen the foundations for effective FP and STD/HIV program take-off, in partnership with other players.

To provide additional basis for assessing it's work, JSI carried out a quick baseline survey in 1994. The result enabled targets to be set in other areas as additions to those stated in the JSI-STAFH contract (T5).

In areas such as Research and IEC where no targets had been set by the STAFH project paper, JSI staff met with national counterpart officials to discuss needs, establish priorities and set targets.

The JSI-STAFH contract implementation involved administrative as well as program activities. The main administrative activities may be summarized as follows.

- Staffing: At its peak, the JSI staff strength was 44, organized into seven technical and administrative units dealing with FP, STD/HIV, Community Services, NGO Programs, Research, IEC, and Finance and Administration.
- Building and maintaining the administrative infrastructure: The main office was established in Lilongwe but for 18 months a sub-office was operated in Blantyre to facilitate the development phase of the NGO Program.
- 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 June, 1997, there were 13 such working groups (appendix 3) (T6).

The program activities are summarized under the following main sub-headings (T7).

- Needs Assessments/Situation Analyses
- Development of Strategies and Implementation Plans
- Development of Policies, Guidelines, Standards and Tools
- Development of Training Curricula and Materials
- Training of Personnel
- Development of IEC Materials
- Procurement and Distribution of Equipment and Furniture
- Set-up, Renovation and Upgrading of Service Delivery Sites
- Design and Conduct of Research and Studies, and Dissemination of their Findings
- Monitoring, Supervision and Evaluation

Achievements

I must repeat here that JSI has, obviously, not been a lone actor in supporting RH programs. Our work has formed only a part of the total national effort. Moreover, in RH as in development in general, four years is a short time to talk about impact. Further more, no evaluation of the work of JSI in Malawi has been done to assess its short- as well as long-term effectiveness. Against the background of these preambles, the following achievements should be assessed more in relation to their strategic significance in building foundations for sustainable RH programs.

Following are the key achievements. As more details will be presented later in the panels, I will only outline them (T8).

1. Increased knowledge about FP, STD and HIV/AIDS as well as the factors affecting them (socio-cultural, behavioural and bio-medical research, and development of IEC materials)
2. Expanded and strengthened physical and material infrastructure for FP and STD service provision (facility renovation and equipping)
3. Increased number of trained FP and STD personnel, including managers, trainers, supervisors and service providers (training)
4. Expanded involvement and strengthened capacity of the NGO and private sectors to participate actively and effectively in FP, STD and HIV programs (NGO grants and private sector support)
5. Development and piloting of strategic directions (STD syndromic management, FBCQI, LTPC, strategic planning support to RHU and NFPC)
6. Strengthened communication and coordination among RH participating institutions (annual STAFH coordination meetings, RHMSTA).

Issues, Lessons and Recommendations

The individual JSI panel presentations to follow have identified a number of specific issues, lessons and recommendations. I will therefore only touch on the key overiding issues.

(T9) Facility renovations, off-shore procurement, and equipment distribution are easily the most obvious areas of the greatest challenges experienced by JSI. In all three areas, the time requirement, obtaining the requisite inputs of collaborating agencies and contractors, and projecting adequate budget levels have proved to be major issues.

The structural location of JSI-STAFH outside the Government has posed a number of questions related to the extent of national "ownership" and "inclusiness" and, consequently, sustainability of the processes and outcomes of JSI-STAFH. But at the same time the question can also be asked: are these issues that necessarily result from the type of location experienced by JSI-STAFH ?

Another aspect of the question of location relates to performance: would JSI-STAFH perfomance have been better or worse if its location had been within the Government ? The "new order" of STAFH provides an opportunity for making comparison later, at the end of the extension phase.

CHILD SPACING OUTPUTS

- MOH hospitals providing comprehensive services increased from 3 to 25
- CHAM hospitals providing comprehensive services incresaed from 8 to 10
- Clinics providing core child spacing services increased from 326 to 593
- Personnel providing CBD services increased from 200 to 868
- Socially marketed oral contraceptives increased from 0 to 1.4 million cycles/year
- Users of modern child spacing methods increased from 68,000 to 280,000
- NFWC established and functioning as the national leadership and coordination body for CS activities and providing a full range of CS services to providers
- GOM commitment of human and financial resources for CS increased

AIDS CONTROL OUTPUTS

- MOH and CHAM hospitals providing comprehensive STD services increased from 0 to 50%
- Large private sector companies and estates with effective AIDS prevention and condom distribution programs increased from 10% to 90%
- Schools providing AIDS prevention education increased from 0 to 80%
- AIDS prevention education programs established for bargirls, STD patients, out-of-school youth, and other at-risk men and women
- Condoms sold through social marketing increased from 0.5 to 4.0 million per year
- Condoms distributed by NACP increased from 3 to 10 million per year
- GOM commitment of human and financial resources for AIDS prevention increased

COMMITTEES, TASK FORCES AND WORKING GROUPS FOR FAMILY PALNNING PROMOTION AND HIV/AIDS/STD PREVENTION[1]

COMMITTEES, TASK FORCES AND WORKING GROUPS	MEMBER ORGANIZATIONS
PRAC (Proposal Review and Approval Committee for the JSI/STAFH project NGO grants)	USAID MOHP-Family Health Unit NACP NFWCM CONGOMA JSI/STAFH
Syphilis Laboratory and Quality Control Working Group	NACP College of Medicine QECH Lab GTZ Lab Lilongwe Central Hospital Lab MOHP - CHSU Lab JSI/STAFH
STD Technical Advisory Working Group	NACP Lilongwe Central Hospital MOHP - Essential Drugs Program Central Medical Stores DHO Kasungu Blantyre Adventist Hospital JSI/STAFH
National Population Research Committee	University of Malawi -Demographic Unit Centre for Social Research NFWCM MOHP - PHRDU Malawi Institute of Education College of Medicine Ministry of Research and Environmental Affairs National Statistics Office JSI/STAFH

[1] This list is not intended to be comprehensive, but illustrative of the types of collaboration already taking place.

COMMITTEES, TASK FORCES AND WORKING GROUPS	MEMBER ORGANIZATIONS
National Youth Sexual Health and HIV/AIDS Coordinating Committee	MOYSC NFWCM NACP College of Medicine College of Nursing Demographic Unit Chancellor College - Psychology Dept. Center for Social Research Ministry of Education Ministry of Women and Children's Affairs, Community Services and Social Welfare MOHP Ministry of Information, Broadcasting and Telecommunications CHAM Moslem Association of Malawi BLM CPAR Youth Arm Student Alliance for Development EU AIDS Project UNESCO National Commission UNFPA UNICEF JSI/STAFH
Work Place Task Force	NACP NFWCM USAID Project HOPE PSI SCF-US IEF BLM EU AIDS MACRO ECAM Ministry of Labour Limbe Leaf MCTU Tea Association of Malawi IMPACT JSI/STAFH

COMMITTEES, TASK FORCES AND WORKING GROUPS	MEMBER ORGANIZATIONS
Facility Upgrading Committee	MOHP- Planning Unit MOHP - Family Health Unit NFWCM CHAM USAID JSI/STAFH
Continuous Quality Improvement Task Force	MOHP - FHU NFWCM Nurses and Midwives Council Regional Health Office (C) JSI/STAFH
VSC Task Force	MOHP - Family Health Unit Lilongwe Central Hospital JSI/STAFH
Tinkanena Review Committee	NFWCM NACP MOHP- Health Education Unit MOYSC UNICEF MBC Rural District Education Unit JSI/STAFH
Family Planning Logo Development Task Force	MOHP - Health Education Unit MOHP - Family Health Unit NFWCM BLM GTZ Malawi Institute of Education Malamulo Hospital Ekwendeni Hospital World Vision International JSI/STAFH

COMMITTEES, TASK FORCES AND WORKING GROUPS	MEMBER ORGANIZATIONS
IEC Material Pretesting Working Group	NACP NFWCM MOHP - Health Education Unit MOHP - Family Health Unit District Health Offices in testing areas JSI/STAFH
IEC Material Users Guide Working Group	NACP NFWCM MOHP - Health Education Unit MOHP - Family Health Unit MACRO JSI/STAFH

STAFH TRANSITION CONFERENCE
CAPITAL HOTEL, LILONGWE
SEPTEMBER 30, 1998.

FAMILY PLANNING TRAINING, QUALITY ASSURANCE, AND LONG TERM AND PERMANENT CONTRACEPTION STATUS REPORT

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INTRODUCTION

The main objective of the Family Planning component of the STAFH Project is to improve knowledge and attitudes about family planning as well as access to and use of quality FP services. Over the last four years, JSI-STAFH has supported the realisation of this objective by supporting the expansion of service delivery points, training of FP service providers and ensuring that quality of services are improved on a continuous basis.

The expansion of family planning services was planned to be effected at the 3 levels of FP service delivery system:

1. Comprehensive FP services, which encompass the provision of all Core FP methods: Oral Contraceptive Pills, Depo Provera, Intra uterine Contraceptive Devices, Condoms and Spermicides, plus Minilaparatomy under Local Anaesthesia (ML/LA), Norplant insertion and removal and Vasectomy services in a select number of facilities.

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

3. Community Based FP services. This level includes the provision of pills, condoms and spermicides at the community level by CBD agents. (This level of service provision will be presented separately)

With respect to quality improvement, the plan was to design and test a simple facility based model for replication later. In addition, Interpersonnal Communication and Counselling was given a special focus in order to improve the quality of provider/client interaction.

1. COMPREHENSIVE SERVICES (LONG TERM AND PERMANENT CONTRACEPTION)

Since all the 326 health facilities were providing core FP services at the beginning of the project in 1994, a special programme was specifically designed to focus on the out of the 4 additional Long Term and Permanent Contraception (LTPC) methods which were not as readily available and accessible to a large population of FP users. These methods were Minilaparatomy Under Local Anaesthesia (ML/LA), Vasectomy and Norplant. Intra-Uterine Contraceptive Devices, which form part of LTPC, were not included in this programme since they were already introduced together with core FP methods at the beginning of the FP programme in 1982. The target for comprehensive services was therefore, to increase the number of facilities providing LTPC services, as follows.

	ML/LA		NORPLANT		VASECTOMY	
	From	To	From	To	From	To
MOHP	3	24	1	23	0	5
CHAM	8	9	0	9	-	-

In order to achieve the stated targets, JSI-STAFH put in place a number of activities which were all aimed at ensuring that the targeted facilities would be fully functional. The planned activities included the following:

- defining roles, responsibilities and relationships of various organizations providing FP services
- assessing facility needs for service improvement and expansion
- monitoring and supervision of facility improvement process
- assessing clinical equipment needs
- procuring theatre equipment according to the needs identified
- training 22 teams in ML/LA
- training 25 teams in Norplant insertion and removal
- training 5 teams in Vasectomy procedures
- monitoring the sites providing LTPC services and providing technical assistance

ACTIVITIES UNDERTAKEN

1. Training of LTPC Service Providers:

A total of 20 Clinical Officer/Doctor and Nurse teams have been trained in ML/LA skills. Ten teams were trained at Nkhoma Mission Hospital for 8 of the CHAM facilities and 2 MOHP Hospitals. Four teams and 6 teams for MOHP hospitals were also trained by Dr. Lema and AVSC International respectively.

Participants who received training were drawn from the following facilities:

Ministry of Health and Population	CHAM
Chitipa District Hospital	Embangweni
Mzimba District Hospital	Ekwendeni
Nkhata Bay District Hospital	St Annes
Mchinji District Hospital	Nkhoma
Dedza District Hospital	St. Lukes
Lilongwe Central Hospital	Malindi
Ntcheu District Hospital	Malamulo
Thyolo District Hospital	Mulanje Mission
Nsanje District Hospital	
Machinga District Hospital	
Zomba Central Hospital	
Balaka Rural Hospital	

The addition of more trained teams has resulted in a total of 13 out of 24 MOHP and all 9 non-Catholic CHAM facilities providing ML/LA services. All the 9 CHAM facilities are also providing Norplant services in addition to ML/LA. Listed below are MOHP facilities which are providing ML/LA and Norplant services:

FACILITY	PROVIDING ML/LA	PROVIDING NORPLANT
Chitipa District Hospital	yes	no
Mzimba District Hospital	yes	yes
Nkhata Bay District Hospital	yes	no
Lilongwe Central Hospital	yes	yes
Dedza District Hospital*	no	no
Mchinji District Hospital	yes	no
Ntcheu District Hospital	yes	no
Balaka Rural Hospital	yes	yes
Machinga District Hospital	yes	yes
Mangochi District Hospital*	yes	yes
Zomba Central Hospital	yes	no
Queen Elizabeth Central Hosp.	yes	yes
Nsanje District Hospital	yes	no
Total 13	12	6

Note: 1. No services are currently being provided at Dedza District Hospital because the Surgeon was transferred to Ntchisi District Hospital.

2. The Surgeon trained for Thyolo District Hospital got transferred to

Mangochi District Hospital where he is now providing services.

3. Most of the facilities are not performing Vasectomies because of the low clientele and providers have not yet been trained to provide this service

2. Training of Trainers

Five teams selected from Mzimba District Hospital in the Northern Region; Lilongwe Central Hospital and Nkhoma Mission Hospital in the Central Region; and Mangochi and Machinga District Hospital in the Southern Region were trained as National LTPC Trainers to continue with the process of training LTPC Service Providers for the remaining district hospitals and other prospective LTPC service delivery sites in the country. The TOT they received was in ML/LA and Norplant insertion and removal. Performing Vasectomy procedures, which is part of the training package was not done due to absence of clients. The same Trainers will be given training in facilitative supervision to ensure provision of quality service through regular supervision.

3. Monitoring and supervision

Monitoring and supervision visits were conducted to all MOHP sites providing LTPC services in order determine progress of services as well identify problem areas. Among the problems identified were that infection prevention practices were not up to standard; consent forms were not being attached to the client cards; and some of the providers' skills were inadequate. On-the-job training was done where necessary and appropriate recommendations made to the providers as well as the respective District Health Management Teams for improvement of infection prevention practices. In addition, the LTPC Client Card was revised to incorporate the Chichewa and Tumbuka versions of the Consent Form, which have formed part of the client card. Ten thousand copies of the card were printed and some of the cards were distributed to all MOHP and CHAM hospital which are providing LTPC services. The rest were distributed to the three Regional Health Offices for storage and distribution to the centres as needed.

4. Provision of Theatre Equipment:

1. One Hundred ML/LA kits and 20 Non-Scapel Vasectomy kits were ordered and received by JSI-STAFH. Twelve ML/LA kits and 4 NSV kits were distributed to some of the facilities. The rest are in the JSI-STAFH warehouse awaiting distribution as more LTPC Providers get trained and ready to provide services.

2. Other theatre equipment comprised of 7 Theatre Tables, 3 Theatre Lamps, 9 Autoclaves and 14 Air Conditioners, were also ordered for the renovated theatres.

5. Renovation of Theatres:

One of the activities under the improvement of LTPC services was the renovation of operating theatres in some districts. This activity was intended to create space for LTPC operations as well as provide space for waiting before and recovery after surgery.

6. Assessment of Facility Needs for Service Expansion

In the initial phase of the LTPC Programme, JSI-STAFH worked together with MOHP, CHAM and AVSC International to conduct a Needs Assessment which identified information on which further expansion of the programme was based. The needs assessment which was conducted in 1995 provided information on, among other things, the number and type of health facilities providing LTPC services, number of personnel trained and the type of equipment and supplies lacking. The information obtained was very instrumental in the development of the 5-Year Strategic Plan.

7. Development of the 5 year LTPC Strategy

A 5-Year Implementation Strategy for Long Term and Permanent Contraception was developed by MOHP, BLM, CHAM, NFPC and other stakeholders with technical assistance from JSI-STAFH and AVSC International. The Strategy was developed to provide focus for future expansion of the programme. Following the strategy development, two workshops were held in April and May, 1998, to plan the implementation of the programme during its first year. Participants for the two workshops included all District and Regional Health Officers and FP Coordinators, Reproductive Health Unit, CHAM, BLM, USAID, DFID, AVSC International and JSI-STAFH. All workplans developed by the district level personnel were collected by the Reproductive Health Unit for consolidation into the National LTPC Workplan. After consolidation, the district workplans were expected to be returned to the respective districts with feedback.

ISSUES AND LESSONS LEARNED

1. The Programme has been moving at a very slow pace, especially after the retirement of the LTPC Coordinator in the MOHP. Her replacement took a long time and the new Coordinator is still in his early stages of getting acquainted with the programme.

2. The charge of K100 imposed on the provision of Norplant insertions has discouraged the would-be clients from choosing the contraception as a method of choice because most of the clients cannot afford to pay the fee. The lack of clear guidelines for Norplant charges has resulted in some facilities requesting a fee and others providing it free of charge.

3. The acceptance of IUCD's has declined over the past four years due to rumours and misconception and unavailability of qualified personnel to insert the devices. The shortened FP courses do not include IUCD insertion, as a result all the service providers trained from 1994 lack the skill for providing IUCD's.

4. Publicity for Long Term and Permanent Contraceptives is still very low, with most of it being done by only those health personnel who were trained to perform the operations. Other FP providers regard the responsibility of publicising the methods and motivating the clients as belonging to trained LTPC providers.

5. The LTPC programme has many activities, such as IEC, provision of services, training, monitoring and supervision and general management support. All these activities require the involvement of other organizations to assist MOHP to move the programme.

RECOMMENDATIONS

1. After the phase-out of JSI-STAFH which has taken a very active role in providing human/technical support to move the programme to its present status, other organizations, such as NFPC should actively get involved in implementing the various components of the LTPC strategy, especially the IEC component

2. The NFPC should follow up on the recommendations made in the FP training guidelines to establish the 2-week IUCD training for service providers in high demand areas.

3. Ministry of Health and Population should write clear guidelines for charges regarding the provision of Norplant and circulate these to all service delivery sites providing Norplant services.

2. TRAINING OF FAMILY PLANNING SERVICE PROVIDERS

In the area of training, JSI-STAFH supported training of personnel for three family planning programmes. These are:

- The Family Planning Practitioners Training Programme (4-6 weeks training)

- The Core Family Planning Service Providers Programme (Three-Day or Checklist)
- The Interpersonal Communication and Counselling Training

2.1 Family Planning Practitioner Training Programme

Planned activities in this component consisted of:

- Establishing a Training Mangement Information System TMIS)
- Monitoring the TMIS
- Providing technical support in the training of 576 FP service providers
- Providing technical support in providing Contraceptive Technology Update courses for 200 service providers

ACTIVITIES UNDERTAKEN

1. In the area of FP Practitioner training, JSI-STAFH contribution was in monitoring and provision of technical assistance in the training of 576 Service Providers in 3
training sites supported by USAID through MOHP.

To date, 137 Service Providers have been trained using USAID funds. A total of 469 FP service providers have been trained since courses resumed after the revision and shortening of the FP Curriculum in 1994. The total sum of trained providers has been the contribution of several donor agencies as indicted below:

Donor agency/Organization	Number of Providers Trained
USAID	137
CIDA	44
UNFPA	268
BLM	20
TOTAL	**469**

2. To increase the pace of training, JSI-STAFH held discussions with the National Family Health Coordinator and the STAFH Project Accountant in the MOHP to develop guidelines for speeding-up the liquidation of funds from the training centres.

3. Sets of training equipment have been procured and will be distributed to the training centres soon. Each set consists of an Overhead Projector, Slide Projector, TV Monitor and Recorder, Pelvic and Breast Models, Photocopier, a Dry-wipe board, and a set of clinic equipment. The equipment will enable trainees to practise their skills prior to working with real clients in the clinic.

4. The Training Management Information System data base was established to track the number of personnel who have received training since its inception in 1995. Copies of data sheets from all the districts were given out in May to the respective DHO's and FP Coordinator for updating. Currently only 3 districts have submitted back the forms with the required updates.

ISSUES AND LESSONS LEARNED

1. The 4-week training for Registered Nurses and Clinical Officers does not provide adequate time for the providers to competently develop their clinical skills. Trainers have also complained that they are not able to cover all the topics in the curriculum, and to make up time, some topics are given to the trainees to read as homework assignments.

2. All the training centres, except Lilongwe, use rented facilities for training. This situation makes training a costly venture since a large amount of money is used pay rent. In some instances, some of the training sites have been moving from one facility to next in search of cheaper accommodation, and this situation as resulted in courses being delayed. Although Lilongwe training centre has got its own accommodation, the centre does not have a classroom. As such, the centre still has to borrow or rent classroom accommodation somewhere away from the training centre.

3. Management of the training sites is difficult because of their varied needs as well as their scattered nature.

4. Requests for training funds have been made for 2 or 3 courses at a time. Given the slow process for obtaining the funds, there have been long periods in which no training was taking place at the 3 USAID supported training centres. In some cases, training took place using UNFPA funds.

RECOMMENDATIONS:

1. The 4-week training course need to be increased to 6 weeks to enable trainees to gain more clinical skills. In addition the extra time will be beneficial for the trainers who will have enough time to cover all the topics in the curriculum, especially the integrated STD Syndromic approach and CDLMIS.

2. The training centres should plan courses for the whole year, develop the budgets and submit them to the National Family Health Coordinator and the STAFH Project Accountant in MOHP. The plans should also include budgets for follow-up of trainees. After consolidation of all training courses and budgets, one Project Implementation Letter (PIL) for the whole year should then be submitted to USAID for funding.

3. Lilongwe training centre should be made into a National FP Training Centre since this is the only facility which has its own accommodation and enough space on which further extensions can be made. The extensions should include at least 2 classrooms, a library, an office for the trainers, a recreation room, and storage space. Alternatively, two other permanent training centres can be established in the Northern and Southern Regions in order to have 3 Regional Training Centres.

4. The idea of using preservice training institutions should be explored further in order to cut the cost renting. This measure should be taken while waiting for the establishment of a permanent training centre or centres.

2.2 Core FP Service Providers Programme (Checklist).

This is a bridging activity to enable health workers who are not yet trained in the 4 or 6 week training to use a Hormonal Contraceptive Checklist. In order to further increase access to FP methods, JSI- STAFH supported the programme by putting in place the following activities:

1. Development of Three-Day Curriculum.

2. Training of District level trainers for all the districts and Regional FP Co-ordinators.

3. Monitoring of training for Core FP providers.

4. Printing and distribution of printed curriculum to all the District Trainers

ACTIVITIES UNDERTAKEN

1. The Three-Day Curriculum was developed with technical and financial assistance from JSI-STAFH. Participants who took part in this exercise were drawn from MOHP, NFPC, CHAM, BLM, and the FP training centres.

2. The Curriculum was pretested during the Training of Trainers in all the 3 regions and the training of service providers in the Northern Region.

3. Fifty-two Core FP Trainers from the three regions were trained (Northern Region 11, Central Region - 20, and Southern Region - 21)

4. Following the pretests, NFPC organised a 5-day workshop to review the Curriculum and incorporate comments from the pretests.

5. JSI-STAFH continued to monitor the training of Core FP service providers in the Northern Region, where 317 providers were trained.

ISSUES AND LESSONS LEARNED.

1. After the training in the Northern Region, UNFPA continued to provide funding to support training of more Core FP Providers in the Central and Southern Regions. However, not all districts were provided with funds. In consequence they have never conducted any training in their districts even though the demand from health personnel is high.

2. The training Curriculum has not been submitted to JSI -STAFH for printing and distribution to districts.

RECOMMENDATIONS

Ministry of Health and Population and NFPC should identify funding mechanisms for supporting training in the districts.

After the final review, NFPC should identify other donors to fund the printing of the Training Manual.

3. Interpersonal Communication and Counselling (IPCC)

Interpersonal Communication and Counselling was part and parcel of the planned activities. It was included to contribute towards the provision of quality core and comprehensive FP services and make them user-friendly. The FP and IEC department of JSI-STAFH worked on this training activity together and in collaboration with MOHP, CHAM, NFPC and other organizations.

Planned activities included the following:

Developing the IPCC Curriculum

Training IPCC Trainers

Training of 425 service providers in effective counselling

Monitoring IPCC activities

ACTIVITIES UNDERTAKEN

1. The IPCC Curriculum was developed by the FP and IEC departments in collaboration with NFPC, MOHP, Health Education Unit, CHAM, Malawi College of Health Sciences, FP Trainers and service providers. Topics addressed in the Curriculum include use of verbal and non-verbal communication skills, use of counselling skills, such as eye contact and body language; provider and client perceptions and how they affect communication; the counselling process using GATHER; rumours and misconceptions and informed chice and consent. The IPCC course was designed to be conducted over a period of 6 days to allow trainees topractise their skills in the clinical setting.

2. The Curriculum was pretested on a group of Core FP Trainers and the comments from the pretest were used to review and finalise the document.

3. A two-week TOT was conducted in January 1997 at Lilongwe Hotel. JSI-STAFH IEC and Quality assurance departments provided technical assistance in the preparation for the TOT and contributed funds for running the course. A total of 27 IPCC trainers (2 from each of the 24 districts and 3 from the Regional Health Offices) were trained.

4. Almost all the districts have conducted 3 training courses for service providers. Plans were made for NFPC to provide funds for the first and fourth rounds of training and JSI-STAFH was to fund the second and third sessions. Money was provided by JSI-STAFH for the second session of training from which 243 providers were trained. National FP Council requested JSI-STAFH not to fund the third courses because they wanted to use their soon-to-be expired money to fund the third sessions. As a result, JSI-STAFH proceeded to fund the fourth round of training, but only 11 districts received funding according to the new strategy which was jointly devoloped by NFPC and JSI-STAFH (see Issues and lessons learned below). One hundred and sixty-five (165) providers were trained from the 11 districts, making a total of 408 service providers trained using JSI-STAFH

funds. (68% of the targeted numberof service providers). To date a total of 921 out of the targeted 600 service providers have received IPCC training.

5. A training of Regional and District Accountants was conducted to orient them on the processes and procedures for handling JSI-STAFH funds.

ISSUES AND LESSONS LEARNED

Through monitoring visits conducted by NFPC, it was discovered, among other problems that the districts were training any facility personnel regardless of their training and involvement in FP service delivery. The discovery prompted a change in the funding and monitoring strategies. A few districts instead of all 24, were selected for funding and monitoring and it was agreed that lessons learned from the selected districts would be used to improve training in the remaining districts.

RECOMMENDATIONS

National FP Council should identify sources of funding from other donors to enable them continue supporting and monitoring the IPCC training programme.

3. QUALITY IMPROVEMENT

Continuous Quality Improvement is an aspect which was included in all activities related to provision of FP services, both Core and Comprehensive.

To determine an appropriate model, a Facility Based Continuous Quality Improvement approach was piloted in 6 sites in 2 regions under the direction of an interagency task force composed of MOHP, NFPC, CHAM, Nurses Council and JSI-STAFH.

Planned activities consisted of the following:

1. Development of plans for continuos quality improvement
2. Identification of pilot sites
3. Conducting training for pilot site personnel
4. Monitoring of pilot sites
5. Documentation of CQI experiences
6. Dissemination of experiences

ACTIVITIES UNDERTAKEN

1. Plans for piloting the Facility Based Continuous Quality Improvement approach were developed in collaboration with MOHP and NFPC. An interagency task Force composed of members from MOHP, NFPC, CHAM, Nurses and Midwives Council, and the Regional FP Coordinators (Central and South), was formed to steer the pilot activity.

2. Six pilot sites in two regions were selected. The sites were Mchinji District Hospital, Kochilira Rural Hospital and Nkhwazi Health Centre in Mchinji District; Chiradzulu District Hospital, Namitambo Rural Hospital and Namadzi Health Centre in Chiradzulu District. The sites were selected in the districts where no other donor activities were taking place, and various levels of service delivery points were selected to compare the performances and experiences given the variations in staffing patterns.

3. A Continuous Quality Improvement Curriculum and data gathering tools were developed

4. Two training courses for 24 personnel from the pilot sites were conducted. The first training introduced the concepts of continuous quality improvement, data collection and team work. The second training was on problem solving skills.

5. The pilot sites worked in teams composed of Nurses, Clinical Officers, Administrative staff, Health Surveillance Assistants and Ward Attendants. As the teams worked on their problem solving exercises, they were monitored and supervised continuously to provide support and on-the-job coaching. Personnel from JSI-STAFH and the Regional Health Offices conducted about six visits to each of the sites to provide supervision. Experiences were documented as pilot sites worked on their problem-solving exercises which included long waiting times for clients and orientation of facility personnel on the types and availability of FP services.

6. Experiences from the pilot sites were disseminated to health personnel MOHP, CHAM and MOLG institutions. The dissemination exercise was jointly organised by JSI-STAFH and Medical Council in September 1997.

7. In the course of implementing the CQI activities in the pilot sites, task force members who had been specially oriented to provide support, were most of the time not available to provide assistance. In consequence, most of the follow up and supervision was provided by one member of JSI-STAFH. Nine CQI Coaches were trained in coaching skills to complement the efforts of the JSI-STAFH person in providing supervision and coaching. The CQI Coaches

were drawn from 2 each of the District Hospitals, one from Namadzi Health Centre, one from Kochilira Rural Hospital and one from each of the three Regional Health Offices.

After the dissemination, subsequent follow up visits were conducted to all the 6 sites to determine further progress on the problem solving activities. It was found that two of the six sites had proceeded on to the next problem, while the remaining four were making preparations to move on to the next problems

ISSUES AND LESSONS LEARNED

1. A special course was specifically conducted for training CQI Coaches from the pilot sites and Regional Health Offices to provide them with skills to conduct on site coaching and also to facilitate continuity of the approach and expansion to other facilities. However, their involvement in the pilot sites has been very minimal and they have not taken any proactive actions to continue with the exercise because of their involvement in other activities.

2. One of the pilot sites no longer has all its original staff who were trained in CQI because they were all transferred to other health centres. One member went for further training. This situation made it difficult for the new staff to continue with the approach in an effective manner in the absence of on-the-job training.

3. The Facility Based Continuous Quality Improvement approach is a simple exercise that has empowered health personnel in the 6 pilot sites to improve the quality of their services. It can be easily replicated in other health centres and also in any section of the health services.

4. Continuous follow up is needed, especially in the initial stages, to provide technical support.

RECOMMENDATIONS

1. Since it has been established from the pretest that CQI can be employed in the service delivery sites, it is important that the FP Co-ordinator be trained as CQI Coaches. After training, they can conduct on site orientations for health centre personnel in their districts.

2. A formal evaluation of the pilot site activities should be conducted to access the impact made by the exercise and use the experiences and lessons learned in the expansion phase.

In summary, the tables below show the activities planned at the beginning of the project and the status of implementation:

FAMILY PLANNING TRAINING

Planned activities	Activities Undertaken
• Establishing a training Management Information System • Monitoring TMIS • Developing Curriculum for Core FP • Training Trainers for Core FP • Print and distribute Curriculum • Providing support and monitor training of 576 providers • Providing support and monitor the update in contraceptive technology of 200 service providers • Developing the IPCC curriculum • TOT for IPCC Trainers • Training of 425 service providers	• All activities were undertaken as outlined in the initial plan, except the update of 200 service providers in contraceptive technology • Training equipment purchased, awaiting distribution • Guidelines for liquidation of training funds developed • IPCC training programme implemented
Present status	**Activities for Transfer**
• Training Management Information System developed, waiting information from districts to update it • Core FP Curriculum waiting to be printed • 52 (100%)Core FP trainers trained • 317 Core FP providers trained • 137 out of 576 FP providers trained • No CTU conducted • IPCC curriculum developed, being used for training • 27 (100%) IPCC trainers trained • 921 (321 more than the target number of 600) service providers trained	• Follow up and monitoring of service provider training • Contraceptive Technology Update training courses • Printing of the Core FP curriculum • Updating the training Management Information System

LONG TERM AND PERMANENT CONTRACEPTION

Planned Activities	Activities Undertaken
• Assessment of facilities for service expansion • Procuring theatre equipment • Distributing equipment • Training 22 Dr./Clinical Officers and 22 Nurses in ML/LA • Training 25 Dr./CO in Norplant insertion • Training 5 Dr./CO and 5 Nurses in Vasectomy • Establishing and monitoring LTPC sites	• Needs Assessment conducted • Theatre equipment purchased • Training of 20 CO/Theatre Nurse teams in ML/LA/LA at Nkhoma, QECH, Machinga by Nkhoma Hospital, Dr. Lema and AVSC • Training of 5 teams in Norplant insertion and removal • Training of LTPC Trainers by AVSC • Renovation of theatres
Present Status	**Activities for transfer to other agencies**
• 20 CO/Theatre Nurse teams trained in ML/LA (12 MOHP and 8 CHAM). • 5 CO/Nurses trained in Norplant and insertion and removal (TOT) • 13 MOHP and 9 CHAM Hospitals providing ML/LA • No training in Norplant and Vasectomy for LTPC service providers • Distribution underway for some furniture • Planning and organising to distribute theatre equipment	• Continue training 11 ML/LA teams for 11 District Hospitals • Train 5 CO/TN teams for Vasectomy • Train CO/TN teams for Norplant services (# to be determined after needs assessment) • Equipment still undistributed to be taken over by MOHP for distribution

QUALITY IMPROVEMENT

Planned activities	Activities Undertaken
• Developing plans for continuous quality improvement • Identifying 6 pilot sites • Conducting training for CQI • Implementing and monitor CQI in pilot sites • Documenting CQI experiences	• As in planned activities, plus • Training of CQI Coaches • Dissemination of pilot site experiences • Follow up after dissemination of experiences
Present Status	**Activities for Transfer**
• Two of the 6 pilot sites completed solving second problem. The rest are in the process of solving 2nd problems • One of the sites is no longer with the original team which underwent training	Monitoring of pilot sites

STAFH TRANSITION CONFERENCE AT CAPITAL HOTEL

ON SEPTEMBER 30, 1998

COMMUNITY BASED DISTRIBUTION - TRAINING AND SERVICES: A STATUS REPORT

JANE FRANCES BANDA

NGO PROGRAM ASSOCIATE

Introduction

According to the contact JSI-STAFH and MOHP signed, the family planning component of the project included the strengthening and expansion of the family planning services through the comprehensive, core family planning and community based delivery of family planning services. The planned activities in Community Based Distribution which I will report on are expanded service provision, training of CBD trainers, CBD agents and supervisors. The CBD program facilitates the delivery of family planning services in the rural communities. JSI-STAFH was expected to train 800 CBD agents and 68 CBD supervisors depending on the needs of the NGO's funded. Nine Non Governmental Organizations grantees that JSI-STAFH provided funding for family planning and STD/HIV prevention were in two groups. First , NGO's which had CBD activities in place and these are Ekwendeni, Malamulo, Nkhoma Hospitals, World Vision International and Adventist Health Services; and second, those that were implementing new CBD services and they are St. Annes Hospital, ADMARC, NABW, and Phwezi Foundation. The NGO's listed above have most of their clients located in the under served areas in the rural community hence their selection.

Implementation

a) **Development of CBD Guidelines and CBD Curriculum**

Although the CBD services were in place the government also needed support in getting other logistics in place. National Family Planning Council [NFPC]in collaboration with JSI-STAFH conducted an analysis of Quality of Family Planning CBD Services in Malawi in 1995 and findings revealed that CBD agents lacked adequate knowledge and skills in managing family planning clients and that there were differences in the duration of training, content of the course and the reporting and recording format. To address this problem, National Family Planning Council and it's partner agencies with financial and technical assistance from JSI-STAFH, developed the CBD guidelines and later the national CBD curriculum starting in 1996 to standardize the CBD activities.

The CBD curriculum was then pre-tested on the three JSI-STAFH grantees. The CBD curriculum process has taken a long time than planned because of the problems CBD trainers who pre-tested the English version of the curriculum experienced. The curriculum had to be translated in Chichewa before it could be taken to the printers. JSI-STAFH also funded the printing of the following CBD documents:

- CBD Guidelines
- Chichewa CBD Handbooks
- Chichewa CBD Trainers Manual
- English CBD Curriculum
- English CBD Handbooks

The documents listed above are available to all 38 CBD projects through the National Family Planning Council.

b) **CBD Training**

Since the CBD curriculum included new information such as CBD supervisor content and assessment tools and the number of CBD trainers was inadequate, JSI-STAFH and its partner agencies felt that there was need to orient all CBD trainers on the curriculum before the CBD trainers could use the document. To address this felt need, a two week CBD trainers orientation and a four week CBD training of trainers courses were conducted and 32 trainers successfully completed the course in July and August, 1997 respectively. The CBD trainers were drawn from MOHP, NFPC, BLM, ACTION AID, Save the Children USA, Project Hope and the JSI-STAFH funded CBD projects. These CBD trainers are assisting the CBD agents with initial CBD training and refresher courses throughout the country including the 3 to 4 rounds of refresher courses for 9 NGO's. The Chichewa CBD Handbooks and CBD Manuals are very handy in training CBD agents in the central and southern regions of Malawi. However, the CBD projects in the northern region have to translate the content into Tumbuka before teaching thus increasing the work load on the trainers. Nine NGO's mentioned above trained 477 new CBD agents and new 115 supervisors (See Table 1).

c) **CBD Services**

The nine CBD Projects funded by JSI-STAFH were visited every quarter by the NGO Associates. This gave NGO Associates the an opportunity to monitor the progress in the implementation of content learned during the CBD training for both the CBD agents and, CBD supervisors and assistance was given where necessary. Only 9 CBD trainers were observed either during a refresher course or an initial CBD training. Secondary CBD supervisors supervise, primary CBD supervisors on monthly basis. Contraceptive supplies are given to primary CBD supervisors by the secondary CBD Supervisors at the clinic linked to the CBD agent. However, primary CBD supervisor's assist CBD agents on monthly basis and more after depending on needs of the CBD agents. The primary CBD supervisors supply contraceptives and supplies to CBD agents on monthly basis. The most common problems experienced by both CBD agents and supervisors are record keeping in client registers for the CBD agents and on contraceptive logistics form LMIS 02 respectively. The CBD supervisors know the required amounts of contraceptives the CBD agents need but not all contraceptive supplies were available. Since CBD guidelines were only developed after project proposals, funds were not adequate to buy equipment for CBD agents and supervisors. According to the 1997 NFPC Community Based Distribution of contraceptive services statistics annual report, NABW, Ekwendeni Hospital, Adventist Health Services and Malamulo Hospital provided FP services to 10, 421

new FP clients. (See Table 2) The number of subsequent FP clients for clients on oral contraceptives was 34, 431 and those using condoms were 11, 354 (See Table).

The Role of the Public Sector in CBD Work

MOHP provides technical assistance when establishing the CBD projects, by helping NGO's identify the undeserved areas, provision of family planning methods, provision of contraceptive logistics forms and monitoring and supervision of CBD agents. Since the government has many health centers, the health centres near the CBD projects, save as linkages for the CBD agents where clients can be referred for other family planning methods not provided by the CBD agent. The health center is a referral site for clients needing physical examination and for patients with side effects. In future when CBD projects increase, MOHP should consider training the health center FP Provider as an immediate CBD supervisor since the CBD agent is linked to that health center.

Accomplishments

- 477 new CBD agents and 114 supervisors have been trained.
- 213 peer educators were trained.
- 7 NGO's were trained in social marketing of Chishango.
- The following documents have been printed.

- CBD Guidelines 300 copies
- Chichewa CBD Handbooks 3000 copies
- Chichewa CBD Trainers Manuals 150 copies
- English CBD Curriculum 100 copies
- English CBD Handbooks 500 copies

- A six months supply of CDLMIS forms 01 to 04 were distributed to 9 NGO's with CBD projects.
- 828 CBD agents and 135 CBD Supervisors attended three to four rounds of CBD refresher courses.
- All 9 NGO grantees were monitored every quarter.
- 34 CBD trainers were trained.
- Bicycles for CBD supervisors, lockable boxes, raincoats, umbrellas, bags were distributed to CBD agents.
- 10,421 new family planning clients seen in 1997

ILLUSTRATION OF NUMBER OF FP CLIENTS SEEN

TABLE 2

NAME OF CBD PROJECT	NUMBER OF FP CLIENTS FOR 1997
NABW	3,229
EKWENDENI	2,880
AHS	2,671
MALAMULO	1,641
TOTALS	**10,421**

TABLE 3

ILLUSTRATION OF SUBSEQUENT FP CLIENTS AND CHOICE OF FP METHODS FOR 1997

NAME OF CBD PROJECT	ORAL CONTRACEPTIVES	CONDOMS
NABW	1,919	1,275
EKWENDENI	5,772	4,636
AHS	12,212	2,226
MALAMULO	14,528	3,217
TOTALS	**34,431**	**11,354**

TABLE 1

SUMMARY OF NGO CBD AGENTS TRAINED

NAME OF NGOs	TARGET	NEW		OLD		MALE MOTIVATION	TOTAL CBD
		CBDA	SUPERVISOR	CBDA	SUPERVISOR		
EKWENDENI HOSPITAL	20	34	14	90	40	62	124
PHWEZI	70	52	15	0	0	0	52
NKHOMA HOSPITAL	30	55	14	52	2	0	107
ST. ANNES HOSPITAL	120	78	11	0	0	0	78
WORLD VISION INTERNATIONAL	50	52	10	20	0	0	70
ADVENTIST HEALTH SERVICES	75	63	14	15	0	0	78
MALAMULO HOSPITAL	40	37	1	87	10	0	104
NATIONAL ASSOCIATION OF BUSINESS OF WOMEN	30	40	12	0	0	0	28
ADMARC	50	46	7	0	0	97	44
TOTAL	**485**	**477**	**115**	**351**	**52**	**159**	**657**

Lessons Learned

- If MOHP is involved in the planning phase of a CBD project and there is no staff turn over during the implementation phase of the project, the NGO's are supported throughout the implementation of the project.
- Non-health related NGO's can participate in FP services provision and HIV/AIDS education programs as long as they are backed by health personnel.
- Although most of the CBD agents are volunteers, it is becoming apparent that many CBD agents expect incentives.

Recommendations

- Monitoring and supervision of CBD agents and supervisors is essential.
- Refresher courses for 54 new CBD agents who were trained in April and May, 1998 are needed.
- CBD agents selected should be within the same location to assess the impact of the services and for easy monitoring.
- Evaluation of the impact of CBD training needs to be considered.
- Translation of the CBD curriculum into Tumbuka has not been done.

Issues

Follow-up of CBD trainers and trainees in MOHP and other organization has not been done.

NGO's IMPLEMENTING CBD_ACTIVITIES

OLD

- Ekwendeni Hospital
- Malamulo Hospital
- Nkhoma Hospital
- Adventist Health Services
- World Vision International

NEW

- NABW
- ADMARC
- St. Annes Hospital
- Phwezi Foundantion

MINISTRY OF HEALTH AND POPULATION
COMMUNITY BASED DISTRIBUTION (CBD)

PROGRAMME OVERVIEW AND FUTURE PLANS

A PAPER PRESENTED AT
STAFH TRANSITION CONFERENCE
Capital Hotel, Lilongwe - 30 September, 1998

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INTRODUCTION

The provision and utilisation of family planning services in most rural areas of many developing countries including Malawi is poor. The services are mainly offered through clinic-based approach. This approach has proven to be expensive for most of the developing world. In order to provide and promote the utilisation of Family planning services through such an approach, more facilities have to be established so as to ease accessibility to the community. Alternative strategies and approaches for delivery of services therefore have ben identified and tested with the active involvement of the community members, in the distribution of family planning contraceptives.

The worldwide experience over the years have shown that community based family planning programmes can be successfully implemented through properly instructed and adequately supervised village level workers with support from the health care delivery system.

Community Based Distribution system in the Ministry of Health and Population was first planned in the 1988-1992 family planning 5 year strategic plan as an alternative delivery system to clinic based, to make family planning services available at community level.

The pilot site was identified, Dedza East where baseline survey was conducted . The plan was to train CBDAs, TBAs and HSAs in distribution of contraceptives and clients motivation. This plan did not materialise due to some problems beyond the community control. However, the present draft Family Planning Strategy (1998-2002) has planned to expend and improve on CBD approach to cover all districts in Malawi.

General Objective

To increase Ministry of Health and Population health service delivery outlets offering high quality services and accessible family planning.

In 1992-1996 strategic plan the objectives were as follows: To make CBD a programme within FP programme not projects.

Specific Objectives

- To inform and educate the community to accept family planning
- To increase CBD sites from 21 to 45 by the year 1998
- To provide training to CBD agents, supervisors, trainers and managers
- To produce CBD reference materials
- To solicit local, national and international technical assistants, resources to support CBD programme
- To develop CBD guidelines and curriculum
- In each district to have two CBD trainers
- Consolidate existing CBD to reach under served and rural population

Organisation Structu

Reproductive Health Unit is headed by the Assistant Controller of Preventive Health Services who is the overseer of all reproductive health activities including CBD. The CBD Officer who directly reports to the SFHO ensures that activities on CBD are properly implemented, coordinates with other agencies, i.e. National Family Planning Council of Malawi.

At Regional level there is a Regional Family Health Officer and at District level there are family planning coordinators who are able to plan, implement, monitor and evaluate CBD activities.

Currently Ministry of Health and Population has the following CBD projects:

Lundu area in Blantyre with 18 CBD agents
Mimosa area in Mulanje with 59 CBD agents in 3 sites
Chionde area in Salima with 26 CBD agents in 2 sites
Misolo area in Mangochi with 19 CBD agents
Mitundu area in Lilongwe with 11 CBD agents
Tengani area in Nsanje with 15 CBD agents

Future Plans

In the present draft Family Planning Strategy (1998-2002) it has been planned to expand and improve on CBD approach to cover all districts in Malawi. Ministry of HEALTH AND Population is developing CBD Project proposal with the help of World Bank to expand the existing CBD projects.

- To look at incentives in order to reduce dropout and sustainability of programme
- Continued collaboration and coordination among stakeholders
- Supervision mechanisms especially provision of transport.
- To solicit funding for district CBD activities i.e. training, refresher courses

References

1. *Wolf A. W. et (1990) Beyond the Clinic Walls, Case Study in Community Based Distribution*

2. *Concept Paper on Community Based Distribution of Contraceptives*

3. *Family Planning Strategic Plan (1992-1996)*

4. *Reproductive Health Strategic Plan (1998-2002)*

APPENDIX 7

CONTINUITY OF JSI-STAFH PROJECT REPRODUCTIVE HEALTH SERVICES DURING THE TRANSITION PERIOD

BY

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SEPTEMBER, 1998

1. INTRODUCTION

The end of the JSI-STAFH Project presents challenges and opportunities for both donor agencies and service providers in Reproductive Health Care. The end brings challenges to donors, as there is a need to ensure that services that were provided with support from the JSI-STAFH Project are not discontinued especially during the transition period, and opportunities for providers to integrate provision of RH services supported by different donors

As Reproductive Health care is one of the priority areas for Malawi, the Ministry of Health and Population in collaboration with UNFPA will work with District Health Management Teams to ensure continuity of Reproductive Health services that were supported by JSI-Stafh Project. Priority components of Reproductive Health identified by the Ministry include

- Family Planning
- Safe Maternal Health Care
- Prevention and Management of STD/HIV/AIDS
- Prevention and Management of unsafe abortion
- Adolescent Reproductive Health

The UNFPA support for family planning services will continue in all the districts of the country, while provision of an integrated package of Reproductive Health service will be limited to four local impact areas namely: Mangochi in the Southern Region, Dedza and Mchinji in the Central Region and Nkhata-Bay in the Northern Region. In these four districts, the Ministry is attempting to institutionalise the concept of Reproductive Health to ensure that "each sexual activity is not coerced and free of infection; that each pregnancy is intended, and that childbirth is safe and free from injury". To meet this noble goal, the DHMTs and local leaders with support from National Reproductive Health Managers proposed the number of strategies to address priority components of Reproductive Health as identified by the Ministry.

2. DISTRICT REPRODUCTIVE HEALTH STRATEGIES

To ensure availability and accessibility of reproductive Health services to all people in the respective districts, the DHMT and their local leaders agreed upon the following strategies:

i) Institutionalising RH concept at district level
ii) Monitoring RH status of the district
iii) Improving the quality of RH care
iv) Improving access to RH services in the district
v) Strengthening community participation in RH care

Activities for implementing these strategies include:

- Integrating RH action plans within the district action plan.
- Assessing Reproductive Health Training Needs Assessment of different categories of health workers in the districts.
- Renovation of facilities to provide adequate space for RH services and storage of RH commodities and records.
- Integration of HIS monitoring during supervisory visit.
- Introducing referral feedback mechanism between TBAs and health facilities.
- Instituting confidential maternal death inquiry system.
- Provision of bicycle ambulances and radio communication for timely referral of obstetric cases.
- Provision of essential equipment and supplies including MVA equipment and contraceptives.
- Training of CBDAs and TBAs
- Training of health workers in obstetric life saving skills, family planning, STD syndomic management, postabortal care, counseling and adolescent RH care.
- Integrating FP services and STD management in all outreach clinics.
- Training of DHMTs and RH service coordinators in supportive supervision
- Training of local dram groups and bands for community based RH IEC.
- Provision community based RH IEC .

- Advocating for community support for RH services through meetings with local leaders and members of the District Development Committee.

- Training of Ward Clerks, Health Workers for proper collection compilation of and analysis of RH data.

3. STATUS OF IMPLEMENTATION

Implementation of the RH package of interventions commenced in 1997 and will cover the entire period of the current UNFPA Country program (i.e. 1997 to 2001). The budget for implementing these activities is USD 4,000,000. However, to implement all the activities identified by the districts an additional USD 2,000,000 is required and UNFPA are in process of soliciting for this money. The activities that have been implemented from 1997 and to date include:

- Procurement and distribution of essential equipment and supplies, TBA kits, including bicycle ambulances and radio communication for emergency referral of complicated obstetric cases.

- Development of a curricular for life saving skills training and training of health workers in obstetric life saving skills and family planning.

- Procurement of computers for Health Information System.

- Training of Data Entry Clerks and FP Coordinators in computer skills for HIS.

- Training of TBAs including construction of TBA huts.

- Procurement and distribution of contraceptives.

- Procurement of ordinary bicycles for supervisory activities of health center personnel.

- Reproductive Health Advocacy meetings with District Development Committee members from the four districts.

As implementation of the district RH plans is a continuous process, the UNFPA supported districts will incorporate any additional activities that were previously supported by JSI-Stafh Project. The National RH Program Managers will support the DHMTs with this task as it is important to ensure

that any demand for RH care that might have been created by JSI-Stafh Project is matched with continuous provision of services during the transition period

STAFH TRANSITION CONFERENCE

CAPITAL HOTEL, LILONGWE

30th September, 1998

STD AND HIV/AIDS EDUCATION AND SERVICES :

A STATUS REPORT

BY
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HIV/STD ASSOCIATE

ACRONYMS

AIDSCAP	AIDS CONTROL AND PREVENTION PROJECT
AIDSCEC	AIDSECRETARIAT
BLM	BANJA LA MTSOGOLO
CHAM	CHRISTIAN HEALTH ASSOCIATION OF MALAWI
CHSU	COMMUNITY HEALTH SCIENCES UNIT
CMS	CENTRAL MEDICAL STORES
CSW	COMMERCIAL SEX WORKERS
DHMTs	DISTRICT HOSPITAL MANAGEMENT TEAMS
DHOs	DISTRICT HEALTH OFFICERS
GUD	GENITAL ULCER DISEASE
GTZ	GERMAN FUND FOR TECHNICAL COORPERATION
HCWs	HEALTH CARE WORKERS
H/C	HEALTH CENTRE
HIS	HEALTH INFORMATION SYSTEM
HIV-NET	HUMAN IMMUNO DEFICIENCY VIRUS NET WORK
KCN	KAMUZU COLLEGE OF NURSING
KFW	(GERMAN DONATION)
LCH	LILONGWE CENTRAL HOSPITAL
MAM	MEDICAL ASSOCIATION OF MALAWI
MCHS	MALAWI COLLEGE OF HEALTH SCIENCES
MCM	MEDICAL COUNCIL OF MALAWI
MIS	MANAGEMENT INFORMATION SYSTEM
MNMC	MALAWI NURSES AND MIDWIVES COUNCIL
MOHP	MINISTRY OF HEALTH AND POPULATION
NACP	NATIONAL AIDS CONTROL PROGRAMME
NFPC	NATIONAL FAMILY PLANNING COUNCIL OF MALAWI
NGOs	NON GOVERNMENTAL ORGANISATIONS
OJT	ON THE JOB TRAINING
PVOs	PRIVATE VOLUNTARY ORGANISATIONS
QECH	QUEEN ELIZABETH CENTRAL HOSPITAL
RACs	REGIONAL AIDS COORDINATORS
STD	SEXUALLY TRANSMITTED DISEASES
UD	URETHRAL DISCHARGE
UNC	UNIVERSITY OF NORTH CAROLINA
UNFPA	UNITED NATIONS FUND FOR POPULATION AGENCY

BACKGROUND

As per the contract document the JSI- STAFH HIV/STD Unit was expected to carry out the following activities;

- Training of all HCWs in each district in STD management.
- Piloting STD activities in 3 to 6 sites throughout the country and then replicating the lessons to other areas.
- Supporting upgrading of laboratory facilities at reference laboratory and referral hospitals.

These activities were then translated into the operational plan of activities and processes. For each of the planned activities, progress will be discussed in tables stating the baseline, projections and current status followed by a discussion on actual activities undertaken. Furthermore issues/lessons, recommendations and proposed transition actions will be discussed in a separate table.

ACTIVITY	BASELINE	PROJECTION	STATUS
1. 50% increase of MOHP and CHAM providing comprehensive STD prevention and control services for female and male clients by 1998	1 (QECH)	22 hospitals providing STD prevention control service (50% of MOHP and CHAM)	32 hospitals providing STD services.

ACTUAL ACTIVITIES

The unit continued with some of the work that AIDSCAP had already begun as a basis for the programme. These activities were carried out in collaboration with NACP.

- A base line survey of STD case management was conducted in 1994 in collaboration with NACP. The survey showed shortfalls among HCWS

in knowledge, skills, condom promotion and distribution and also showed sub-optimal utilization of laboratory tests. These findings were presented at MAM meeting in Lilongwe, 8-9 April,1995, MOHP, at international conferences e.g. the Third HIV/AIDS Prevention Conference (USAID), Washington DC, 7-9 August 1995 and through publications and reports, e.g. International Journal of STD & AIDS July,1996; 7: 269-275.

- 3 NACP pilot sites were established in consultation with MOHP and JSI-STAFH and AIDSEC in 1994.These were QECH,LCH and Mzuzu H/C.The sites were identified basing on logistics that at least each region must be represented; some of the sites Eg.. QECH was already conducting studies and providing STD services to a lesser extent through Johns Hopkins University; in addition a high clientele also was a determining factor. The number of sites were then increased to 5 by 1995. The additional sites were Mangochi and Nkhatabay district hospitals. Since the other three sites were central and h/c facilities, there was need to learn from district hospital experiences. Hence, the establishment of these two other sites.

- Based on the antibiotic efficacy study conducted in 1992 on Gentamicin, Doxycycline, Erythromycin,Cotrimoxazole, Clavulanet, Amoxicillin,Probenecid,Trimethoprim and Ciprofloxacin a revision of management guidelines was carried out by an STD technical committee which was established by NACP in 1995. The review incorporated information from the validation study carried out in 1994 on vaginal discharge and other genito-urinary complaints in women. To this end 1,000 copies were printed and distributed to MOHP, CHAM, NGOs, PVOs, Health teaching institutions and other partner agencies.

The results are shown in table below.(Lule,1994)

Ineffective:	-APC Amoxicillin 3mg,probenecid 1gm,clavulanate 125mg orally single dose. -TMPSMX Trimethoprim 320mg/sulphamethoxazole 1600mg orally for 2 days (2 DS tabs once daily)
Effective	-APC-D APC plus doxycycline 100mg BD for 7 days -GENT Gentamicin 240mg IM single dose -CIPRO Ciprofloxacin 250mg orally single dose.

Based on both efficacy and cost ,gentamicin 240mg IM single dose was adopted as treatment of choice for gonorrhea with a cure rate of 95% in 1993.

- STD training documents were developed for training service providers and trainers in 1995. STD content was also incorporated in family planning training curriculum. Furthermore, STD content was incorporated in the pre-service curriculum for health teaching institutions and 26 tutors and lectures were given a three day orientation to syndromic client management. Following the above initiative, STD training manuals and reference handbooks were developed for MCHS, KCN and all Enrolled Nursing and Midwifery technician schools in 1997. Other learning and teaching materials were also supplied to some of the schools e.g. demopens, picture transparencies, flip charts, flow charts and management guidelines.

- Renovation of some rooms at NACP pilot sites like at Mzuzu H/C, LCH, and Mangochi to provide audiovisual privacy and the provision of furniture like tables, chairs, couch, lockable drug cupboard were also carried out .

- Supply of STD drugs to 5 NACP pilot sites.Two systems were introduced to the sites on drug storage and dispensing.Depending on hospital management decision ,more so in facilities that had standing STD clinics drugs were dispensed within the consultation rooms whilst in some drugs are dispensed at pharmacies.At QECH drugs are made available to providers at ANC and this allows for treatment on first contact and aviods long waiting hours by antenatal mothers and their partners.To effect

proper drug use and monitor quality of care rendered, a computerised MIS was established. More effort was put on assisting service providers to record and report on syndromes and consumption of drugs.The sites were provided with daily activity registers which were capturing the following variables: patient number; date; name; sex; age; client type whether it was a new visit ,revisit or partner to index patient; syndrome; any other diagnosis; medications and quantities dispensed; and remarks.On monthly basis the register forms were sent to JSI-STAFH for entry and analysis. Accompanying the registers were the monthly return forms which helped in reviewing the following : syndromes; quantities dispensed ; and total number of clients seen. In this case drug supply was based on actual consumption per site . Feedback through MIS summary reports were given to all the sites and interested parties biannually and sometimes when need arises.To elaborate on distribution of drugs below is a table showing a whole drug consignment to NACP pilot sites.

DRUGS AND SUPPLIES	QUANTITY SUPPLIED
Gentamicin (80mg vials)	158,000
Erythromycin (250mg tablets)	1,440,000
Doxycycline (100mg tablets)	871,000
Metronidazole (250mg tablets)	337,000
Benzathine Penicillin (2.4mu vials)	167,400
Sterile Water (10 cc vials)	167,400
Nystatin (100,000 unit pessaries)	1,650
Syringes (10 cc)	43,000
Needles (21 G)	43,000

Gentamicin had arrived with a short shelf life and could not be used before the expiry date in the pilot sites.Efforts were made to distribute to a wider range of users with a suspended USAID restriction on using the drug only on STD patients. However, 76,000 vials of Gentamicin had expired whilst at user

points and CMS. The other districts which were supplied with STD drugs were: Mchinji, Mulanje,Thyolo, Chikwawa, and Ntcheu. Some drugs like Benzathine Penicillin 39,300 vials and Erythromycin 536,600 tablets in March 1997 and Benzathine Penicillin 46,000 vials and water for injection 74,000 were supplied to CMS for distribution to all districts and CHAM units.

Due to some difficulties in procuring drugs by USAID, JSI-STAFH could not continue with the distribution and hence the hospitals continued supporting the pilot sites with their own drugs.This move was not appreciated by most of management in the sites.However, this was complimented by the KFW drugs donation to MOHP for STD treatment. Coincidentally,there was an improved drug availability at CMS and therefore hospitals could procure from there.

- STD services were then expanded to 5 other districts like: Chikwawa Mulanje, Thyolo, Mchinji, and Ntcheu. In these districts HCWs were trained in syndromic management, equipment was provided, initial drugs were also provided. There was minimum supervision to all STD activities in all the expansion sites by JSI-STAFH and AIDSEC. This was based on an assumption that the STD services are the same as any other service provided at a health facility.Therefore, the DHMTs were expected to provide the service providers with the required management support and supervision. The hospitals had difficulties supporting the programme more especially with drugs, consultation rooms with privacy, equipment and person power. In trying to further expand the services, HCWs from CHAM, NGOs, PVOs, Private companies and MOHP were trained in syndromic STD client management.

- Provision of equipment - all the 5 STD pilot sites were supplied with equipment to help the service providers examine and diagnose accurately using sterile equipment. The equipment was also supplied to 19 CHAM hospitals and 60 H/C. In addition, more equipment was procured for 22 MOHP District hospitals and 15 rural hospitals. This consignment is now being distributed to user points using a hired vehicle. (See details on page 18).

- Over 1,200 service providers were trained by 44 trainers using the old curriculum. These were drawn from MOHP, CHAM, NGOs, PVOs, Private companies, and the armed forces. The learners were mostly of

different background since the courses were held within their locality. This step was undertaken to avoid complete withdrawal of staff that provide a similar service from an already short staffed working environment.

- 2 briefing sessions on management guidelines for syphilis screening were held for DHMTs and laboratory personnel in November, 1996. This was also facilitated by a donation of reagents and Benzathine penicillin to ten NACP sites namely Mchinji; LCH; Rumphi; Karonga; Mzimba; Mangochi; Mulanje; Kasungu; Nsanje and Zomba by the then ODA. A mechanism for monitoring syphilis screening was put in place and AIDSEC was charged with the responsibility of monitoring through the RACs. A needs assessment was carried out with funding and technical assistance from JSI-STAFH. The national guidelines (MOHP) for the management of antenatal syphilis were revised allowing for fewer doses of penicillin per patient. In addition laboratory testing for syphilis (VDRL) was found to be unreliable at many sites throughout the country. A needs assessment has therefore been carried out on the quality of syphilis testing nationwide.

- Research studies were conducted to increase the body of knowledge for country- specific clinical presentations and behavioral studies for HIV/AIDS. Several clinical studies were conducted and these were as follows:
  - "Effects of STDs on HIV in semen", was conducted in January 1996, in collaboration with the University of North Carolina and funded by WHO. The study also measured the contribution of trichomonas to non-gonococcal urethritis and gentamicin efficacy in the treatment of gonorrhea. The findings were that trichomonas is responsible for 20% whilst chlamydia is responsible for only 2% of urethral discharge.

  - Genital ulcer study to determine the organisms that cause the disease. The specimens were shipped to UNC for laboratory analysis. Due to a mechanical error in the transferring media the specimens could not be further analysed. In view of this development the study will be repeated at the end of this year by HIV NET.

- Gentamicin efficacy study was conducted in 1996 and the findings were that the drug is still effective. The clinical efficacy data showed a trend towards resistance to gentamicin with a cure rate of 95% in 1993 and 92% in 1996, but the difference was not statistically significant. However another study was conducted in March 1998 and the analysis and final report are underway. In view of the change in trends of STDs and use of other second line antibiotics by various practitioners it is necessary to conduct an antibiotic efficacy study for all of the drugs used for STD treatment.

- Antenatal syphilis study where by JSI- STAFH was to assist AIDSEC was postponed indefinitely due to funding problems with Johns Hopkins University.

- Capillus Rapid HIV test was conducted in 1997. The report and findings of the study were disseminated to policy makers. AIDSEC was not in favour of the test due to the high sensitivity and low specificity.

- Technical assistance to AIDSEC and MOHP to formulate guidelines for more effective screening and treatment of CSWs for STDs was given.

- Consequently, AIDSEC has informed all RHOs, DHOs and medical directors of CHAM hospitals outlining the revised policy.

- Assisted AIDSEC in developing plans for annual Syphilis/HIV surveillance. JSI-STAFH has been funding the activity for 3 years, currently AIDSEC has already submitted its budget and JSI-STAFH is in the process of disbursing the funds.

- There has been dissemination of STD training and service delivery to senior officers in the government in order to share ideas and facilitate program planing and policy formulation. Furthermore, paper presentations were made at JSI-STAFH and partner agencies coordination meetings and during orientation for peace corp volunteer toAIDS activities.

ACTIVITY	BASELINE	PROJECTION	STATUS
2. All health care providers in each district trained in STD management (defined as doctors, clinical officers, medical assistants,RN and ENM)	0	Approximately 960 (40 per district)	-1,200 STD service providers were trained -44 STD trainers -26 health educators RETRAINING (1998) -28 trainers for service providers -10 trainers for supervisors -11 supervisors -105 service providers.

ACTUAL ACTIVITIES

- As discussed earlier on training handbooks were developed and had incorporated recommendations made from the baseline survey, antibiotic efficacy studies, and revised management guidelines.

- Briefing sessions were held in all the three regions to management on the syndromic client management.

- Efforts were also made to increase capacity of AIDSEC and in 1995 the NACP STD Officer was sent to Boston University for a Masters degree course in Public Health. The officer's salary was met by USAID

- A national training of trainers workshop was held in December 1994 involving 18 participants.These trainers trained approximately 200 HCWs. In the pilot sites STD content was incorporated in the revised FPPTC. In view of this 18 family planning trainers were trained in STD syndromic client management in order to effectively integrate STDs in FP services.These trainers were drawn from MOH family planning training centers, BLM, Project Hope, and NFPC. In September 1996, a refresher course for the18 trainers was conducted and an additional 23 new

trainers were trained by a consultant from South Africa, education specialist and NACP and JSI-STAFH personnel .

- These trainers trained 1,200 service providers drawn from MOHP, CHAM, NGOs, and Private companies. The courses were mostly conducted in 3 or 4 days.The courses were held within the districts and were expected to reach H/C HCWs. Selection of participants to the course was done by management within the units. Based on person power per district a decision was made that HCWs of different background could be trained in the same course in order to avoid denying patients services that are rendered by certain groups of people at a facility. During the training participants had 3 or 4 days of theory without practicals.Upon course completion learners were certified and had a manual for reference. It was then expected that their immediate supervisors will be in a position to supervise STD services in their respective units.

- Monitoring and supervisory visits were conducted on quarterly basis to the 5 NACP pilot sites.Two supervisory tools were developed and pretested in1996. An intensified supervision using the tools was carried out more especially on performance of service providers and OJT was always provided. During the visits client/provider interaction was being observed, equipment and drugs were supplied and monitored, infection control was reinforced, partner notification and management and documentation was reviewed. Feed back was given to sites through MIS reports which was depicting treatment accuracy using the two WHO indicator syndromes of GUD and UD. However reports from the pilot sites for the period of July to December 1997 and January to June 1998 are being analysed. The delay was due to the illness and death of the Data Entry clerk .

- In 1997 MOHP in conjunction with JSI-STAFH conducted an evaluation of the extent to which STD service providers were correctly implementing the syndromic approach to STD management throughout the country. This revealed deficits in diagnosing, treating, and supervision.The recommendations made were : upgrading of training and increasing level of supervision.

The conclusion was based on the fact that staff at pilot sites supported by regular visits from JSI-STAFH personnel performed significantly better, e.g.

	PILOT	NON PILOT
correct use of algorithms	56%	25%
treatment accuracy	67%	17%

The final report was printed and 85 copies were distributed to all key players in STD /HIV program.

- Following the evaluation a major activity was undertaken to revise the training manuals for trainers and service providers.In brief the handbooks have incorporated research study recommendations ,help to prepare the service provider, to review the context in which they work, bring in a humanistic approach to service delivery, empower the provider to communicate effectively and assist clients with negotiation skills for introducing safe sex practice and reviewing their role in the community In trying to improve quality of care in STD service delivery, an in- built graduate and programme monitoring and evaluation system was established through development of 2 supervisory handbooks for trainers of supervisors and supervisors of STD services.

- In view of all the revisions and developments in STD training, a strategy was developed which is as follows:

  -orientation of DHMTs to STD client management and training to promote ownership and support.
  -development of District/hospital STD work plans
  -training of STD trainers for 2 weeks
  -training of trainers of supervisors for STD services for 1 week
  -training of supervisors for 1 week
  -training of service providers for 2 weeks

-in service education to maids/servants on symptom recognition and where clients could seek STD services on the job.
-community participation in STD programme activities as and when necessary. (See diagrammatic illustration on page 20)

- In implementing the plans JSI-STAFH in collaboration with NACP and NFPC have conducted orientation workshop of DHMTs from 8 districts/hospitals; STD work plans have also been developed, what is required is to convene a meeting to formulate implementation strategies with donors and coordinators. So far with the current approach to training, a few HCWs have been trained (see table on page 9) These were drawn from 5 NACP pilot sites 3 UNFPA local impact areas,3 CHAM units and 10 private companies. In addition, 42 other service providers have been trained in Mzimba and Mangochi.Technical assistance was provided in the form of trainers, teaching and learning materials.To this end not many service providers have been retrained due to unavailability of funds at AIDSEC to conduct nationwide training of HCWs in various courses for STD programme. In an effort to assist AIDSEC obtain funds from USAID a scope of work for strengthening STD training and service delivery was developed by JSI-STAFH HIV/STD unit and was reviewed and submitted by AIDSEC to USAID. Nevertheless, with the current changes in STD program and phasing of JSI-STAFH the funds have not been made available, hence delays in training.

- Training documents have been pretested and adopted for training in Malawi, more so the supervisory documents and system. The training documents are as follows:- Managing People With STDs In Malawi: A Handbook for;
  - -Trainer of STD service providers
  - -Service providers
  - -Trainer of supervisor of STD services
  - -Supervisor of STD services

  As discussed above, not many copies of the handbooks were printed and this affected plans for STD training for other partner agencies for they were requested to meet printing costs or wait until funds were available to AIDSEC.

- Three preservice documents have also been developed for MCHS, KCN, and Enrolled nurse midwifery technician schools and are currently in use. However, the tutors and lecturers require training in STD syndromic management. Performance of students on STD questions during council examination 1998 was below standard and could be attributed to inadequate preparation of the educators or other factors which are yet to be established.

ACTIVITY	BASELINE	PROJECTION	STATUS
3. 3-6 pilot sites for STD activity initiated	1	4	5 facilities with STD activity initiated.QECH, LCH,Mzuzu, Nkhatabay and Mangochi.

ACTUAL ACTIVITIES

- Establishment of pilot sites in collaboration with MOHP and AIDSEC
- Renovations and furnishing of rooms to provide privacy and security for drugs.
- supply of drugs and equipment (see pp 4-6)
- maintaining MIS for drugs and quality of care by assessing accurate diagnosis and treatment, partner notification and management, condom promotion and distribution.
- Provision of patient and provider reference materials e.g. desk reference cards,a set of male and female flipcharts, STD leaflets, demonstration penis, partner notification slips or rubber stamps and ink pads, management guidelines, and training handbooks.

- Training of different groups of HCWs more especially service providers and supervisors.(see table on page 9)

- Monitoring and supervision was conducted on quarterly basis by JSI-STAFH and AIDSEC.(see details on page10)

ACTIVITY	BASELINE	PROJECTION	STATUS
4 Laboratory facilities at the reference lab and referral hospital upgraded	0	1 reference lab 1or 2 reference hospitals(.part of the 50% target)	nil

ACTUAL ACTIVITIES

- A needs assessment was conducted by the National Laboratory Officer of NACP with financial assistance from JSI- STAFH and had compiled a list of laboratory requirements including training needs at each district hospital.

- A quality control study was conducted by Professor G. Liomba which revealed that the laboratories and skills of laboratory personnel were of substandard and had recommended on training and upgrading of the laboratories with equipment.

- A list was submitted to JSI-STAFH however procurement was not done due to inadequate funds.

- Some work was already done at QECH laboratory in terms of equipment procurement and training by The Johns Hopkins University project and a similar upgrading of LCH laboratory was expected to be done by the HIV-NET UNC project.

- A review of the reference laboratory at CHSU was also made and it was found that the necessary materials and equipment was available.In respect of this activity GTZ was also interested in it .It was therefore

concluded that MOHP (CHSU),GTZ and JSI-STAFH should work in collaboration. However not much progress has been made.

ACTIVITY	BASELINE	PROJECTION	STATUS
5. STD management improved in "food handlers"clinics	0	-	Technical assistance to AIDSEC and MOHP in formulating the "food handlers" policy

The 4 year period has seen the above achievements and the following table summarises issues/ lessons, recommendations, transition actions and proposed responsible agencies

ISSUES/LESSONS	RECOMMENDATIONS	TRANSITION ACTIONS	RESPONSIBLE AGENCY
Lack of STD policy and service standards	Formulation of policy and service standards	Identify areas requiring attention	AIDSEC/MOHP DONOR/MNMC/ MCM.
Inadequate numbers of trained STD service providers	Train and retrain HCWs	Identify funds for printing training materials	AIDSEC/MOHP Donor
The efficacy of other STD drugs not yet established	Conduct efficacy studies for all antibiotics	Establish a system for efficacy studies	AIDSEC/MOHP CHSU
Syndromes not captured in HIS	Revise HIS to incorporate the syndromes	Determine areas of intervention	AIDSEC /MOHP CHSU

60% of STD clients reporting at STD clinics will have been to a Traditional healer	-Increase collaboration between Traditional healers and HCWs -Establish a referral system	Conduct consultative meetings with the herbalist association of Malawi	DHO/Traditional healers
Lack of job descriptions	-Develop job descriptions -Orient HCWs to their job descriptions	-Establish task force to revise /develop job descriptions -Advocate open appraisal system	MOHP/AIDSEC
Antenatal syphilis screening not done in most centers	-Procure laboratory equipment -Train laboratory assistants -Screen all antenatal mothers	-Identify funds -Review plans for partner management and new born babies in postnatal wards	AIDSEC/MOHP DONOR
Inadequate supervision of STD services	-Increase supervision at all levels -Train supervisors -Advocate team approach to supervision	-Adopt supervisors training documents -Establish teams -Orient DHMTs to supervision	DHO/MO/AIDSEC MOHP
Limited capacity of AIDSEC to coordinate STD national activities	-Increase capacity of AIDSEC	Identify gaps and make plans to fill those gaps	MOHP/AIDSEC DONOR
Lack of district STD work plans	-Orient DHMTs to STD client management. -Assist DHMTs to develop work plans	-Identify funds for orientation -Convene meeting with all partner agencies	AIDSEC

Syphilis and HIV/AIDS trends are not static	-Continue with annual national surveillance of Syphilis and HIV in antenatal mothers	-Identify funds -Incorporate findings in policy development and programme planning	AIDSEC/MOHP/ Donor
Lack of second line STD treatment in Government facilities	-Introduce second line treatment on pilot	-Needs assessment -Follow up of patients coming for retreatment	AIDSEC/MOHP
Health care workers face difficulties in discussing sexual health and safer sex practices	-Empower HCWs through training	-Emphasize the areas during training	AIDSEC/MOHP
Training learners of different backgrounds in the same course	-Continue with the current approach to training	-Review advantages and disadvantages in relation to staffing, training venue and financial implications	AIDSEC/MOHP

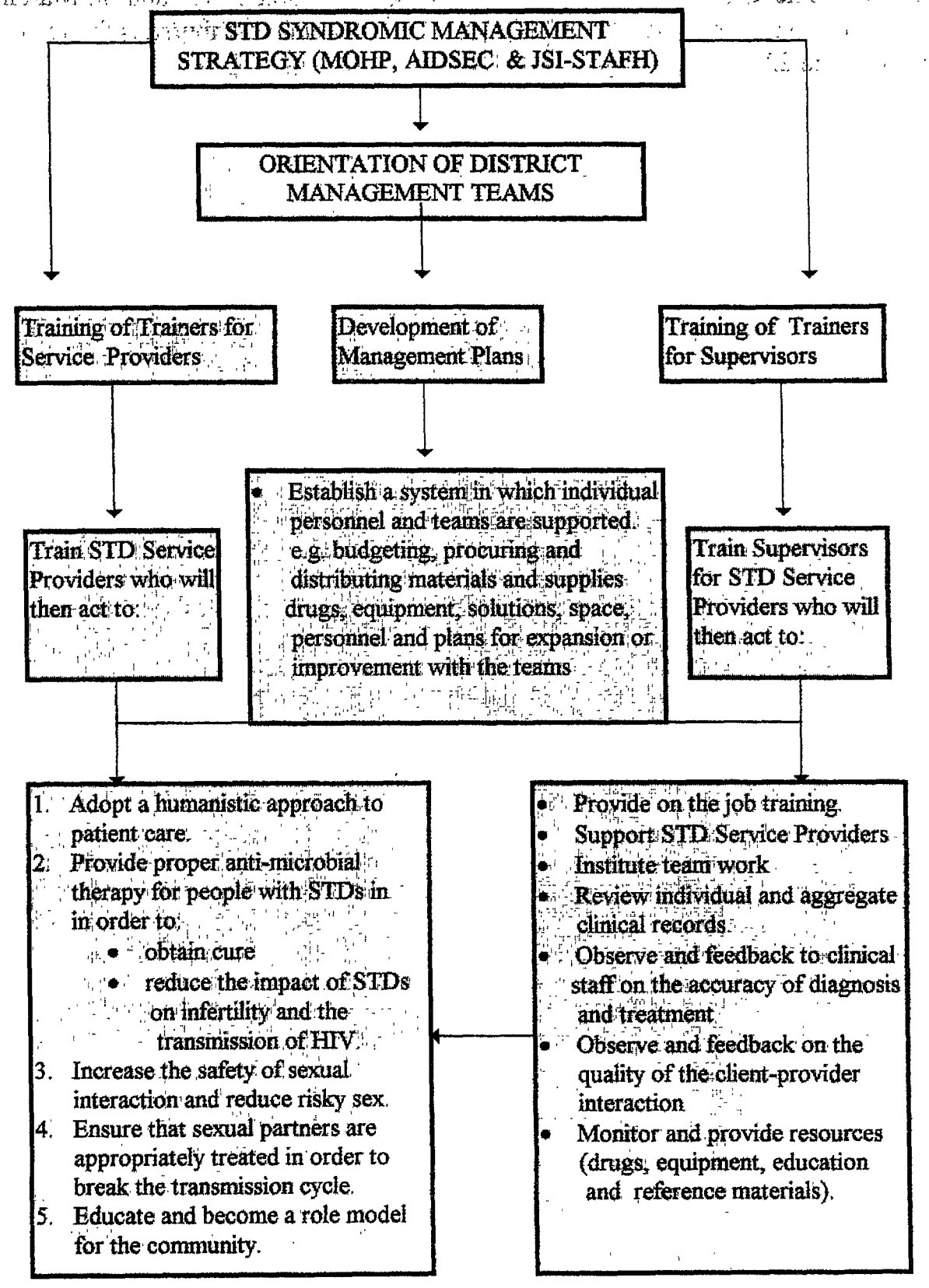
DISTRIBUTION OF EQUIPMENT

A standard kit for STD equipment was reached in collaboration with AIDSEC. The following were the recommended list of items per kit.

ITEM	QUANTITY
Trolley	1
Examination light	1
Specula- S	2
Specula- M	5
Specula- L	10
Tray with covers-L	2
Gallipots-M	2
Receivers- M	2
Cheatle container	1
Cheatle forceps	5
Basins	1
Sterilizer	1
Torch	1
Pedal bin	1

It was then noted that the sterilizers did not have electrical codes and hence they needed external heat source. A quick assessment was made at user points finding out whether they have electricity or not. This therefore had necessitated JSI-STAFH to purchase either hotplates or paraffin stoves more especially for the rural hospitals.
Equipment was procured in two phases: the first consignment was for the 5 NACP pilot sites and JSI- STAFH NGO Grantees. Under listed below are the facilities that were supplied with the first lot: - LCH, QECH, Mzuzu H/C, Nkhatabay ,Mangochi, Phwezi (5H/C), Malamulo, WVI (5 H/C), AHS (15 H/C), and Cobbe/ ADRA .
The other lot went to 16 Units under CHAM and these are: Phalombe; Trinity; Mulanje; Montfort; Mlambe; St. Lukes; Likuni; Madisi; St Gabriel; Kapiri; Mua;

Mtengowanthenga; Katete; David Gordon Memorial; Embangweni and St. Martins. The second consignment which has just arrived and is being distributed is for 15 rural hospitals and 22 district Hospitals for MOHP.


STD SYNDROMIC MANAGEMENT STRATEGY (MOHP, AIDSEC & JSI-STAFH)
ORIENTATION OF DISTRICT MANAGEMENT TEAMS
Training of Trainers for Service Providers
Development of Management Plans
Training of Trainers for Supervisors
Train STD Service Providers who will then act to:
• Establish a system in which individual personnel and teams are supported. e.g. budgeting, procuring and distributing materials and supplies drugs, equipment, solutions, space, personnel and plans for expansion or improvement with the teams
Train Supervisors for STD Service Providers who will then act to:
1. Adopt a humanistic approach to patient care.
2. Provide proper anti-microbial therapy for people with STDs in in order to:
• obtain cure
• reduce the impact of STDs on infertility and the transmission of HIV
3. Increase the safety of sexual interaction and reduce risky sex.
4. Ensure that sexual partners are appropriately treated in order to break the transmission cycle.
5. Educate and become a role model for the community.
• Provide on the job training.
• Support STD Service Providers
• Institute team work
• Review individual and aggregate clinical records.
• Observe and feedback to clinical staff on the accuracy of diagnosis and treatment
• Observe and feedback on the quality of the client-provider interaction
• Monitor and provide resources (drugs, equipment, education and reference materials).

APPENDIX 9

BUILDING NGO CAPACITY FOR EXPANDED F/P, STD & HIV/AIDS PROGRAMS: A STATUS REPORT

USAID CONTRACT NO. 623-0238-C-00-4058.00

PREPARED BY:

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30 SEPTEMBER 1998

BUILDING NGO CAPACITY FOR EXPANDED FP, STD AND HIV/AIDS PROGRAMS: A STATUS REPORT

1. Introduction

The JSI-STAFH was mandated to fund 24 NGO grants with a budget of US$ 2.4million for F/P, STDs, HIV and AIDS. To date 24 NGOs have been funded and budgets for these NGOs have ranged between $23,000 to $136,000. NGOs have been found to share the commitment and dedication to helping the Malawi Nation face the challenge of AIDS and rapid population growth.

The grants were awarded and signed for as follows:

7 NGOs in January 1996
6 NGOs in June 1996
4 NGOs in July 1996
6 NGOs in August 1996
1 NGO in October 1996

These Projects were to be funded up to June 1998, and as you can see from the dates that the grants were awarded, the duration of the projects varied between 18 months to 30 months. For the young, new and unexperienced NGOs time was also lost as they tried to put things in place before the project could take off.

2. Grant development process

JSI-STAFH developed a set of criteria for identifying the NGOs who had the potential to develop and implement projects in any of STAFH Project priority areas which were in IEC, F/P, HIV/AIDS and STDs prevention education and research. JSI-STAFH worked with CONGOMA and other NGOs such as CHAM to identify active NGOs. These NGOs were then informed about the JSI-STAFH and the grant opportunities. They were requested to complete a Rapid Institutional Assessment (RIA) questionnaire and based on the results, the selected NGOs were asked to select their proposed project's from the list of STAFH projects priority areas.

On 16th February 1995, in Blantyre the NGO grants programme was officially launched. Following this activity 3 workshops were conducted in 1995 at which 38 participants from 28 NGOs were assisted in developing their grant proposals. Other NGOs which could not attend the workshops were assisted on a one to one basis. STAFH members and consultants were assigned to the NGOs to continue assisting in the development of the proposals. NGOs were required to discuss their planned activities with the DHO or other relevant authority and to obtain a letter of endorsement in their proposal. Once the proposal had been developed, it was reviewed by STAFH Project Review Team and later on sent to the Proposal Review and Approval Committee (PRAC) for guidance and ultimate approval. PRAC was established in 1996 as an independent committee

comprising of AIDSEC, National Family Planning Council (NFPC), Ministry of Health and Population (MOH/P), CONGOMA (represented at their request by CHAM), USAID and JSI-STAFH. During the PRAC meetings, JSI Financial Advisor provided a report regarding the NGO financial capacity to manage and account properly for any funds provided and in some instances recommendations to hire a qualified accountant or provision of office equipment was accepted.

Finally, with all the PRAC comments and other changes incorporated, a revised proposal was sent back to the NGO for review and concurrence. If accepted to both parties, project agreement was signed, funds were advanced, the project initiated and JSI's role became one of monitoring and supervision.

3. The Implementation Stage

Since funding of the 24 NGO grants in 1996, two NGOs have been terminated. The NGOs have implemented various activities which included service delivery, behaviour change and media. During this stage the role of the NGO Program Unit has been:

- Provision of technical assistance directly by the NGO Program Unit.
- Provision of technical assistacne through services of other JSI personnel in:
  - * private sector involvement
  - * STD/HIV
  - * IEC
  - * Behavioural research
  - * FP quality assurance
  - * Logistics
  - * Financial management
- Provision of training
- Procurement and distribution of office, clinical, and other equipment:
  - * Computer sets
  - * Photocopiers
  - * Audio-visual sets
  - * FP and STD clinic equipment sets

- Facilitation of exchange/transfer of experience:

  * Quarterly meetings
  * International study/observation tours
  * Sponsorship of participation in/presentation of papers at national and international conferences

- Tracking, monitoring and supervision of field activities. This was done on quarterly basis.

During these quarterly visits to the NGOs several weaknesses were identified mainly on programmatic and financial management. In order to address such weaknesses, quarterly exchange of experiences meetings were initiated and conducted. These one and a half to two days meetings provided fora for learning from each other and an opportunity for personnel of JSI-STAFH to provide technical assistance. Most of the NGOs were found to have problems in following JSI-STAFH financial procedures and policies, and a two days financial management system workshop was organized and proved a success.

As we continued to work with the NGOs, it became apparent that Capacity Building (CB) of NGOs was required to be undertaken to improve the NGOs management capacity to deliver the F/P, STD & HIV/AID prevention education and services. Since CB was not an activity in the original plan, funds were not enough to implement this activity for all the 22 NGOs. It was then agreed that only 8 NGOs would be selected for CB and they were selected using a set of criteria. JSI-STAFH hired a Management Associate to undertake this activity. The process that these selected NGOs have gone through to reach where they are with CB has been;

- Initial visits to NGOs to solicit their views regarding the Capacity Building exercise. All the NGOs accepted and welcomed the idea.

- Institutional Assessment was conducted with 7 NGOs except one.

- Strategic plan workshops for each NGO were conducted and strategic plans developed.

- First 90 days implementation plans developed.

- Most of NGOs have started implementing their 1st 90 days implementation plans.

As the Management Associate continued with the 8 NGOs, it was observed that skills in proposal writing and fund raising for sustainability of NGO be provided. It is pleasing to say that Ekwendeni and St. Anne's Hospital have had a workshop on proposal writing and 5 other NGOs had conducted a workshop on fund raising. The document that was produced at the fund raising workshop has been distributed to all 22 NGO grantees for their information.

4. Accomplishments

- All the NGOs were able to implement the activities that they had planned to be executed under JSI-STAFH grant and these were:

  - Family planning services - clinic based.
  - Community based Family Planning services (CBD).
  - Social marketing of "Chishango" condoms.
  - STD treatment and HIV/AIDS and STD prevention education.
  - Research.
  - Development of IEC materials.
  - Peer education.

- 24 NGOs funded and supported. Compared to the budget of $2.4million, $1.9million has been disbursed to date to the NGOs. In addition, $0.5million has been spent on activities benefiting more than one NGO.

- 421 health care providers trained in STD syndromic case management.

- 79 NGO hospitals and clinics providing FP and/or STD syndromic services.

- Institutional assessment of 8 selected NGOs completed, with active involvement of stake-holders.

- Five-year strategic plans developed for 8 selected NGOs, including implementation plans for first 90 days and year one.

- 213 Peer educators were trained.

- 101 community volunteers for Family Planning education messages were trained.

- 108 community volunteer for STD, HIV and AIDS prevention education were trained.

- 13 NGOs were trained in condom social marketing and they are involved in condom social marketing.

- All 24 NGO were supervised and monitored every quarter.

- An internal midterm project review was done.

- Financial audit by an external financial firm was done.

- Coordination and Involvement of AIDSEC, MOHP and NFPC.

  - Participation in PRAC meetings.

5. Lessons Learned

NGOs have a good track of innovative ideas and commitment in working with the community at grass root level in implementing programs and this is the case with JSI-STAFH grantees who have been seen to significantly complement public sector in extending the coverage and accessibility of Family Planning, STD & HIV & AIDS programs. From the selection process of the NGO grantees to the implementation stage, few lessons have been learnt.

- Proposal Review and Approval Committee (PRAC) constituted an important committee in guiding the NGO Grant Unit regarding NGO grantees.

- The opportunity of quarterly exchange of experiences meetings for NGOs enhanced their morale and commitment to project implementation.

- Non-health related NGOs can participate in FP service provision and HIV/AIDS and STDs prevention educational programs.

- Any young and inexperienced NGOs included non-health related NGOs require technical assistance.

- NGOs had written unrealistic targets regardless of duration of the projects and their management capacity.

- Donors financial policies and procedures need to be clearly explained at the inception of the project if funds are to be accounted properly.

- NGOs provide services which would otherwise not be provided, and can improve and extend such services if given CB support.

- Institutional assessment is essential before a development of strategic plan.

- In view of limited human resources, capacity building should be designed to avoid overloading individual personnel.

- Program and institutional objectives should be based on staff levels and capabilities. As staff levels and capabilities are increased, activities can be expanded accordingly.

- In view of limited human resources, capacity building should be designed to avoid overloading individual personnel.

6. **Transition of activities**

Activity	Responsible Organization
1. Training of STD Supervisor in Supervision.	AIDSEC DFID
2. Refresher training for STD service providers.	AIDSEC DFID
3. Funding & Technical Assistance to 8 NGO for the implementation of strategic plans.	CABUNGO- Concern Universal Donors

7. **Recommendations**

1. Proper orientation on donors financial policy and procedures and program management. This should take a form of workshop lasting for 2 days.

2. Donors must be willing to fund accounting personnel cost.

3. NGO quarterly exchange of experience meetings should be conducted inorder to address NGOs issues and provide other Technical Assistance.

LIST OF NGOs THAT RECEIVED STD EQUIPMENT

1. Malamulo Hospital
2. Ekwendeni Hospital
3. Adventist Health Services
4. St. Johns Hospital
5. St. Anne's Hospital
6. Cobbe Barracks
7. Tea Association of Malawi
8. ADMARC
9. Nkhoma Hospital
10. World Vision International/Malawi
11. Phwezi

12. CHAM

* Phalombe Hospital
* Trinity Hospital
* Mulanje Hospital
* Montfort Hospital
* Mlambe Hospital
* St. Lukes Hospital
* Likuni Hospital
* Madisi Hospital
* St. Gabriel Hospital
* Kapiri Hospital
* Mua Hospital
* Mtengowanthenga Hospital
* Katete Hospital
* David Gordon Memorial Hospital
* Embangweni Hospital
* St. Martins Hospital

STAFH TRANSITION CONFERENCE

Capital Hotel, Lilongwe
30th September, 1998

FP, STD AND HIV/AIDS PROGRAMS IN THE PRIVATE SECTOR: A STATUS REPORT

By

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25th September, 1998

ACRONYMS

ADMARC	Agricultural Development and Marketing Corporation
AIDS	Acquired Immune-deficiency Syndrome
B&C	Brown and Clapperton
BLM	Banja La Mtsogolo
ECAM	Employers Consultative Association of Malawi
ESOM	Electricity Supply Commission of Malawi
FP	Family Planning
HIV	Huma Immune-deficiency Virus
JSI	John Snow Incorporated
KFCTA	Kasungu Flue Cured Tobacco
MACRO	Malawi AIDS Counselling and Resource Organisation
MOHP	Ministry of Health and Population
NACP	National AIDS Control Progrmme
NFPC	National Family Planning Council
NGO	Non Governmental Organisation
NSCM	National Seed Company of Malawi
OILCOM	Oil Company of Malawi
PVO	Private Voluntary Organisation
SOBO	Southern Bottlers
STAFH	Support to Aids and Family Health
STD	Sexually Transmitted Diseases
SUCOMA	Sugar Corporation of Malawi
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WPTF	Work Place Task Force

LIST OF TABLES

1. BACKGROUND

JSI-STAFH, in its four year contract assisted the government in implementing policies and programs that Malawians have developed in order to reduce total fertility and HIV/AIDS/STD transmission through increasing contraceptive prevalence rate and promoting behavior change.

In order to achieve the above goal, JSI-STAFH targeted employed males for special attention in STD/HIV and family planning. These men have additional income which put them at risk. They also have a major decision making role in matters of family planning.

The activities included in the project were designed to improve and expand knowledge about, and provision of services for Family Planning and AIDS prevention through the Private Sector which has a labour force of approximately 380, 000.

To this end the following were JSI-STAFH contractual targets:

- Reach 90% of companies with 300 or more employees (about 186 companies)
- Increase by 64 the number of private sector facilities that have FP and STDs clinics (to 70).
- Increase by 24 the number of Private Practitioners that have FP services (to 34)

2. RANGE OF ACTIVITIES AND ACCOMPLISHMENTS

In order to reach the planned targets a number of activities were planned and implemented. It should be noted that it has taken much longer than planned to develop the private sector program. However, the momentum has been built and there is now greater interest and receptivity on the part of companies which are begining to request assistance on their own initiative.

2.1 Family Planning Promotion and Services

JSI-STAFH focus on private sector FP promotion and services was on supporting the incorporation or upgrading of core service capability at an additional 64 private sector facilities and the integration of core FP service capability at an additional 24 private practitioners facilities.

To this end the following activities were planned.

- Incorporate core FP service capability in the private sector
- Identify registered private sector clinics in liaison with medical council
- Conduct a needs assessment of HIV/AIDS/STDs and FP service delivery through the private commercial sector and private medical practitioners in Malawi. This assessment was meant to establish the basis for further assistance to be offered to private sector companies to facilitate development of FP, STD and HIV/AIDS programs and service
- Distribute FP equipment to private sector facilities.

Accomplishments

- 8 companies provide core FP services
- A needs assessment of HIV/AIDS/STDs and FP services delivery through the private sector and Private Medical Practitioners in Malawi has been conducted. The recommendations arising from this study emphasize on the provision of adequate, appropriate and standardized training on STD and FP service management; to upgrade the capability of these health facilities to provide wider ranges of STD and FP services including VSC; and to assist encourage the private sector to properly keep records of their patients and clients and do regular monitoring and evaluation of their services.

Table 1 ***Transtion actions family planning promotion and services***

Activity	Proposed Organisation
♦ Incorporate core FP service capability in the private sector	NFPC
♦ Defining the selection criteria for private sector health facilities to be provided equipment	NFPC
♦ Distribution of clinical equipment for core FP to private sector health facilities	NFPC
♦ Training of FP providers in the private sector	NFPC

2.2 STD Prevention Education and Control

In this area the target group is composed of men employed in industries and agricultural estates. They have disposable income, are sexually active, often have STDs and usually have permissive sexual norms. JSI-STAFH focus on private sector STD prevention and control had been the improvement of STD services (diagnosis, treatment, counseling, partner notification) in private industry and estate clinics and in private health facilities. The major activities include

- Assist the private sector in the procurement of STD drugs
- Assist the private sector to design, implement and monitor the STD referral system
- Train private sector health workers in STD syndromic management
- Conduct a study on the cost implication of HIV/AIDS in 2 private sector companies

Accomplishments

- One STD syndromic Management course for health care workers from the private sector was held. A total of 12 participants were drawn from PEW, David Whitehead and Sons, Limbe Leaf Tobacco, Illovo Sugar Company

- (SUCOMA), Reserve Bank, Press Corporation, Blantyre Print and Packaging, Portland Cement and Jika Private Clinic

- Two research studies on the cost implication of HIV/AIDS (B&C and Makandi Estates) were conducted to motivate management of private companies to develop in house policies for implementing HIV/AIDS prevention programs in the work place. The results of the two studies indicate an increase in the annual cost of medical services, death in service benefits and absenteesim

Table 2 ***Transtion actions on STD prevention and education***

Activity	Proposed Organisation
♦ Assist private sector in procuring STD drugs	NACP/NFPC
♦ Train more private sector health workers on STD syndromic management	NACP/NFPC
♦ Assist the private sector to design, implement and monitor the STD referral system	BLM/NACP
♦ Develop tools for conducting the cost implication of HIV/AIDS in the private sector	NACP/NFPC

2.3 Integration of Family Planning and STD/HIV/AID

The focus in this area had been on assisting private sector to initiate or strengthen FP, STD and HIV/AIDS programs. To this end the following activities were planned.

- Establish a Work Place Task Force (then known as Private Sector Task Force)
- Develop an integrated strategy plan which would form the basis for integrating the education and/ or services on HIV/AIDS and FP provided to private sector

- Assist through TA and workshops private sector organizations to provide FP, STD and HIV/AIDS services
- Develop a 'boiler plate' strategy to guide private sector companies in planning or replanning the establishment of FP, STD and HIV/AIDS programs in their company activities.

Accomplishments

- A Work Place Task Force (WPTF) was established which comprises family planning and HIV/AIDS prevention organizations. These include NACP, NFPC, JSI-STAFH, USAID, Project Hope, Banja La Mtsogolo, Population Services International, Save The Children (US), Employers Association of Malawi, Malawi Congress of Trade Unions, EU AIDS Project, Limbe Leaf, ESCOM, International Eye Foundation, Thandizani Moyo (Tea Estates), MACRO, Ministry of Labour. The Task Force Secretariat, previously located at JSI-STAFH has been transferred to the NFPC. The task force is co-chaired by NFPC and NACP. This is a major accomplishment in coordinating the approaches to the private sector companies and maximizing the resources for private sector programs.

  In addition it serves to bridge the gap between the private sector and the government for the provision of HIV/AIDS and FP education and services (see Table 3 on the role of the WPTF).

Table 3 **The role of the Workplace Task Force**

- With AIDSEC coordinate AIDS activities in the work place
- With NFWC coordinate Family Planning activities in the work place
- Provide technical assistance on HIV/AIDS and Family Planning to the work place
- Establish a link with the private sector and MOHP
- Evaluate work place HIV/AIDS and Family Planning activities
- Integrate Family Planning and HIV/AIDS
- Prepare work place guidelines
- Maintain a database for private sector companies

- A Community Services Strategy Document for HIV/AIDS & Family Planning was developed for designing, implementing, monitoring and evaluating FP and HIV/AIDS services in the workplace. This document is a component of the JSI/STAFH Project and supports the national plans developed by the Malawi Government to introduce integrated reproductive health programs in the private or parastatal organizations and estates. The Strategy provides a comprehensive model for introducing and implementing HIV/AIDS and FP programs in the work place.

- A data base of all companies in Malawi with over 300 employees is documented and computerized for use by the WPTF. The data base provides concise information on the name of the company, FP/HIV agency operating at the company, number of employees, kinds of program currently in place. The database is flexible and constantly being updated.

- Through JSI-STAFH technical and financial assistance to the WPTF training manuals, guidelines, information bronchure and strategy documents were developed to support and strengthen existing program or guide initiating new ones (Table 4) In addition training courses, workshop and follow up visits were conducted. (Table 5).

- A "Boiler Plate" strategy has been developed. It is prototype for the development of new private sector or review of existing projects. The main objective of the strategy is to provide guidelines for the formulation of private sector proposals based on identified best practices. The strategy proposes a basic framework for the design of the proposals, outlines some important steps that should be followed; and highlights critical issues that should be tackled at each step.

Table 4

Materials developed for use by NGO/PVO and Private Sector Companies

1. AIDS and Family Planning: The Role of the Private Sector in Malawi (a motivational bronchure)
2. Managers Information Portfolio (an orientation packet for managers)
3. Workplace Guidelines (a management guide for NGO/PVO and managers)
4. Community Services for HIV/AIDS Prevention and Family Planning: A Strategy Document (a generic approach for developing in-house strategies)
5. A Peer Educators Curriculum a training guide for use by NGO/PVOs
6. A Peer Educators Manual; a reference items for peer educators and trainers
7. A Boiler plate strategy framework; a companies own guide to the process of developing, implementing and evaluating their FP, STD and HIV/AIDS programs

Table 5 **Training courses, workshops and folow up visits**

Type of course/workshop	Number of courses/workshops	Duration
1. Peer educators course	18	3 days
2. Training of trainers of peer educators	6	5 days
3. Managers orientation	4	3 days
4. Development of a Peer educators Manual	1	6 days
5. Follow up visits	12	1 day per company

- Of the 186 companies with 300+ employees, a total of **103** (55%) companies have been reported as reached which constitutes **80%** of the target population. The above was accomplished through collaboration with members of the WPTF. Of the 103 companies reached, **15** companies have been reached directly by JSI (Table 6). These companies include Limbe Leaf, B&C, Universal Industries, OILCOM, Southern Bottlers, Universal Industries, ESCOM, Dwangwa Sugar Corporation, Blantyre Water Board, KFCTA, Air Malawi, Press Agriculture-Kasungu east, ADMARC, NSCM, Kabwafu Estates and Portland, with a combined work force of **70,641(23%)**

- A total of **14** companies have had their key persons trained as peer educators to increase awareness of STD/HIV and FP among peers; promote condom use through education and distribution; motivate and support behavior change; and offer care and support to fellow employees affected by HIV/AIDS. Follow up activities have been made to 10 companies to provide technical assistance on peer education activities.

- To sustain the peer education program a total of 70 peer educator trainers have been trained in the 14 companies. A total of 130 Managers have been oriented/sensitized to provide support to FP and HIV/AIDS work place FP and HIV/STD programs (see Table 6)

Table 6 **Private companies that have received peer education, TOT for peer educators, and mangers orientation**

Private Company	Peer Educators trained	Peer Educator Trainers trained	Managers oriented
1. Limbe Leaf Tobacco	39		8
2. Brown and Clapperton	22	4	4
3. Universal Industries	23	2	5
4. KFCTA	9	1	---
5. Press Agriculture	31	1	10
6. SOBO/Carlsberg	26	19	---
7. ESCOM	88	4	3
8. OILCOM	26	1	1
9. Air Malawi	20	15	3
10. Blantyre Water Board	---	---	3
11. Dwangwa Sugar Corp	---	---	67
12. ADMARC	71	---	26
13. National Seed Company	15	---	---
14. Kabwafu	---	23	---
15. Portland Cement	---		
Total	370	70	130

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Table 7 ***Transtion actions on the integration of family planning and STD/HIV/AIDS***

Activity	Proposed Organisation
♦ Continued efforts to coordinate peer education training and follow up activities in the remaining 83 companies with 300+	NFPC/NACP

3. LESSONS AND RECOMMENDATIONS

Table 8.

LESSONS	RECOMMENDATIONS
1. There is limited time provided by the private sector management for peer education activities on reproductive health despite the inapparent commitment to the program.	1.1 Management should be fully involved from the outset 1.2 A program/schedule for peer education activities should be drawn in advance and present it to management.
2. Work based peer education programs often lack resource materials and supplies.	2.1 The programs should be assisted to link up with organizations such as UNFPA, IPPF, WHO, etc. which provide these at little or no cost.
3. The work place presents a captive audience for reproductive health program	3.1 Reproductive Health organisations should be encouraged to expand their programs with the private sector
4. The private sector has demonstrated its willingness to support the cost of its FP and STD/HIV programs 5. It often takes considerable time and continuous advocacy to convince private sector management to commit to FP and STD/HIV/AIDS programs	RH organisations should invest more in building a strong foundation for the program, including the development of a strong advocacy strategy and guidelines.

STAFH TRANSITION CONFERENCE

Viphya Suite, Capital Hotel

30 September, 1998

FP, STD and HIV / AIDS INFORMATION AND EDUCATION

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21 September, 1998

FP, STD AND HIV/AIDS INFORMATION AND EDUCATION : A STATUS REPORT

BACKGROUND INFORMATION:

INTRODUCTION: The STAFH Project has been operating in Malawi since 1992 when Family Health International (FHI), a USAID-funded international contractor, initiated STD activities, as a measure of preventing further sexual transmission of HIV. FHI also inherited the project of teaching AIDS Education in Malawi's schools from AIDSCOM, another USAID-funded project. JSI-STAFH came into the scene in October 1998 and inherited these activities from the previous USAID contractors. JSI-STAFH has been implementing the project for almost four years to-date.

PURPOSE : The purpose of STAFH is to increase the contraceptive prevalence rate (CPR) and to promote behavioural change to reduce the prevalence of HIV /AIDS / STD.

Key strategies to achieve the project's goal and purpose

The STAFH project document/JSI contract specify the following broad strategies:

- expanding FP services through training and up-grading clinics
- promoting an integrated approach to reducing fertility and STD / HIV transmission.

In practical terms, over the last four-years (1994 - 1998), JSI-STAFH has worked with its partners, other STAFH project agencies, donors and other international organizations to achieve results in the following key strategic areas[1]:

⇒ increasing the availability of and access to quality FP education and services;
⇒ expanding STD and HIV/AIDS prevention education and services;
⇒ expanding the involvement and strengthening the capacity of NGOs and the private sector to develop, implement and manage FP and AIDS projects;
⇒ strengthening logistics management;
⇒ training for program and service expansion;
⇒ developing FP and STD training manuals and guidelines;
⇒ increasing the availability of quality IEC materials; and
⇒ researching technical and programme development issues and disseminating findings.

[1] JSI-STAFH/COP

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IEC goals, strategies, activities and outputs specified in the project document & JSI-STAFH contract

In both documents, IEC goals, strategies, activities and outputs were very broadly defined; i. e. to:-

"Design and implement a comprehensive IEC program to:

- increase knowledge of contraceptive options, and dispel rumours, fears and misconceptions about contraception;
- counter the large family planning bias in the society; and
- inform Malawians and influence their knowledge and behaviour regarding AIDS prevention and control".

The only quantifiable IEC output specified in the project document was, " The percentage of schools providing AIDS prevention education will increase to 80%"

This situation underscored a compelling need for the development of an IEC strategy Additionally, collaborating and partner agencies in the country were already implementing visible IEC work in the areas of FP and HIV/AIDS. Therefore, a STAFH/IEC strategy was absolutely necessary to ensure that:

- existing efforts should be efficiently and effectively complemented, and
- duplication should be avoided.

Consequently the first activity which the IEC unit planned and implemented and, which also set the stage for the JSI-STAFH's IEC activities over the four-year period was the development of an IEC strategy.

THE STRATEGY DEVELOPMENT PROCESS:

IEC Needs Assessment / Situation Analysis:

An IEC Needs Assessment (N/A)/situation analysis in the areas of FP, STDs and HIV/AIDS in Malawi was conducted. The need assessment process involved the following activities:

◊ Contact & consultations with partner agencies

◊ Literature search, review and documentation

◊ Consultations with STAFH project participants

◊ Analysis of the findings

◊ Formulation of recommendations

◊ Utilization of findings to articulate the STAFH/IEC strategy.

Major Findings of the Needs Assessment:

a) Knowledge, Attitudes and Practices gap "KAP Gap" on FP and HIV/AIDS, very wide

b) High unmet need for family planning

c) Poor quality and depth of FP and HIV/AIDS information

d) Awareness creation not matched with services

e) Little or no pre-testing of IEC materials

f) No evaluation of IEC materials & interventions

g) Other constraints identified were:

- lack of funds and IEC personnel
- inappropriate materials
- poor IPCC skills
- minimal coordination of IEC efforts
- negative attitudes of service providers
- missed opportunities to integrate STD, HIV/AIDS & FP services
- poor education on STD management.

The Family Planning Market Situation (MDHS, 1992)

Married Women:

⇒ 7.4% used a modern FP method;

⇒ 37% wanted to wait 2 or more years before becoming pregnant;

⇒ 41% (615,000 of the approximately 1.5 million fertile women) wanted to use a method within the next 12 months. Indeed we had a ready market of 615,000 women who wanted to use FP.

⇒ If we linked these 615,000 women to quality FP services, we could attain a total CPR (the 41% of women who said they intended using FP and the 7.4% who were at the time using a modern method) close to 50%.

Lessons Learned from the IEC Needs Assessment and Recommendation -

The need to:

1) produce more method - specific FP materials

2) use vernacular language as much as possible

3) produce target - specific materials

4) encourage the production of gender-specific materials

5) dispel fears, rumours and misconceptions

6) address married women too

7) develop more visual than text in materials for low literates

8) strengthen IPCC and community mobilization efforts

9) address and strengthen STD symptom recognition and correct management.

10) ensure that IEC materials distribution channels work

11) make FP and STD clinics client-friendly.

STAFII PROJECT'S OVERALL IEC STRATEGY

STAFH Project Goal:

To reduce total fertility & to reduce sexuality transmitted HIV

STAFH Project Purpose:

To increase CPR and to promote behavioral change to reduce the prevalence of STD/HIV/AIDS

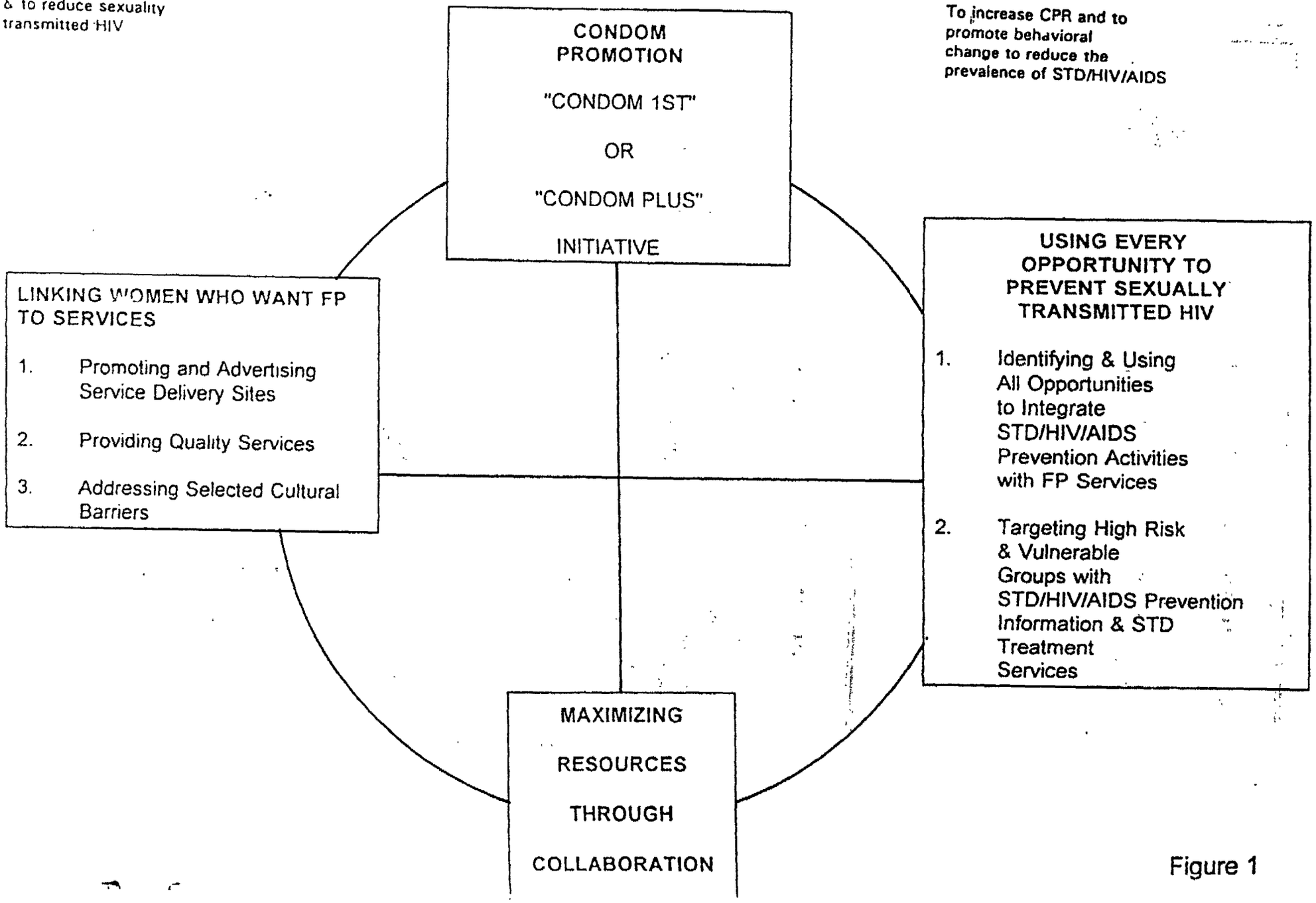

Figure 1

STAFH PROJECT'S OVERALL IEC STRATEGY

As originally planned, the STAFH Project's goal is to reduce the total fertility rate (TFR) and the incidence of sexually transmitted HIV. The project's purpose is to increase the contraceptive prevalence rate (CPR) and to promote behavioural change that will reduce the prevalence of STD/HIV/AIDS. In order to support the STAFH Project in its attainment of its goal and purpose, the four key strategies developed for the Overall IEC Strategy were:

1. **Promoting the condom using the "Condom First" or "Condom Plus Another Method" Initiative.** Given the vulnerability of married women to HIV infection, the condom had to be promoted as the #1 family planning method within health facilities and in the community- and employer-based programs. In the event that women choose hormonal methods, the IUCD or VSC, they would be encouraged to use the condom as well. This strategy had to be supported by a policy to that makes "free" condoms readily available at health facilities and was aimed at complementing PSI's Chishango Social Marketing Program.

2. **Linking women who want to use family planning to appropriate services as they become available.** In order to do this, services are being marketed by: (a) promoting and advertising service delivery sites; (b) providing quality services, and (c) persistently addressing selected cultural or social barriers to the use of family planning, i.e., allaying fears about methods and addressing male-related concerns and barriers posed by other groups who are influential in reproductive (health) decisions.

3. **Using every opportunity to prevent sexually transmitted HIV.** The approaches included: (a) identifying and utilizing all opportunities for integrating STD/HIV/AIDS prevention activities with family planning services where appropriate and (b) targeting high-risk and vulnerable groups including youth with STD/HIV/AIDS prevention information and STD treatment services.

4. **Maximizing resources through collaboration with other donors, government agencies, NGOs, and technical assistance groups involved in implementing reproductive health IEC programs and positioning the STAFH Project to have a unique IEC role.**

These components, particularly the first three, are interrelated. Therefore, some of the planned and implemented activities for one strategy were the same for the others. Condom promotion had to be a central theme in ALL STAFH activities, whether it be in the context of family planning or disease prevention as the condom is what makes integration possible - the "Condom First"... strategy had to be modified.

WHAT WAS UNIQUE ABOUT THE IEC STRATEGY? WHAT WAS IN IT THAT DIFFERED FROM OTHER EXISTING IEC STRATEGIES FOR FP, STD & HIV/AIDS REVIEWED IN 1994/95?

The strategy brought into focus the need to:

⇒ use every opportunity to integrate STD, HIV/AIDS & FP messages and materials whenever appropriate.

⇒ market FP services especially MOHP & CHAM facilities to clients who want to use them, as they become more available and accessible; in other words, making them more client friendly and, with more contraceptive options.

Strategy implementation, approaches and planned activities.

Initially, tough to implement because the STAFH/IEC strategy, as articulated, appeared to have the proverbial "finger in every pie". The IEC strategy did not only confine itself to the STAFH components/units of the project but, with a more holistic view envisaged, planned for several activities that cut across the RH board; this had obvious implications for implementation - the most critical implication being, limited resources. This situation called for prioritization of activities under the four IEC strategies, based on perceived impact and available resources. Funds were also leveraged from other donor agencies; hence the co-funding arrangements of Tinkanena with UNICEF, IPCC with UNFPA and so on.

PLANNED AND IMPLEMENTED ACTIVITIES, CHALLENGES/MODIFICATIONS AND PROPOSED TRANSITION ACTIVITIES PER STRATEGY

Strategy # 1 : Promoting the condom using the "Condom First" or "Condom Plus another method" initiative.

Planned and implemented activities:

- Incorporated Condom Promotion into all FP, STD and Peer education Training manuals, including the CBD Training Curriculum (English and Chichewa versions), the four STD training hand books, HIV/AIDS in the workplace training manual, FP curriculum for the 4-6 week training course, IPCC training manual and the Life Planning Skills curriculum for young people in Malawi
- Mechanisms to promote the condom in health centres and the community were enhanced by working with and through STAFH project partners, NGOs and PVOs (particularly PSI). Staff training in CDLMIS also aimed at improving the availability of condoms at all levels.

- 'Demopens' (simple wooden penis models) were used to teach people how to use the condom correctly.
- Regular condom promotion messages on the radio - mainly by PSI and in the Tinkanena radio drama soap opera.
- A variety of print materials were produced and distributed; these included:

a) Posters - condom testimonials by a bargirl and a youth (football player), promoting condom use.
b) Picture code: illustrating condom negotiation
c) simple, mainly pictorial condom leaflet giving information on correct condom use.

Main challenges/Modification:

1) MOHP did not approve the **"Condom First" or "Condom Plus another method" strategy;** clients were therefore encouraged to make an informed decision about the contraceptive method they want to use in this era of the HIV/AIDS epidemic.

2) To a large extent, FP methods which do not protect against HIV are still being advocated today, 'as if contraception and sexual infection are separate issues and as if pregnancy was a woman's worst fate' (BLM Reproductive Health Document, 1994).

3) Free condoms were not always available at user points.

4) Labeling of condoms as FP vs. AIDS condoms by some health service providers continued to be a hindrance.

5) The issue of free vs. commercial (chishango) condoms, handled by the same CBD agents, remains unresolved.

6) Condoms are still not accepted by some influential groups in society.

7) The prevalence of fears, rumours and misconceptions about condoms, though addressed in a variety of communication media channels still require constant attention in the community.

Proposed Transition actions/activities:

⇒ **The seven challenges outlined above need to be followed up both at policy and implementation levels.**

Strategy # 2: Linking women who want to use family planning to appropriate services as they become available:

Planned and implemented Activities:

- **Fostering positive provider attitudes** through the successful development, pre-testing, revision and production of a training manual on Interpersonal Communication and Counseling (IPCC) for service providers. This highly acclaimed manual is being used to train trainers to conduct district level IPCC trainings for FP providers and has also been adopted for the Safe Motherhood Initiative in Malawi.

- **Marketing FP Services** : the development, extensive pre-testing, revision, production and launching of a national family planning logo that incorporates easy to understand illustrations/symbols and, a catchy slogan ("Kulera: chiyambi cha tsogolo la bwino" = Family planning: the way to a better future), to promote the family planning effort in Malawi was successfully accomplished. The launching ceremony was a big media event particularly on the national radio (MBC). **Other activities in preparation for, and in support of the logo launch and family planning promotion were:**

◊ Planning and implementing a 5-day FP messages and materials development workshop, during which 17 well targeted messages were developed and are now being disseminated through a variety of media channels.

◊ A one-day consultative meeting for news media editors and health program managers, closely followed by a six-day workshop for news reporters and health workers/educators were conducted.

◊ A Press conference was held in which the Minister of Health and Population, and representatives of FP donor agencies expressed great concern about the unmet need for FP and what the Ministry and all FP stakeholders in the country have done and continue doing to meet the need.

◊ Developed, pre-tested, revised, printed and distributed a variety of materials promoting the logo and FP. These materials were: 2500 T-shirts, 5000 meters of chitenjes (cloth), 50,000 fliers, billboards (4), sign posts (2), 10 murals, 5000 posters and 141 car door stickers.

◊ A radio jingle and 10 spot messages have been produced promoting FP.- its benefits, available methods (emphasizing long-term and permanent methods), dispelling rumours and correcting misconceptions. Messages developed during the messages and materials development workshop provided the source/information for writing the radio scripts; the scripts were written by an advertising agency - Studio K. Although the ten messages have been professionally produced, appealing to the ears and very informative, so far, only three of them have been

repeatedly aired over a three-month period (May - August, 1998). Seven of them await funding for purchasing air-time on MBC.

◊ Community launching of renovated FP clinics and the FP logo: three renovated clinics in the central and one in the Southern region have been launched/handed over to MOHP in what can rightly be described as colourful festivals featuring messages on FP in poems, songs, drama and dance by different community groups; speeches by political, religious and community leaders, articulating their support for the family planning programme.

- **FP IEC support materials for service providers and clients to foster informed decisions and method compliance** : developed, pre-tested, revised, printed and distributed the following print materials in Chichewa:

◊ six method-specific FP leaflets - condom, pills, injectable (Depo), IUCD, vasectomy and TL;
◊ 10,000 wall charts on available contraceptive options in Malawi;
◊ distribution of the Kulera and Kabanja flipcharts to NGOs (STAFH grantees).

- **Allaying fears about FP methods:** accomplished through 30 - 60 seconds radio spots; all FP training manuals including IPCC and the CBD manual adequately address the issue; hence trainees including CBDAs, other FP service providers and a number of journalists have received training related to identifying and dealing with fears, rumours and misconceptions. They should therefore contribute in allaying fears about FP methods.

- **Addressing male-related constraints and barriers posed by other influential groups** -done through the following channels:

◊ radio spots,
◊ a flier and a leaflet on the 'Role of men',
◊ orientation/meetings with community leaders - chiefs, traditional authorities, religious and political leaders, drama and dance groups, song writers and choir groups, are regular agenda items during the preparations for community launching of FP renovated clinics and the FP logo.

Main challenges

1) Making FP clinics more available and accessible: improving and maintaining the quality of service, creating and sustaining positive provider attitudes - and maintaining client friendly clinics;
2) Generating durable demand for FP services;
3) Continuously identifying and dealing with fears, rumours and misconceptions; and,
4) Continuously targeting community influentials as well as emphasizing more male involvement on reproductive health matters.

Proposed Transition actions/activities:

⇒ **The four challenges outlined above need to be followed up at implementation levels**

⇒ **To make an impact, the 10 studio-recorded radio spot messages promoting FP, its benefits, available methods - emphasizing long term and permanent methods, etc., should be broadcast repeatedly on both MBC I and II. These were produced by studio K and delivered to the Commercial Section of MBC. All that is needed is funding to purchase air-time.**

⇒ **Continue utilizing the FP logo via a variety of media channels to promote FP service delivery points around the country - e.g. through community launching of renovated FP clinics, mural paintings, reproduction of promotional materials etc.**

⇒ **All FP/IEC stakeholders esp. MOHP, NFPC and donor agencies have a role to play in continuing these activities.**

Strategy # 3: Using every opportunity to prevent sexually transmitted HIV

Planned and implemented activities:

- Integration of STD/HIV/AIDS Prevention into all FP trainings including IPCC - accomplished.

- Integrating STD/HIV/AIDS prevention messages into FP materials - leaflets, posters, flipcharts, songs, drama and radio messages, accomplished/ongoing in some of the media channels.

- Targeting high risk and vulnerable groups: e.g.:

◊ STD clients: (materials developed for this target group include: partner notification slips, laminated desk reference cards, leaflet on the importance of completing treatment, early symptom recognition and partner notification, flip charts, posters, patient and community education leaflets).

◊ Bar girls, freelancers and bar-owners - STAFH supported EU's ongoing effort with IEC print materials - mainly posters and picture codes

◊ Employed men: on-going peer education by the private sector task force.

◊ Out-of-school Youth:

a) By September 30, 1998, 209 episodes of the Tinkanena radio drama soap opera would have been produced and aired. A multi-sectoral review committee, a creative writer (W. Kamthunzi) and MBC's Producer Augustin Lubani have successfully run the show for four years. This medium has been used to disseminate information on HIV/AIDS, STDs and unwanted/teenage pregnancies, with co-funding from JSI-STAFH and UNICEF. A detailed assessment report has also been disseminated.

b) Over 100 youth workers around the country have been trained in Adolescent Reproductive Health, utilizing the manual, 'Life Planning Skills: A Curriculum for Young People in Malawi'. The lead agencies involved in this activity have been NFPC and Scripture Union of Malawi (a STAFH NGO grantee). The participants were drawn from the following districts : Lilongwe, Mangochi and Mchinji; Blantyre, Kasungu, Thyolo and Chitipa. The organizations involved were: MOYCS's Department of Youth, Project HOPE, Youth Arm, AIDS Secretariat, UNICEF and JSI-STAFH. Other agencies were: the Catholic Secretariat, Islamic Centre, Youth and Credit Scheme, Youth Clubs (Edzi Toto & Pamodzi), BLM, Inter-Aide, CPAR and EU AIDS Project. The trained Managers of Adolescent RH are expected to utilize the acquired knowledge and skills to improve and expand youth centre activities in their respective districts.

◊ In-school Youth:

a) 16000 primary and 450 secondary school teachers oriented to teach AIDS education in the classroom utilizing the AIDSCOM teacher's guide and learners' handbooks; 98.5 % of primary schools were reached.

b) Working with the Malawi National Examination Board (MANEB), AIDS education is currently a testable subject in public examinations.

c) An Evaluation of the School AIDS education effort was conducted in 1996-97 - a report, outlining the recommendations for the way forward has been disseminated.

d) The new orientation is the introduction of Life Skills Education (LSE) in the school curriculum at all levels of the education system. "Life Skills are abilities for adaptive and positive behaviours that enable individuals to effectively deal with the demands and challenges of daily life" (WHO, 1993). HIV/AIDS, teenage pregnancies, substance use and drug abuse are among the challenges which LSE is designed to address, utilizing participatory, learner-centred teaching and learning methodologies. With partner agencies and donors, MOE is taking the lead in introducing LSE into Malawi's schools

Main challenges/Modifications:

1) This strategy is directly linked with the modified 'condom 1st/condom plus another method' strategy.
2) Inspite of the dual benefit of condom use in relation to FP, STD & HIV/AIDS prevention, most FP providers have a hard time promoting the condom as an FP method in its own right - because of it's perceived failure rate and low CYP, it is still prescribed, in the majority of instances, only as a back-up FP method. This is indeed a missed opportunity for preventing sexually transmitted HIV and other STDs, particularly in the family.
3) The existing Malawi school AIDS Education materials (teachers' guides and learners' handbooks) give factual information but lack the skill-based learning activities and experiences which would enable the youth to cultivate low risk behaviours for HIV or to make informed behaviour change in relation to their reproductive health life - hence the new LSE orientation which needs to be advocated for.

Proposed Transition actions/activities:

⇒ **The three challenges outlined above need to be followed up at policy and implementation levels by MOHP (# 1 & 2) and MOE (#3), respectively.**

⇒ **Some specific actions/activities on LSE:**

◊ **Advocacy meetings to be conducted at technical and political levels**

◊ **NB: the LSE scope and sequence chart for primary schools and a syllabus for standard four have been developed (with funding from UNICEF). The syllabus and life skills materials for standards 1-3, 5-8 and post secondary institutions need to be funded and then developed. The development of a full-fledged LSE programme entails the following activities:**

a). the development of a scope and sequence chart (already accomplished for primary schools only)
b) development of a syllabus for each grade level (each class)
c) selection and training of writers
d) actual writing/adapting of the materials and supervision of writers
e) reviewing and revising scripts
f) pre-testing the materials
g) revision, incorporating pre-tests results
h) printing
i) planned distribution of the materials
j) training of teachers in LSE nationwide
k) implementation of LSE
l) monitoring and evaluation

⇒ **Each step of the LSE effort, among other requirements, has financial implications and is worth the effort and expenses.**

Strategy # 4: Maximizing resources through collaboration with other donors, government agencies, NGOs, and technical assistance groups involved in implementing RH/IEC program

Planned and implemented activities:

JSI-STAFH's IEC Unit, with its skeleton staff (1-2 persons at any given time) in the life of the project, has successfully collaborated with other units within the project, all RH stakeholders - i.e. government agencies, donors, NGOs and technical assistance groups involved in RH/IEC to accomplish the tasks in Strategies #1 -3 above.

Key players in strategy One were:

- ◊ All STAFH project units, including PVOs
- ◊ Government Ministries: MOHP, MOIBT, MOWYCS
- ◊ NFPC & AIDS Sec.
- ◊ NGOs
- ◊ Donors : USAID
- ◊ Advertising agencies (Graphic Advertising Ltd., Parre Communications/Studio K, Impact Advertising and MBC)

Key players in strategy Two were:

- ◊ All STAFH project units particularly FP, Research, Fin/Admin.
- ◊ Government Ministries: MOHP, MOIBT, the District Commissioner and his team
- ◊ NFPC
- ◊ NGOs
- ◊ Donors (USAID, UNFPA and WHO)
- ◊ Advertising agencies

Key players in strategy Three were:

- ◊ All STAFH project units particularly NGO, Private Sector, Fin/Admin. & PVOs.
- ◊ Government Ministries: MOHP, MOIBT, MOWYCS, MOE, MANEB, MIE.
- ◊ AIDS Sec.,
- ◊ NGOs - Scripture Union of Malawi
- ◊ Donors (USAID, UNICEF, UNFPA, UNAIDS, WHO and EU)
- ◊ Advertising agencies

The structure and form of collaboration in all these efforts were done through:

- meetings
- joint working sessions
- co-funding of some activities.

Lessons learned/Recommendations for future IEC actions and improvements.

- The articulation of a comprehensive strategy guided the implementation of the IEC component of the project.- it is key to all IEC efforts.

- Without the 'c-words' (cooperation, collaboration, coordination, concertation and communication), very little or even nothing would have been accomplished.

- Audience research must be conducted to ensure comprehension and acceptability of all IEC messages and materials; particularly with regard to sensitive but educative materials like the condom and STD leaflets. **NB:** In a number of instances, the analysis of audience research findings showed that health workers tend to be more sensitive to explicit messages and illustrations than the target groups for which the materials are intended in the community.

- Men and youth may be more motivated to comprehend, accept and participate in FP if clinics were more male- and youth-friendly.

- IPCC and community mobilization (drama, songs and dance) should be continued, reinforced and strengthened in order to sustain durable demand for, and utilization of available services.

- Continue improving the IEC materials distribution network by establishing a data base at HEU, for tracking all types of available materials produced, in/out of stock, where to obtain them, distribution outlets, etc.

- Organize training and refresher courses targeting district IEC officers, other health and extension workers including CBDs on the correct use of IEC materials -**NB:** a user guide for print IEC materials has just been developed in English and in Chichewa - a graphic artist needs to be identified and contracted to do the illustrations.

- Introduce Life Skills in all adolescent reproductive health training targeting in and out of school youth.

- Increase the numbers of IEC materials printed in order to facilitate more effective distribution; e.g. at least 100000 leaflets, 25000 posters, etc. for better coverage of the target audience.

Lessons learned/Recommendations for future IEC actions and improvements

- The articulation of a comprehensive strategy is key to all IEC efforts.
- With the 'c-words' a lot of accomplishments is assured.
- Audience research - a must in all IEC materials development efforts.
- More male- and youth-friendly clinics needed
- Strengthen IPCC and community mobilization to sustain durable demand for, and utilization of available services.
- Continue improving the IEC materials distribution network - data base at HEU.
- Training on correct use of IEC materials.
- Introduce Life Skills in all adolescent RH training.

- **Increase the numbers of IEC materials printed in order to facilitate more effective distribution; e.g. at least 100000 leaflets, 25000 posters, etc.**

APPENDIX 12

STAFH TRANSITION CONFERENCE
Capital Hotel
30 September, 1998

CONTRACEPTIVE LOGISTICS MANAGEMENT AND EQUIPMENT DISTRIBUTION

A STATUS REPORT

By

Richard Makowa Msowoya
Logistics Associate

1. Background

The goal of STAFH (Support to AIDS and Family Health) is to decrease sexually transmitted HIV and to lower the fertility rate. This is 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. JSI-STAFH strategy in accomplishing that goal was to ensure "widespread availability of condoms and other contraceptive methods as necessary, ..., to achieve its target of reducing fertility and decreasing HIV transmission", *JSI Project Contract*. In addressing this particular requirement, JSI-STAFH, working closely with the Ministry of Health and Population and other partner agencies, began to take a leading role. JSI-STAFH joined and participated actively in the Logistics Sub-committee.

The National Family Planning Council, JSI-STAFH and other members of the logistics sub-committee conducted a pilot study in Lilongwe district. The study looked at the nature of reports and reporting rates, storage, stock availability and amounts being held and the capacity to hold required months of supply. Findings indicated that many facilities were not reporting regularly as specified by Ministry of Health and Population guidelines. This was attributed to lack of stationery and a crippling mail transfer system as the postal frank was being withdrawn from sites at the time.

Many facilities were found to be holding too many contraceptives. The overstocking by product ranged from 85% for ovrette to 25% on foaming tablets. Apart from depo provera all methods were seriously overstocked. For example the average consumption of condoms in Lilongwe in April, 1995 as reported on Monthly Return Forms was 1503 pieces. At the same time the district physical count was 45, 344 pieces. This meant that Lilongwe had 30.2 months of supply of condoms.

Storage conditions for all contraceptives were very poor. Contraceptives were stored in drawers together with food stuffs thereby attracting rodents in the storage area. Sometimes contraceptives were put very close to chemicals.

Most of these chemicals could affect both the potency and safety of contraceptives. Other findings included lack of a standardized system in managing contraceptives. Different facilities had different forms and format of reporting. In some they had made up their own forms. While this may have been fine for each clinic and may be district health facility, it was difficult to make decisions at the central level regarding the distribution of contraceptives throughout the country. The non-availability of a standardized logistics system also created serious problems at Community Health Sciences Unit (CHSU) where this information is recorded and kept for use by research organizations and decision makers. The Ministry realized this shortfall I August, 1995.

2. **Designing CDLMIS**

In October 1995, a "design" workshop was held to design a standard logistics system for the entire country. This workshop involved representatives of the MOH&P, Central Medical Stores, National Family Planning Council, Christian Health Association of Malawi, National AIDS Control Program, Community Health and Sciences Unit, Family Planning Coordinators, Pharmacy Assistants, CBD Program Managers and Agents. These people reviewed all levels of the system - from CBD to health centre to district to region - and agreed upon a standard way in which to manage the distribution of contraceptives throughout the country. They also agreed on standard set of forms on which to collect data and report it to higher levels. These data are used to make important decisions about how and where contraceptives are distributed. The final result of all these activities was the Contraceptive Distribution and Logistics Management Information System (CDLMIS). This an integrated system which can be used by MOHP in managing other drugs.

3. **Training for Implementation of CDLMIS**

After the Ministry had established this standard contraceptive logistics system, orientation and training had to follow. JSI-STAFH played a central role in planning, organizing, and implementing the CDLMIS training program nationwide. FPLM provided the technical assistance required to the local logistics personnel to enable them implement the system.

3.1 Training of Trainers

USAID, through Family Planning Logistics Management (FPLM), funded a five weeks TOT in March/April, 1996. Logistics and Training Experts from FPLM conducted the course and selected seven out of thirteen participants to implement the national training program. Those selected included; B. Banda (MOHP, RHU), K. Mhango (MOHP, FP Training School), B. Mijoni (NFPC, E. Kumalonje (NFPC), M. Moyo, (CHAM), M. Mchombo (JSI-STAFH) and R. Msowoya (JSI-STAFH). The first two weeks covered Regional and District Level, Health Centre Level and CBD Level logistics curricula. Training skills and methodology lasted for three weeks.

3.2 In-Service Training

To make sure that by the beginning of 1997 all facilities should be using the approved contraceptive logistics system, training started soon after the completion of the TOT and training materials were available. The Ministry informed all key personnel handling contraceptives about the impending training in logistics.

A series of training in CDLMIS was then organized by region. The north was the first due to its small size and fewer people to be trained. It was mainly to be used to acclimatize the trainers in either their new field of training or logistics. Also to identify if any changes needed to be made to the curricula before it went to the larger groups. Daniel Thompson, FPLM and Nem Chakhame , USAID were present during the first sessions to observe trainers and evaluate participant understanding of the new system. The training was inaugurated by Dr. W.C. Nkhoma, Controller of Preventive Health Sciences at Kaka Motel in Mzuzu.

3.2.1 Training Site

As training sites, institutions that could accommodate participants and provide training facilities were preferred. This was done in order to minimize the hazardous logistics of moving trainees to the training venue. Trainers were

accommodated in Protea Hotels wherever possible for proper pre-training planning and post-training evaluation meetings.

In the north trainers stayed at Mzuzu Hotel while trainees were accommodated at Kaka Motel which also provided the training hall. Health Centre and CBD personnel in Karonga and Chitipa districts were trained at Mufwa Lodge in Karonga where the trainers were lodged. In central region training was conducted at Mambiya Lodge in Salima whilst all trainers stayed at Crystal Waters. In the south training was conducted at Domasi Education Institute. Trainers were accommodated at the Government Hostel in Zomba. JSI-STAFH provided backup in form of transport for trainers from Lilongwe to the three training venues including local movement.

3.2.2 Training Methodology

Regional and district level personnel were trained using a five day curriculum. A maximum of 20 participants per class was recommended to allow better trainer and trainee interaction. Daily sessions of the curriculum were shared among the trainers either in groups of two or three depending on the amount of work to be covered.

Health Centre and CBD personnel went through a one day curriculum which after the Impact of Training Assessment conducted by FPLM, results showed that participants felt the one day was not adequate. The curricula were designed to allow a lot of time for exercises on how to fill different columns of the new forms.

The training was conducted from May to December, 1996 with breaks between regions to allow for the purchase of stationery and preparation of handouts. JSI-STAFH in collaboration with MOHP organized and implemented the whole training program. About 1,500 people in MOHP, local government and CHAM facilities had received training by December, 1996. Constant liaison with FPLM was maintained throughout the training period.

3.2.3 CDLMIS In The FPP Training Curriculum

JSI-STAFH funded the incorporation of CDLMIS in the Family Planning Practitioners Training Curriculum (FPPTC) in May, 1997. During the 9 days workshop the following family planning trainers received training in CDLMIS before identifying relevant sections of CDLMIS that were incorporated into FPPTC; W. Mzembe, E. Gondwe, T. Soko, G. Mlava, R. Mbewe, O. Mtema, E. Mtupanyama, D. Chinyama, E. Ng'anjo, L. Ng'omang'oma, E. Kapenda, K. Mhango, E. Msiska. The new curriculum is already being used by all family planning training centres throughout the country. Graduates of these training centres are new family planning providers and those continuing but go through the training centres for refresher courses. JSI-STAFH has supervised some training to assess the quality of the content being taught. The impression is that all is going well both for the trainers except that they lack training materials which are to be reprinted by MOHP with logistics funding from USAID.

3.3 Pre-Service Training

In order to institutionalize CDLMIS into various training programs of the Ministry of Health and Population for key personnel handling contraceptives in the contraceptive logistics system a number of interventions were and are being discussed by concerned parties. All institutions that provide graduates handling contraceptives and drugs are targeted to include CDLMIS in their curricula. Some of these institutions are; all Family Planning Providers Training Centres for new/and continuing providers, Lilongwe School for Health Sciences for Pharmacy Assistants and Clinical Officers, all Nurses Training Schools for Enrolled Nurses and Medical Assistants, Kamuzu College of Nursing for State Registered Nurses and the College of Medicine for Doctors.

4. **Second Series of Training**

During the series of training conducted in 1996, there were some people who for one reason or another missed the training. Others have joined or have been moved to key positions managing contraceptives between that time and now. These people needed to receive training in CDLMIS immediately. The CBD program has also expanded considerably as compared to the time training was conducted as such many CBD primary supervisors are operating without training. MOHP with funding from USAID conducted the regional and district level training in July, 1998 and the health centre ones in August, 1998.

The other crucial activity is the systematic provision of on-the-job (OJT) training. Some graduates of CDLMIS training have indicated that despite attending the training they are not confident enough in filling various forms available at their level. There is need to visit sites and assess the common areas of concern and determine if they can be addressed during refresher courses organized by training centres, on-the-job orientation or re-training the group.

To ensure that all new Pharmacy Assistants who man pharmacies in all the district hospitals and Enrolled Nurses and Medical Assistants who become providers/in-charge in various service delivery points are knowledgeable and skilled in CDLMIS, two workshops similar to the one conducted for FP trainers need to be conducted soon. One workshop will group trainers/tutors at the Lilongwe School for Health Sciences and the other will group trainers/tutors of Medical/Nurses School. Incorporation of CDLMIS into curricula of these two institutions would ensure that all new graduates have the knowledge and skills to manage the CDLMIS.

The above activities have been tabled by the Ministry of Health and Population to USAID for funding. Members of the Logistics Sub-committee and CDLMIS Trainers planned to carry out these activities in the last quarter of 1998.

5. **On-Going Training**

Due to staff movements on the same or from one level to another within the contraceptive logistics system it is important that there should be a

systematic provision of on-the-job training on site by CDLMIS trainers and members of the logistics sub-committee. This will ensure that correct data/information is collected and submitted according to schedule to the level above for decisions to be made. These trips could be organized in two ways. In the interim CDLMIS trainers should be the ones providing the OJT. Immediately after training FP supervisors and managers, OJT in CDLMIS will be one activity carried out during field visits.

6. **Long-Term Training Plans**

Since the final goal is to make sure that all key personnel handling contraceptives have knowledge and skills to manage the CDLMIS similar workshops need to be conducted with lecturers of Kamuzu College of Medicine and the College of Medicine. This will target all graduating State Registered Nurses and Doctors who become Regional/District Family Planning Coordinators and District Health Officers respectively.

7. **Results**

With the continuing improvement in the logistics management of contraceptives:-

1. Loss due to poor storage of contraceptive is minimal.

2. Overstocking and understocking has been greatly controlled since resupply of commodities depends on consumption.

3. The system has also streamlined the movement of contraceptives including condoms at all levels.

4. Contraceptive procurement tables which in the past used demographic data for estimating future use now depend on actual consumption thereby eliminating oversupplies from donors.

5. Improved reporting allows the headquarters to know and assess the situation at lower levels of the system.

8. Proposed Transition Activities

CDLMIS is a new contraceptive logistics system in Malawi and as such continuous efforts need to be made to strengthen it. A considerable amount of money, human and material resources have already been spent. In relation to this, JSI-STAFH proposes:

1. Ongoing monitoring and supervision of CDLMIS.
2. An evaluation of the system after its two years of operation to determine what is or is not working well.
3. Continuous refresher courses in CDLMIS should be encouraged.
4. Incorporation of CDLMIS in all Medical Schools curricula in Malawi.
5. Training Family Planning coordinators and Pharmacy personnel in logistics monitoring and supervisory skills.
6. Training FP Coordinators and Pharmacy personnel in CPT preparation.

9. FP Equipment Distribution

JSI-STAFH distributed clinical equipment and furniture to selected health facilities around the country. The first round of distributions extended from May to November, 1997. The second round began June, 1998 and currently on-going.

The selection of recipient sites was done by MOHP in consultation with District Health Officers. The recipient facilities are attached in appendix I. 228 facilities which include MOHP, MOLG and CHAM received Family Planning clinical equipment. A kit per facility also included some clinical supplies. Each facility received:

- examination couch
- examination light (electric or batteries)
- specula
- sponge bowls
- sphygmomanometer
- stethoscope
- weighing scale

- kidney dishes
- iodine cups
- instrument tray
- cheatle jar and forceps
- instrument trolley
- pedal bin
- homeostatic forceps
- sterilizer
- sponge forceps
- four drawer filing cabinet
- stove(paraffin or electric)
- scissors
- cardex box
- plastic bucket

The JSI-STAFH hired a truck that was used to distribute this equipment. Consultations with relevant personnel within MOHP were done in advance. In some cases USAID and MOHP officials escorted the truck during distributions.

The equipment distribution met with some problems: truck breakdowns and non availability of spares, expensive genuine parts and inaccessible roads. The co-operation received from personnel in the field that we worked closely with during distributions was however commendable. JSI-STAFH was cordially welcome at all facilities and that provided a good opportunity to conduct on site orientation on the assembly of the couch and the functioning of sterilizers.

10. STD Drugs and Equipment Distribution

JSI-STAFH managed drug and equipment logistics of 5 STD pilot sites (Mzuzu, Nkhata Bay, Lilongwe, Mangochi and Blantyre) and 4 expansion districts (Mchinji, Mulanje, Thyolo, Ntcheu and Chikwawa). Some of the major responsibilities included:

1. identifying a warehouse for the STD drugs purchased by USAID.

2. storing and accounting for the drugs.

3. supplying STD pilot sites with drugs.

4. preparation of MIS for STD drugs for use by pilot sites.

5. renovation of STD pilot sites.

6. analysis of MIS reports and re-supplying drugs to pilot sites based on consumption.

10.1 STD drugs and Sites

Gentamicin (80 mg vials)	158, 000
Erythromycin (250 mg tablets)	1,440, 000
Doxycycline (100 mg tablets)	871, 000
Metronidazole (250 mg tablets)	337, 000
Benzanthine Penicillin (2.4 mu vials)	167, 400
Sterile Water (10 cc vials)	167, 400
Nystatin (100,000 unit pessaries)	1, 650
Syringes (10 cc)	43, 000
Needles (21 G)	43, 000

Gentamicin arrived with a short shelf life and all could not be used before expiry. Efforts were made to distribute to a wider range of users and with a suspended restriction on use. USAID restricted the use of STD drugs to treating STD patients only. Despite this 76,000 vials of Gentamicin expired on the shelves of STD sites and others.

STD Pilot Sites

Lilongwe Central Hospital
Queen Elizabeth Central Hospital
Mzuzu Dispensary
Nkhata Bay District Hospital
Mangochi District Hospital

Expansion Districts

Mchinji District Hospital
Mulanje District Hospital
Thyolo District Hospital
Chikwawa District Hospital
Ntcheu District Hospital

Some drugs were distributed to all district hospitals and CHAM units through Central Medical stores;

March 1997

Benzathine Penicillin	39,300 vials
Erythromycin	536,600 tablets

September 1998

Benzanthine penicillin	46,000 vials
Water for Injection	74,000 vials

In the STD pilot sites and expansion districts JSI-STAFH did its work through consultation and collaboration with AIDSEC and MOHP. The sites' selection was a consultative effort between AIDSEC, MOHP and JSI-STAFH. Initial orientation on the MIS was conducted by JSI-STAFH and AIDSEC in all the pilot sites and expansion districts when they started STD treatment using drugs donated by USAID.

The failure to continue supplying pilot sites and expansion districts with STD drugs was the biggest embarrassment to the program. However, that coincided with improved drug availability at CMS and many hospitals were able to compliment the shortfall created by stock outs at JSI-STAFH warehouse.

10.2 STD Equipment to NGOs

JSI-STAFH also purchased and distributed STD equipment to NGO grantees. The list of recipients is attached as appendix II.
The type and number of equipment varied according to the assessed need. Composition of equipment was the same as the equipment that is listed above for FP clinics.

10.3 STD Equipment to District Hospitals

This equipment arrived from South Africa this September. Distribution to hospitals in the north is currently going on. All the Std equipment for facilities in the south and Centre is stored by JSI-STAFH. This will be handed over to MOHP through the National STD Coordinator.

10.4 Theatre Equipment

Some of the theatre kits are already in the JSI-STAFH warehouse. The other pieces have not yet arrived. Since JSI-STAFH will be terminating lease agreements the equipment will be transferred to MOHP. The sites to receive this equipment are: Rumphi, Dedza, Dowa, Lilongwe, Mangochi, Ntcheu and Nsanje.

11 Recommendations

1. MOHP and donors should continue to support the CDLMIS for it to be sustainable.

2. Encouragement should be made to the MOHP for them to create budget lines for logistics activities in contraceptive, including condoms.

3. Donors should continue to assist MOHP with the logistics of distributing donated items to avoid them sitting in warehouses for long thereby depriving a service to the population.

4. An effort should be made by MOHP to start applying CDLMIS in the distribution of drugs through CMS, and encouraging all programs like EPI, Malaria, etc. to adapt CDLMIS.

5. Attention should be paid during design of projects to sustain program components in order not to frustrate the people that implement. The drug stockout/expiry in the middle of the program was one.

STAFH TRANSITION CONFERENCE

Capital Hotel, 30th September, 1998

FAMILY PLANNING FACILITY UPGRADING

A STATUS REPORT

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SEPTEMBER 24, 1998

STAFH TRANSITION CONFERENCE PAPER ON
FAMILY PLANNING FACILITY UPGRADING
Capital Hotel: 30 September, 1998

1.0 Background

One of the JSI-STAFH's goals is to complement and support the efforts of the Malawi Government to reduce total fertility rate (TFR). In order to achieve its goal, STAFH developed the Facility Renovation Program with the view to increasing and improving family planning (FP) facilities and make FP services more accessible to all who need them within MOHP, MOLG, CHAM and the Private Sector. The program involves the construction of new structures as well as the renovation/upgrading of existing buildings.

2.0 Planned Activities

A study of FP services in Malawi was carried out by Clinical and Building Evaluators in an attempt to improve quality, access and use of family planning services. It was found that out of 756 facilities, only 326 were providing services. Thus, this was an area that needed improvement if FP services were to be made more accessible.

JSI-STAFH identified and approved 267 facilities for small scale construction and renovation. However, due to inadequate funds the above figure was reduced to 95 facilities. This figure was further reduced to 39 facilities comprising 32 core family planning facilities and 7 comprehensive family planning facilities - see Appendix A.

3.0 Present Status

By 30 September, 1998, 17 facilities will have been constructed/renovated and ready for handovers, and the 10 facilities currently in progress should be completed and handed over by 31 October, 1998.

5 facilities which have not commenced to date have been cancelled and 4 uncompleted facilities have been suspended due to lack of funds - see Appendix B.

3 facilities have since been dropped from the renovations list, namely Ntcheu (comprehensive), Kasungu (comprehensive) and Cobbe Barracks (core) because the facility users say they do not need them.

4.0 Activities Undertaken

In order to succeed in providing the 39 facilities, the following activities were undertaken:

4.1 formation of a Task Force with members from MOHP, MOLG, CHAM and the Private Sector to oversee the implementation of the Facility Renovation Program.

4.2 development of selection criteria for health facilities needing renovations/upgrading.

4.3 evaluation of health facilities by clinical and building evaluators.

4.4 final selection of sites for renovations/upgrading.

4.5 employment of Hanscomb Partners as the Construction Management firm to prepare building plans, and initiate and manage all the construction work.

4.6 selection of building contractors.

4.7 appointment of the Construction Management Associate to co-ordinate the inputs of JSI-STAFH, MOHP, CHAM, MOLG, the Private Sector and Hanscomb Partners.

4.8 obtain approvals from MOHP and partner agencies to allow construction work to commence.

4.9 conduct monitoring/supervision visits in order to assess progress and approve monthly payments for the building contractors.

4.10 Review and approve Progress Reports, Cost Reports and Final Certificates from the Construction Management firm.

5.0 Activities for Transfer

As we have seen (Appendix A, items 4.0 and 5.0), there are 9 facilities which may not be completed by 31 October, 1998. Such facilities may have to be transferred to the Ministry of Health and Population along with activities 4.5 to 4.10 listed above in order to facilitate satisfactory completion.

6.0 Issues and Lessons Learnt

Assessment of the FP facilities for renovation/upgrading is a novel exercise effected by the project under the direction of a task force. The list of facilities generated will serve to provide direction for future expansion when funding becomes available from other agencies. STAFH has provided the NFPCM with such a list of facilities for consideration under the UNFPA funded renovations program.

The nationwide assessment, though intense, has produced valuable information for use by the STAFH project and other organizations and donors.

There were several challenges during the implementation of the Facility Renovations program. Some of the notable ones are as follows:

6.1 the funds available for FP facility renovations were too little to meet the MOHP requirements. This is why a smaller number of facilities will be renovated than

planned for.

6.2 the time allowed for carrying out the program was too short. Actual construction work commenced during the second half of the fifth year (1997) of the 6-year JSI-STAFH Project.

6.3 the recruitment of the Construction Management firm meant that decisions about the construction work from JSI-STAFH and partner agencies to the contractors took longer than was necessary to be acted upon. This caused a lot of delays to the actual progress of work.

6.4 the scattered nature of the works posed supervision problems to the Construction Management firm (Hanscomb Partners). It meant that visits were less frequent in order to save money and little time was devoted to our program in favour of their other bigger and more lucrative projects. We had to constantly remind Hanscomb Partners about lack of supervision and delays resulting therefrom.

6.5 The facility Renovations program has 39 sites as has been already mentioned elsewhere in the paper. The sites were divided into five packages, Contract Nos 1 to 5. Contract Nos 1 and 2 for sites in the Southern Region, Contract Nos 4 and 5 for sites in the Central Region and Contract No 3 for sites in the Northern Region.

Three national building contractors namely, Terrastone Ltd (Contract Nos 3 and 5), Shaanti Construction (Contract No 4) and Barriga's Building Contractors (Contract Nos 1 and 2) were selected to undertake the work. This was done at a time when there was a general downturn of work in the construction industry. This arrangement posed some problems. When the economy improved and workload generally increased, the big contractors were no longer interested in carrying on with the small constructions and renovations. They were perceived to be unprofitable and an unnecessary drain on their scarce resources. The result of this was that Terrastone and Shaanti abandoned the sites without good reason. This action caused considerable delays to the implementation of the program.

In an attempt to savage the situation, Contract No 3 was re-packaged into 4 smaller lots and given to small/medium size local contractors. The result of this action was a general improvement in performance in terms of quality of workmanship and construction period.

A decision was also made to take over Hanscomb's responsibilities by JSI-STAFH for the Northern Region contract. Again, the result was a general improvement in quality and pace at which work was being carried out.

7.0 Recommendations

In order to minimise similar problems in future Facility Renovations program implementation, attention needs to be paid to the following issues:

7.1 sufficient funds should be devoted to Facility Renovation program.

7.2 sufficient time for implementation should be allowed - not less than 3 years.

7.3 management and supervision of the construction work should be done by member(s) of staff within the project's organization specially recruited for the purpose.

7.4 small/medium size local contractors should be preferred for small construction work of scattered nature. The work should be packaged in small groups of probably 3 to 4 sites within a particular geographical area.

APPENDIX A

TO BE COMPLETED BY 31/10/98

1.0 COMPLETED AS AT 24/9/98

1. Matope (C)
2. Makhanga (C)
3. Dolo (C)
4. Chikwawa (C)
5. Thuchira (C)
6. Chimaliro (C)
7. Khasu (C)
8. Kochilira (C)
9. Mbingwa (C)
10. Mayani (C)
11. Dwambadzi (C)
12. Dowa (C)
13. Dowa (CH)
14. Nkhuzi (C)

2.0 TO BE COMPLETED BY 30/9/98

1. Namadzi (C)
2. Mangochi (C)
3. Mangochi (CH)

3.0 TO BE COMPLETED BY 31/10/98

1. Kaporo (C)
2. Karonga (C)
3. Mlowe (C)
4. Phwezi (C)
5. Rumphi (CH)
6. Bolero (C)
7. Mzimba (C)
8. Lilongwe Central Hospital (C)
9. Lilongwe Central Hospital (CH)
10. Namwera (C)

4.0 NOT STARTED

1. Manyamula (C)
2. Kasungu (C)
3. Mtunthama (C)
4. Chileka (C)
5. Bwanje (C)

5.0 SUSPENDED

1. Dedza (C)
2. Dedza (CH)
3. Mchinji (C)
4. Nkhota-kota (C)

6.0 REMOVED FROM LIST

1. Ntcheu (CH)
2. Cobbe Barracks (C)
3. Kasungu (CH)

C - Core FP facilities
CH - Comprehensive FP facilities

APPENDIX B

STATUS REPORT AS AT 24/9/98

SITE		LEVEL OF COMPLETION
1.	Matope	100%
2.	Makhanga	100%
3.	Dolo	100%
4.	Chikwawa	100%
5.	Thuchira	100%
6.	Chimaliro	100%
7.	Kochilira	100%
8.	Mbingwa	100%
9.	Khasu	100%
10.	Mayani	100%
11.	Dwambadzi	100%
12.	Nkhuzi	100%
13.	Dowa	100%
14.	Dowa (Comp)	100%
15.	Mangochi	95%
16.	Mangochi (Comp)	95%
17.	Namadzi	95%
18.	Kaporo	60%
19.	Karonga	50%
20.	Mlowe	60%
21.	Phwezi	50%
22.	Rumphi (Comp)	30%
23.	Bolero	30%
24.	Mzimba	80%
25.	Nkhotakota	50% (Suspended)
26.	Lilongwe Central Hospital	60%
27.	Lilongwe Central Hospital (Comp)	60%
28.	Dedza	75% (Suspended)
29.	Dedza (Comp)	95% (Suspended)
30.	Mchinji	50% (Suspended)
31.	Bwanje	0% (Withdrawn)
32.	Chileka	0% (Withdrawn)
33.	Manyamula	0% (Withdrawn)
34.	Mtunthama	0% (Withdrawn)
35.	Kasungu	0% (Withdrawn)
36.	Kasungu (Comp)	0% (Rejected)
37.	Ntcheu (Comp)	0% (Rejected)
38.	Namwera	50%
39.	Cobbe Barracks	0% (Rejected)

Comp - Comprehensive FP facilities

REPORTS, PUBLICATIONS AND OTHER DOCUMENTS PRODUCED BY JSI-STAFH

JSI-STAFH, Lilongwe
30 September, 1998

REPORTS, PUBLICATIONS AND OTHER DOCUMENTS PRODUCED BY JSI-STAFH

1. Annual Workplans

1st (October, 1994 - September, 1995)
2nd (October, 1995 - September, 1996)
3rd (October, 1996 - September, 1997)
4th (October, 1997 - September, 1998)

2. Quarterly Reports

1st (1 October - 31 December, 1994)
2nd (1 January - 31 March, 1995)
3rd (1 April - 30 June, 1995)
4th (1 October - 31 December, 1995)
5th (1 January - 31 March, 1996)
6th (1 April - 30 June, 1996)
7th (1 October - 31 December, 1996)
8th (1 January - 31 March, 1997)
9th (1 April - 30 June, 1997)
10th (1 October - 31 December, 1997)
11th (1 January - 31 March, 1998)
12th (1 April - 30 June, 1998)

3. Annual Reports

1st (October, 1994 - September, 1995: incorporates progress report for 1 July - 30 September, 1995)
2nd (October, 1995 - September, 1996: incorporates progress report for 1 July - 30 September, 1996)
3rd (October, 1996 - September, 1997: incorporates progress report for 1 July - 30 September, 1997)

4. Final Report

Incorporates the fourth annual report as well as the progress report for 1 July - 30 September, 1998 (under preparation).

5. Socio-cultural research reports

Report Series Number:

1. AIDS in Malawi: An Annotated Bibliography
2. Condom Initiative (Condoms, Contraception and Marriage): Report on Consultation Meeting, Capital Hotel, May 9, 1995
3. Family Planning in Malawi: An Annotated Bibliography
4. Quality of Family Planning Community-Based Distribution Services in Malawi
5. Condom Use in Marriage Among Urban Workers and Their Wives
6. Condom Use Among Family Planning Providers in the Cities of Blantyre, Lilongwe and Mzuzu
7. Evaluation of AIDS Education in the Classroom: A National Survey
8. Female Condom Acceptability Among Family Planning Clients of Blantyre City
9. Cultural Practices Related to HIV/AIDS Risk Behaviour: Focus Group Discussion of Village Leaders in Phalombe
10. Cultural Practices Related to HIV/AIDS Risk Behaviour: Community Survey in Phalombe, Malawi
11. Health Seeking Behaviour and Partner Notification by Clients with Sexually Transmitted Diseases (STDs) in Malawi: An Ethnographic Approach
12. Health Seeking Behaviour 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)
13. Adolescent Commercial Sex Workers in Malawi: A Case Study of Mzuzu and Salima
14. Initiation Rites Among Yao Muslims In the Southern Region of Malawi: *Jando and Nsondo* From Machinga, Mangochi and Zomba.
15. Male and Female Involvement in Contraceptive Decision-Making, Use and Discontinuation in Rural Malawi

6. Biomedical Research reports

1. Effects of HIV in Semen: Treatment of urethritis Reduces the Concentration of HIV-1 in Semen
2. Susceptibility of *Neisseria Gonorrhoeae* to Gentamicin in Malawi, 1998

7. Dissemination Reports

1. Dissemination Strategy (Dissemination of Research Findings, Recommendations and STAFH Project Experiences and Lessons in Malawi

Dissemination Report Series Number

1. Dissemination Workshop for STDs and FP Trainers and Supervisors: Towards Determining the Next Steps
2. IEC Dissemination Workshop on STDs, HIV/AIDS and FP: Towards the Next Steps

8. Annual STAFH Coordination Meetings

1. First Annual STAFH Project Coordination Meeting: Papers and Proceedings
2. Second Annual Coordination Meeting of STAFH Project Partners - Strengthening the Policy Framework for More Effective Services: Proceedings
3. Third Annual STAFH Project Coordination Meeting - The STAFH Project in Retrospect: Applying Practical Lessons for Planning Effective Programs: Proceedings

9. Training Curricula, Materials and Guidelines

1. Managing People with Sexually Transmitted Diseases in Malawi: Handbook for Trainers of Supervisors
2. Managing People with Sexually Transmitted Diseases in malawi: Supervisor's Handbook
3. Managing People with Sexually Transmitted Diseases in Malawi: Handbook for Trainers of STD Service Providers
4. Managing People with Sexually transmitted Diseases in Malawi: Service Provider's Handbook
5. IPCC Curriculum
6. Management of Sexually Transmitted Diseases: A Teaching manual for Registered Nursing/Midwifery Students in Malawi (Febreuary, 1997) (For Kamuzu College of Nursing, University of Malawi)
7. Sexually Transmitted Diseases: Module for Teaching Nursing and Midwifery Technicians (September, 1997)
8. Sexually Transmitted Diseases: Teaching Manual (May, 1997) (For Malawi College of Health Sciences)

10. Other Studies and Reports

1. Report on Strengthening Reproductive Health Management in Malawi (to the Reproductive Health management Strengthening Task Force
2. NGO Grant Programs: Effect on Institutional capacity, Project Accomplishment and Sustainability - Three Cases from JSI-STAFH
3. Evaluation: In-Service Training in Syndromic Management of STDs in Malawi
4. Evolution of the Contraceptive Distribution and Logistic Management Information sysytem (CDLMIS) in Malawi: October, 1995 - March, 1998
5. Database (1997): Private Sector Companies Involved in HIV/AIDS/STD and FP Activities
6. Facility Upgrading for Family Planning: Procurement of Clinical Equipment and Distribution Sites
7. Facility Upgrading for Family Planning: Facility Renovations/Construction
8. Integration of STD in FP Practitioner Training
9. Training Management Information System
10. Report on Pre-Test of Family Planning IEC Materials, 21-31 July, 1996

11. NGO Program

Proposal Review and Approval Committee (PRAC) Meeting (JSI-STAFH Conference Room, 10 January, 1997)

NGO Exchange of Experience Meetings:

1. 1st (Ryalls Hotel, Blantyre, 24 March; and Capital City Motel, Lilongwe, 26 March, 1997)
2. 2nd (?)
3. 3rd (Ryalls Hotel, Blantyre, 25-26 August, 1997)
4. 4th (Capital City Motel, Lilongwe, 26 November, 1997)
5. 5th (Malawi Institute of Management, Lilongwe, 16-17 February; and Zomba Parliament Building, 19-20 February, 1998)

NGO Institutional Assessments

1. Youth Arm Organization
2. MACRO
3. Blantyre Christian Center
4. NABW

5. NAPHAM
6. Tea Association
7. Malamulo Hospital
8. Ekwendeni Hospital
9. St Annes Hospital

NGO Strategic Plans

1. MACRO
2. MASO
3. Ekwendeni Hospital
4. Malamulo Hospital
5. YAO
6. St Anne's Hospital
7. NAPHAM
8. BCC

NGO Audit Reports

1. ADRA/Cobbe Barracks mid-term and final audit reports (set of 2: final report will be ready 31 October)
2. ECAM final audit report (to be ready 31 October)
3. NGO Mid-Term Audit Reports (set of 18)
4. NGO June, 1998 Close-out audit reports (set of 11)
5. NGO September, 1998 Close-out audit reports (set of 8)
6. MAM Close-out audit report (to be ready 31 October)
7. SA close-out audit report (to be ready 31 October)

Other NGO Documents

1. (Report on) Meeting to Launch the NGO/PVO Grant Management System, Njamba Room, Mount Soche Hotel, Blantyre: 16 February, 1995
2. (Report on) NGO Workshop on Proposal Development, Ku Chawe Inn, Zomba: 23-26 April, 1995
3. NGO Financial and Project management Training, Shire Highlands Hotel, Blantyre: 12-21 May, 1997
4. Uganda (Exchange of Experience) Trip Presentation, Capital Hotel, Lilongwe: 2 January, 1998
5. Fund Raising for NGOs in Malawi: An Introduction to Basic Principles of Fund Raising (Based on a Training Workshop with NGOs) (Co-funded by JSI-STAFH and Concern Universal-Cabungo Project.

6. Report on Developing Fund Raising Plan for the National Association of Business Women (NABW): June, 1998
7. Report on Project Development and proposal Writing Training Workshop, Conducted for Staff of Ekwendeni and St Anne's Hospitals: Katoto Beach Motel, Chintheche, 31 August - 4 September, 1998

12. CBD Materials

1. FP Handbook for CBD Agents in Malawi
2. CBD of Family Planning Services: Curriculum
3. Guidelines for Community-Based Distribution of Contraceptives in Malawi
4. CBD Handbook for CBD Agents (Chichewa)
5. CBD Handbook for CBD Trainers (Chichewa)

13. Private Sector

1. A Needs Assessment of STDs, HIV/AIDS and Family Planning Service Delivery Through the Private Commercial Sector and Private Medical Practitioners in Malawi
2. Family Planning, STD and HIV/AIDS Programs in the Private Sector: Overview of Case Studies and Strategy Framework
3. AIDS and Family Planning - The Role of the Private Sector in Malawi: Peer Educators Curriculum
4. AIDS and Family Planning - The Role of the Private Sector: Managers Portfolio
5. AIDS and Family Planning - The Role of the Private Sector: Workplace Guidelines
6. HIV/AIDS Prevention and Family Planning in the Private Sector: (JSI-STAFH) Strategy Document (30 October, 1997)

Closing Remarks By
Marc A. Okunnu, Sr., Chief of Party, JSI-STAFH
at the Closing Ceremony of the
STAFH Transition Conference, Held at the
Viphya Suite, Capital Hotel, Lilongwe
30 September, 1998

Mr Chairman, Ladies and Gentlemen.

The Government of Malawi (GOM) and the United States Agency for International Development (USAID) enabled and empowered JSI to work with the public, NGO and private sectors in Malawi to build or strengthen the capacity for family planning, STD and HIV/AIDS programs. Over the last four years, we have done just that.

As we conclude our four-year long work. we are naturally concerned to ensure that there are other organizations able and willing to take over the batton.

The JSI presentations, both verbal and written, identify the principal activities being handed over. I just wanted to express pleasure and gratitude at the information from this conference that, in deed, many aspects and areas of the work done will be carried forward. For example, in family planning, we know that the RHU, supported by AVSC, will continue with the training of LTPC trainers and service providers. I was also most pleased to know that the DfID will take on further work with STD training and services through a proposed $40m five-year project. The NGO sector will also enjoy continuing support, with nine of the initial pool of 24 grants to be continued by USAID.

Mr Chairman, the partners, friends and well-wishers of JSI are numerous. Personally, I owe a ton of gratitude to partners. Apart from indulging me in my official duties many have also interacted cordially with me as brothers and sisters. I thank you very much.

If JSI is seen as successful, it is because we have had cooperative and supportive partners to work with. All our partners have been most valuable to us but I must single out some for special thanks. I refer to the MOHP, particularly the Controller of Preventive Health Services, his Assistant, and staff of the RHU in general; the NFPC, particularly the Executive Director and his immediate lieutenants, and the NACP Secretariat, particularly the former Program Manager (Lester Chisolu) and the current Acting Program Manager (Rosemary Chinyama, who unfortunately is unable to be present due to illness).

Through the Controller of Preventive Health Services, I would like to convey special thanks to the Principal Secretaries in the MOHP for their guidance, encouragement and support.

In the NGO community, I cannot fail to single out BLM, CHAM and PSI along with IEF, SCF-US and Project HOPE who have been extremely cooperative and supportive.

I would also like to pay tribute to and thank past JSI staff, including Jerry Russel (the first Chief of Party), Cathy Thomson, Celine Daly, Lynette Malianga and many others who started implementation of the contract, helping to translate its vision into the shape and form that have come to be known as JSI-STAFH.

In relation to this conference, I owe many people immense thanks.

- Linda Andrews and Joan LaRosa at USAID for their support in brainstorming the purpose, objectives, and program of the conference;
- My staff at JSI for their extreme hard work and dedication in preparing for the conference;
- The partner and donor officials who kindly agreed and were able to be part of the conference panels;
- You, Dr Wilfred Nkhoma, who at short notice agreed and most ably chaired the conference;
- All you great friends and well-wisher who made the time to come; and
- All the JSI staff, both visible and invisible at the conference, including Alex M'Manja, Doreen Msuku, Clement Mwalweni and Mike Moya who have helped behind the scene to support the conference.

Mr Chaiman, please permit me to conclude these remarks by repeating the invitation to the farewell reception this evening. We appeal to you to please be punctual as the guest of honour has another engagement.

Once again, Mr Chairman, ladies and gentlemen, I thank you most sincerely for your support, cooperation and assistance during the last four years, and for attending this conference.

Farewell and Thank You Remarks
By Marc A. Okunnu, Sr., Chief of Party, JSI-STAFH at the JSI-STAFH Farewell Reception Held at the Viphya Suite, Capital Hotel, Lilongwe, on 30 September, 1998

Dr Kiert Toh, USAID Mission Director
Dr Wess Sangala, Secretary for Health and Population
Dr Teklemichael, WHO Representative
Mr Mubiala, UNFPA Representative
Representative of the EU Delegation
Miz Joan LaRosa, Health and Population Team Leader, USAID
Distinguished Heads of National and International Governmental and Non-Governmental Organizations,
Ladies and Gentlemen

I am most honoured to be given this opportunity to make these remarks.

How does one begin to say thank you to friends and colleagues at such a time ? First, the friends, partners and well wishers are numerous. Second, I am expected and I do want to say thank you wearing three different hats. One for JSI, a second for my staff, and a third for my own self. Although there are overlaps, each of these hats has a large number of friends and well-wishers around it. I hope you can see the enormity of my task, and therefore see it fit to pardon me if I omit any important aspect.

Wearing the first hat, I would like to thank first both the GOM and USAID for giving JSI the opportunity, through the STAFH project, to come and work in Malawi. JSI has learned and gained from this association, which will enrich our expertise and preparedness for future work in the country. In particular, we are most grateful to the Government and people of Malawi for accepting JSI and its

expatriate arm, and for allowing the Malawian staff to work with JSI.

The staff of JSI, comprising past and present Advisors, Associates, and Administrative as well as support staff, owe a depth of gratitude to our partners. Our partners are many and have all been very cooperative and supportive and patient with us. We say a big thank you. In particular, we thank the donor organizations who have indirectly, and sometimes directly, contributed various resources to JSI-STAFH activities. In particular, we convey gratitude to UNFPA and DfID. We are also much grateful to STAFH PVOs (IEF, SCF-US, PSI and Project HOPE), as well as the many national NGOs we have worked with, for their cooperation, support and assistance.

Trying to express gratitude while wearing my own hat is the most difficult. I want to thank all the groups that I have already acknowledged but I also want to single out some individuals, in USAID and in the MOHP. First is Miz Joan LaRosa. She received and briefed and introduced me when I arrived to take up my position. She was and has been a source of direction, encouragement and learning. I have not found her wanting at any critical times of need and I feel very grateful to Joan for all the advice and support and cooperation she has given me.

I also want to thank Nem Chakhame. Before Linda Andrews took over management of the STAFH Project and even after wards, I had many occasions to consult with and depend on Nem for guidance. He has always been open with me and given me advice on procedures. In addition, he has been a friend and a brother, even if a junior one. Nem, Thanks loads.

I will miss Linda Andrews very much. Although I have worked with her for only a year, I have come to rely on her as a friend and

as a colleague. I will miss the many "brainstorming" sessions that Linda often calls for when trying to think-through a problem or an idea with me. She is warm, friendly and caring, and simply easy to relate with. Linda, thanks a million for all the patience and cooperation you have generously given.

How do I thank Jane Namasasu, and Wilfred Nkhoma and Martin Palamuleni, and Rosemary Chinyama, and Effie Pelekamoyo and all those other good people ? You are too may to pay tribute to individually. But I must mention Dr Mwiyeriwa. Our association was a short one but it was rich, filled with immense good will and support, not just for JSI-STAFH but for RH in general. I sincerely appreciate and I am grateful for the inspiration and leadership that you gave, Dr Mwiyeriwa. For all you good people, please permit me to simply say a big thank you from the very bottom of my heart.

As for my staff, I will never be through thanking you. In all my twenty five years in RH I have never found a group of professionals so knowledgeable, skilled and capable, and yet so humble and respectful and patient. You have been extremely cooperative and supportive, and have shown commitment and dedication to your work. I truly and sincerely will miss our association.

This is an occasion that fills me with a lot of emotions. I have been here only two years but that period is sufficient to build strong linkages and attachments. I am not talking about professional collegial attachments only. I also mean personal friendships. But the thing about true friendship is its capacity to endure. So while sad that I have to take leave of personal and professional friends, I can take hope and consolation in knowing that this occasion is not really a farewell but a "see you soon".

I could go on and on but I don't have the time. Let me conclude by thanking Dr Toh for kindly agreeing to be the guest of honour tonight. My thanks also to Dr Sangala for his presence and remarks. Let me pay one final tribute, to Dr Sangala. When he was Chief of Health Services and later after he became the Secretary for Health and Population, he was exceptional in providing me with feedback, useful for guidance and direction, particularly at the beginning of my assignment.

Last but not the least, I thank all our guests tonight for making the time available to come.

Thank you all very much