PROJECT HOPE

Support to AIDS and Family Health (STAFH) Project for Private Agricultural Estate Employees in Thyolo, Zomba, Nkhotakota, and Nkhata Bay Districts of Malawi

USAID Grant No. 690-G-00-99-00230-00

Final Evaluation

Project Location: Thyolo, Zomba, Nkhotakota, and Nkhata Bay Districts
Project Duration: August 1, 2001 – July 31, 2002

Submitted to:
U.S. Agency for International Development
Lilongwe, Malawi

Submitted by:
Project HOPE –
The People-to-People Health Foundation, Inc.
Millwood, Virginia USA 22646
Tel: (540) 837-2100
Fax: (540) 837-1813

October 2002

Prepared by External Evaluators:
Graciela Salvador-Davila, MD, MPH
Anna Kathryn Webb, PhD

Contact persons:
Bettina Schwethelm, PhD, MPH
Director, Maternal & Child Health Programs
Project HOPE/U.S.

Dorothy Namate, PhD, RNM
Country Director
Project HOPE/Malawi

FINAL REPORT

FINAL EVALUATION

OF THE

SUPPORT TO AIDS AND FAMILY HEALTH (STAFH) PROJECT FOR PRIVATE AGRICULTURAL ESTATE EMPLOYEES IN THYOLO, ZOMBA, NKHOTAKOTA, AND NKHATA BAY DISTRICTS OF MALAWI

SECOND STAFH FOLLOW-ON PROJECT – USAID GRANT NO. 690-G-00-99-00230-00
AUGUST 1, 2001 – JULY 31, 2002

PROJECT HOPE/MALAWI
BLANTYRE, MALAWI

PROJECT HOPE, THE PEOPLE-TO-PEOPLE FOUNDATION, INC.
MILLWOOD, VIRGINIA 22636

by

Graciela Salvador-Davila, M.D., MPH
Anna Kathryn Webb, Ph.D.

San Antonio, Texas

October 2, 2002

The findings, conclusions, recommendations, and views expressed in this document are entirely those of the authors and should not be attributed to Project HOPE.

Dedication

This report is dedicated to the children and youth of Malawi who are the light showing the way out of the darkness of the HIV/AIDS epidemic through health education, peer counseling, drama and song, friendship with orphans, care for terminally ill AIDS patients, and many other voluntary activities in support of children, youth, and communities.

Arise

Boys and girls arise to fight AIDS.
AIDS is the killer of my friends.

Boys arise, girls arise, see how people are dying.
AIDS is the killer of my friends.

If you can't abstain, use a condom.
AIDS is the killer of my friends.

Let us join our hands and fight AIDS.
AIDS is the killer of my friends.

Schoolchildren's song
Anti-AIDS Club, Naming'omba Primary School
Naming'omba Tea Estates Ltd.
Thyolo District, Malawi

Acknowledgements

The final evaluation of the Support to AIDS and Family Health (STAFH) Project would have not been possible without the guidance and advice of Petra Reyes, Regional Director for Africa, Project HOPE Center; Dorothy Namate, Country Director, Project HOPE/Malawi; and Miriam Simbota, Program Manager, STAFH Project, in addition to the generous support of Sue Adams, Assistant Director for Africa, and Linda Furcho, Administrative Assistant, Project HOPE Center, and Clifford Matunga, Finance and Administration Manager, Project HOPE/Malawi.

Grateful acknowledgement is given to present and former STAFH project staff, including Alice Bvumbwe, Reproductive Health Trainer; Sheriff Chisamya, Accountant/Administrator; Jane Maseko, Secretary; John Njunga, Community Health Education Trainer; McKennedy Yassin, Community Health Education Trainer; and Ellen Thom, former Reproductive Health Trainer. Very special gratitude is reserved for John Njunga who with grace and ability coordinated the site visits of the two evaluation teams—the clinical team and the community/estate management team.

Our deepest appreciation goes to clinical team members, Jane Banda, RN, and Deliwe Chikuwo, ENM, and to community/estate management team members, Jane Makwakwa, RN, and Noel Mbirimtengerenji, RN, Tutor.

We are profoundly indebted to the many participants in the evaluation—Ministry of Health and Population (MOHP) central and district-level officials, agricultural estate health care providers, community members and volunteers, schoolchildren and youth and school patrons, and estate management—whose contributions were invaluable.

Finally, we are most grateful for the insights of Jane Namasasu, Reproductive Health Program Manager, Assistant Controller of Preventative Services, MOHP; Doreen Sanje, Planning Officer, National AIDS Commission (NAC); and Mexon Nyirongo, Population, Health, and Nutrition Team Leader, United States Agency for International Development (USAID).

Thank you - *Zikomo kwambiri*

Currency Equivalent
Monetary Unit = Malawi Kwacha (K)
US$1.00 = K75.4563 (July 17, 2002)

Acronyms and Abbreviations

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ARH	adolescent reproductive health
BLM	*Banja La Mtsogolo* (Future Family)
CBDA	community-based distribution agent
CO	clinical officer
CPR	contraceptive prevalence rate
CPY	couple year protection
DACC	District AIDS Coordinating Committee
DEO	District Education Office/Officer
DFID	Department for International Development, British High Commission
DHO	District Health Office/Officer
DHMT	District Health Management Team
DYO	District Youth Officer
ENM	enrolled nurse-midwife
FAO	Food and Agriculture Organization
FP	family planning
GPD	gross domestic product
GNI	gross national income
GIK	gift in kind
HCW	home craft worker
HIV	human immunodeficiency virus
HOPE	Health Opportunity for People Everywhere
HSA	health surveillance assistant
IEC	information, education, and communication
IP	infection prevention
LAM	lactational amenorrhea method
MA	medical assistant
MACRO	Malawi AIDS Counseling and Resource Organization
MIS	management information system
MOE	Ministry of Education
MOHP	Ministry of Health and Population
MTCT	mother to child transmission
NAC	National AIDS Commission
NFPCM	National Family Planning Council of Malawi
NFWC	National Family Welfare Council
NGO	nongovernmental organization
NYCOM	National Youth Council of Malawi
OD	on demand
OPD	outpatient department
PEA	Primary Education Adviser
PMTCT	prevention of mother to child transmission
PNC	postnatal care

RH	reproductive health
RHLMIS	Reproductive Health Logistics Management Information System
RHSDGs	Reproductive Health Service Delivery Guidelines
RN	registered nurse
RNM	registered nurse-midwife
STAFH	Support to AIDS and Family Health Project
STD	sexually transmitted disease
STI	sexually transmitted infection
TBA	traditional birth attendant
TfT	Training for Transformation
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Education Fund
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WFP	World Food Programme
YFS	youth friendly services

Table of Contents

Page

Dedication iii
Acknowledgements iv
Acronyms and Abbreviations v
Executive Summary xi
Introduction 1
I. Country Context 1
A. History 1
B. Economy 2
C. Social Indicators 2
D. Poverty 4
E. Food Security Crisis 4
II. History of the STAFH Project 5
A. Background 5
B. STAFH Project, 1996-1998 5
C. First Follow-on STAFH Project, 1999-2001 6
D. Second Follow-on STAFH Project, August 2001-July 2002 7
III. Evaluation Methodology 8
A. Selection Criteria for Site Visits 8
B. Evaluation Teams 8
C. Clinical Evaluation 8
D. Community Evaluation 9
E. Estate Management 10
F. Project HOPE 10
G. Assessment of Project Outcome 10
IV. Achievement of Key Intermediate Results 10
A. Improved Knowledge & Use of Good Reproductive Health Practices & Own HIV Status 11
B. Improved Community Participation in Reproductive Health 20
C. Expanded Range & Quality of Reproductive Health Services for Women, Men, and Youth in the Target Agricultural Estates 39
V. New Initiatives 43
A. Voluntary Counseling and Testing Services 43
B. Prevention of Mother to Child Transmission of HIV/AIDS 44
VI. Monitoring and Evaluation 44
A. Project HOPE Center 44
B. Project HOPE/Malawi 45
C. STAFH Project 46
VII. Implementation Performance 47
A. Project HOPE Center 47
B. Project HOPE/Malawi 47
C. STAFH Project 48
D. MOHP 49
E. Agricultural Estates 49
F. Community Volunteers 49
G. USAID 49
H. Thandizani Moyo 50

I. Others....50
VIII. Major Factors that Affected the Achievement of Project Objectives....50
A. Factors not Subject to Government Control....50
B. Factors Subject to Government Control....50
C. Factors Subject to Project HOPE Center Control....51
D. Factors Subject to Project HOPE/Malawi Control....51
E. Factors Subject to STAFH Project Control....51
F. Factors Subject to Agricultural Estate Control....51
IX. Implementation Delays....52
X. Project Design....52
XI. Sustainability....53
XII. Assessment of Outcome....54
XIII. Lessons Learned and Recommendations....54
A. Project Design....55
B. Reproductive Health Capacity Building....55
C. Reproductive Health Service Provision....56
D. Monitoring and Evaluation....57
E. Partnership Model....57
Bibliography....59
Annex A: The Quality of Family Planning Services....64
Annex B: Youth Friendly Services....66
Annex C: The Youth of Malawi: Confronting the HIV/AIDS Epidemic....68
Annex D: A Partnership Model for Health Care on Private Agricultural Estates in Malawi....74

Tables

Table 1: Key Socioeconomic and Health Indicators in Malawi: Various Years
Table 2: Clinical Evaluation Activities
Table 3: Number of Persons Interviewed by Estate, Category, and Gender: Community and Estate Management Component
Table 4: Second Follow-on STAFH Project Targeted Achieved Results (July 2002)
Table 5: Second Follow-on STAFH Project Training Summary (July 2002)
Table 6: Training Events By Date, Content, Participant Estate and Number of Days
Table 7: Characteristics of Health Infrastructure of Estates Visited
Table 8: Estate-provided Basic Health Care Services by District, Estate Company, and Estate (July 2002)
Table 9: Estate Health Care Workers by Category, District, Estate Company, and Estate (July 2002)
Table 10: HIV/AIDS Prevention Summary of Client-exit Interviews, Thyolo and Nkhotakota Districts
Table 11: Observed Behavior Change by Group and Response
Table 11: Challenges/Problems facing Youth as Reported by Youth Groups
Table 13: STAFH Project Staff Turnover 1996-July 2002
Table 14: Demographics of STAFH Project Staff Turnover 1996-July 2002
Table 15: STAFH Project Staffing, 1996-July 2002
Table 16: Summary of Assessments

Evaluation Instruments

Note to the Reader: The evaluation instruments are presented as a separate document, Evaluation Instruments for the Final Evaluation Report, Support to AIDS and Family Health (STAFH) Project.

1. District Health Officials Interview Guide
2. Client-exit Interview Guide (English)
3. Client-exit Interview Guide (Chichewa)
4. Estate Community Interview Guide (English)
5. Estate Community Interview Guide (Chichewa)
6. Community-based Distribution Agents (CBDAs) Interview Guide (English)
7. Community-based Distribution Agents (CBDAs) Interview Guide (Chichewa)
8. Health Surveillance Assistants (HSAs)/Home Craft Workers (HCWs) Interview Guide
9. Adult Peer Educators and Counselors and Drama Groups Interview Guide
10. Primary Education Adviser (PEA) and School Patron Interview Guide
11. Youth Educators and Counselors, Anti-AIDS Clubs, TfT Youth Leaders, and Youth Drama Group Interview Guide (English)
12. Youth Educators and Counselors, Anti-AIDS Clubs, TfT Youth Leaders, and Youth Drama Group Interview Guide (Chichewa)
13. Agricultural Estate Management Interview Guide
14. Project HOPE Interview Guide

Executive Summary

Background. Malawi is one of the poorest countries in the world, ranked 151 of 162 countries in the 2001 United Nations Development Program (UNDP) Human Development Index. Over six million people, or 65.3 percent of the population lives in poverty; these individuals are unable to meet their basic needs. According to the 1998 Malawi Population and Housing Census, which enumerated a population of 9.9 million, the literacy rate was 58 percent; 66 percent of the population lived in dwelling units that had thatched roofs with mud walls, or walls made of mud and wattle, i.e., traditional structures; 27 percent of the population had access to boreholes as their main source of drinking water, and 25 percent got drinking water from unprotected wells; and 73 percent of the population had access to traditional pit latrines, and 22 percent had no access to any toilet facility. In 1999, per capita income was US$180.

The HIV/AIDS epidemic in Malawi is one of the most severe in sub-Saharan Africa. At the end of 1999, the Government of Malawi estimated that about 15 percent of adults were currently infected with HIV. About 75 percent of all AIDS cases occur among people in the most economically productive age group, 20-45 years. It has been estimated that approximately 20 percent of babies born to HIV-positive mothers will be infected around the time of birth, and one-half of children infected perinatally will die before their fifth birthday. Between 1990 and 2000, the estimated number of Malawian children under 15 who are living without one or both parents grew from 740,000 to 1.2 million, with most of the increase being the result of sharp rises in the rates of adult mortality. Life expectancy is estimated to have dropped from 52 to 42 years as a result of AIDS.

HIV/AIDS is also having a devastating effect on health services in Malawi. In 1996, the annual cost of treating persons with HIV/AIDS was estimated at almost US$2 million, or 7 percent of the Ministry of Health and Population (MOHP) 1995-1996 budget. Absenteeism, illness, and death from AIDS have exacerbated shortages of health care personnel. In the health and education sectors, annual personnel death rates are six times higher than they would have been without AIDS.

At present, Malawi is experiencing a food security crisis. The World Food Programme (WFP) and the Food and Agriculture Organization (FAO) estimate that up to 3.2 million people will be affected by food shortages by the end of the coming year.

History of the STAFH Project. Since 1990, Project HOPE has worked to improve health services for agricultural workers and their families in Malawi, beginning with a pilot project on eight agricultural estates that belonged to a single company, which was expanded in 1991 to include 39 additional estates through a USAID Child Survival grant and again in 1994 through a second Child Survival grant. In 1996, Project HOPE received a new grant from USAID for family planning and AIDS prevention through the Support to AIDS and Family Health (STAFH) Project, which concluded in 1998. The First Follow-on STAFH Project covered the period, 1999-2001, and the Second Follow-on STAFH Project covered the period August 2001-July 2002. Both follow-on projects were supported by USAID grants.

Project goal. The goal of the project was the adoption of measures that reduce fertility and the risk of sexually transmitted infection (STI) and HIV among persons living in the private agriculture estates in Malawi through (a) improved knowledge and use of good reproductive health practices and own HIV status, (b) improved community participation in reproductive health care,

and (c) expansion of the range and quality of reproductive health services for women, men, and youth in the target agriculture estates. A series of activities that chiefly focused on training were developed to achieve the project objectives, along with a set of key performance indicators by which the achievement of objectives could be measured.

Project activities. The activities designed to improve knowledge and use of good reproductive health practices included training estate health clinic staff in adolescent reproductive health services and on youth friendly procedures; the establishment of estate adolescent health services; refresher training of estate clinic health staff in STI syndromic management; training of clinic staff on HIV prevention in women, prevention of mother to child transmission (PMTCT) of HIV/AIDS, and voluntary counseling and testing (VCT); and the quarterly supervision and monitoring of estate health care providers and community volunteers.

The activities in support of improved community participation in reproductive health care included refresher training of practicing community-based distribution agents (CBDAs) and their primary supervisors in family planning; training of estate adult volunteers in peer education and counseling for family planning promotion and STI and HIV prevention; training of estate adult drama groups in theater for development; training of estate youth coordinators and teachers of health education in school as trainers of the peer adolescent sexual and reproductive health program; training of in-school and out-of-school youth in peer education and counseling skills for sexual and reproductive health; training of in-school youth leaders in Training for Transformation (TfT) and Anti-AIDS club management; training of estate youth drama group members in theater for development; and quarterly supervision and monitoring.

The activities to expand the range and quality of reproductive health services for women, men, and youth in the targeted agriculture estates included training new community outreach recruits as health surveillance assistants (HSAs), establishing youth centers at each estate company, training members of District AIDS Coordinating Committees (DACCs) in the preparation of district-level HIV/AIDS activities, training estate clinic and outreach staff in infection prevention (IP); and quarterly supervision and monitoring.

Target areas and populations. The target areas and populations were 47 agricultural estates belonging to 13 estate companies in four districts of Malawi, Thyolo, Zomba, Nkhotakota, and Nkhata Bay, whose total population was estimated at 225,000 persons, including estate workers and their families. The project particularly targeted youth ages 11 to 14 (grades 5-7) for health education, especially HIV/AIDS prevention messages and information, because very little HIV infection is found in this age group, which is called the "window of hope" in combating the AIDS epidemic and for whom prevention messages are a priority.

The partnership model of project implementation. The project was implemented through a partnership of Project HOPE/Malawi, MOHP, the agricultural estate companies and their health clinics, and community volunteers. The project provided the design, planning, and organization of all project activities and supervision and monitoring functions; funded project activities and provided equipment, materials, and supplies; and developed a monitoring system for health education activities and for youth activities, sending monitoring data to the relevant government entities. Project management assisted estate management with the development of health plans and HIV/AIDS in the workplace policies; successfully lobbied for the inclusion of estate clinics in the MOHP program to supply STI drugs; helped to build the planning, management, and leadership

capacity of DACCs; gave support to district commissioners who, as members of the District Assembly, have the responsibility of preparing district health plans; and worked with the National AIDS Commission on HIV/AIDS in the workplace policy, among others. The MOHP provided lead clinical trainers, training curricula, and training venues; conducted limited supervision of some project activities; participated in project-sponsored District Health Office coordination meetings; trained estate clinic health staff in the new Reproductive Health Logistics Management Information System (RHLMIS); supplied contraceptive methods and STI drugs; and provided all necessary policies and guidelines.

Estate management funded the salaries of HSAs; in some cases, paid maintenance costs of project-financed bicycles that are used by HSAs; released estate employees for training; in some cases, made transportation available to adult drama groups and for health clinic staff to attend project-sponsored training; and participated in quarterly meetings. Estate health services provided family planning services, STI diagnosis and treatment, and risk reduction counseling for STI/HIV; clinics also submitted vital statistics and other health data to MOHP. Community adult volunteers promoted information, education, and communication on family planning, STIs, and HIV/AIDS; distributed contraceptive methods; conducted drama performances with health education messages on HIV, STIs and family planning, among others; and provided information and counseling at the workplace on HIV/AIDS, STIs, and family planning. Community youth volunteers provided sexuality and reproductive health education to peers, conducted drama performances based on health education messages, organized and participated in Anti-AIDS club activities such as helping orphans, counseled other students individually or in groups, and in general educated other youth about HIV/AIDS and how to prevent it.

Achievement of project objectives. The project achieved its major objectives with only a few shortcomings, based on the degree to which performance indicators were met, implementation performance, and sustainability. The partnership model made the achievement of objectives more complicated—unlike other projects where project staff have control over inputs, processes, and outcomes. The performance of project staff was highly satisfactory.

The project's major accomplishment is that health services are available that were not available before, including family planning, counseling, and STI diagnosis and treatment. When Project HOPE began work on the agricultural estates, family planning services estates were non-existent, and today they have become institutionalized. The project built capacity, improved, and expanded health services on the estates. Through adherence to and support of national health policies, it contributed to the standardization of local knowledge and practice on the estates, which was especially important because MOHP does not regulate agricultural estate health services. The project's training system allowed service providers to keep their knowledge and skills up-to-date. Training activities were highly esteemed by all participants. Drama performances, in particular, were considered the most effective venue for health education messages; they were well-received both as education and entertainment on the estates, where community-wide social activities are few.

The impact of project activities on behavior change, as reported by the different community groups, was highly significant. For example, youth groups reported a decrease in sexual activity and behavior; a decrease in teenage pregnancies, early marriages, and school dropouts; and increased knowledge about HIV/AIDS/STIs and how to prevent them, among others. The project also had a positive, unintended impact on the tea estates; project activities contributed

to the outcome of independent audits conducted by the Tea Sourcing Partnership on estate and factory health and safety, among other areas.

The project's major shortcoming was the seeming assumption that project activities would continue, therefore, there was no need to prepare a follow-on plan. The project design did not address the issue of sustainability, specifically, it did not provide for a transition phase in which MOHP and the agricultural estates together would plan for and reach agreement on how best to sustain project activities and benefits when the project ended, or provide for the hand-over of the project to MOHP and the agricultural estates at the conclusion of project financing. The project did not have an exit strategy in the event that it succeeded or failed. The project succeeded, project financing ended, and Project HOPE faces the dilemma of what to do. The sustainability of project achievements is uncertain. The sustainability of some activities and benefits is likely, for example, family planning and STI services because they are well-established. The sustainability of other activities and benefits is unlikely or uncertain, for example, the new initiatives such as youth friendly services and PMTCT of HIV/AIDS because the activities and support surrounding the initiatives were not significant. Similarly, the sustainability of community volunteer activities is uncertain because the volunteers are motivated in large part by refresher training courses, which may not be realized in the future.

Sustainability is further jeopardized by the uncertain future participation of MOHP and the agricultural estates. MOHP and the estates evidenced a limited sense of project "ownership" because they were not fully and actively involved in the preparation of the project. Furthermore, MOHP is constrained by the lack of human and financial resources necessary for supervision and training. Estate management was not as fully cognizant, as was supposed, of the critical health issues that the project addressed, and management should have been given more support in this area in order to help gain a commitment to carry on project activities.

Looking to the future. In spite of some weaknesses, the partnership model did work, and it holds considerable promise for the future. Both MOHP and the estates benefited as a result of the project, and the partnership between them was strengthened by virtue of the project. Building upon lessons learned, the partnership model can be replicated for scaling-up across the agricultural estate sector. Project HOPE has played a remarkable role to date in improving health services on the agricultural estates, and the potential exists for greater successes. It is recommended that Project HOPE fully develop the partnership model through consultations with MOHP and estate management toward the end of promoting the model as an effective and efficient means of improving health services on non-participating agricultural estates and of encouraging the sustainability of project activities on participating estates. The proposed model would include a full description of the purpose, activities, and costs of health interventions and of the partnership arrangement, e.g., the roles and responsibilities of each partner and the costs and benefits of participation.

Introduction

1. This report is the final evaluation of the Support to AIDS and Family Health (STAFH) Project, which was implemented by Project HOPE/Malawi with funding from the United States Agency for International Development (USAID). The stated purpose of the evaluation was to "assess the achievements of the STAFH project toward each intermediate result, the impact of STAFH interventions on the behavior of the estate workers, and the effectiveness of the workplace model with the private agricultural estates and the viability of the model developed in a Malawian setting."[1] Moreover, the evaluation would document key lessons learned regarding employer-based community health programs, in particular, the role of private employers in providing reproductive health programs, the quality of family planning (FP) counseling, youth friendly services (YFS), and peer education for youth. The evaluation would cover the entire program; however, greater emphasis would be placed on the activities of the final year.

2. Preparation for the evaluation began in early June 2002, and the formal evaluation was conducted in Malawi during the period, July 1-20, 2002. The evaluation was based on the review of project and other documents and statistical data; site visits to five agricultural estates; interviews with community groups, estate health service providers and clients, estate management, Ministry of Health and Population (MOHP) central and district-level personnel, and Project HOPE headquarters and Malawi staff. Debriefings were held with the Regional Director for Africa; Country Director and Program Manager, Project HOPE; the Population, Health, and Nutrition Team Leader, USAID; the Reproductive Health Program Manager, MOHP; and the Planning Officer of the National AIDS Commission (NAC).

3. Chapter One presents background information on Malawi. Chapter Two summarizes the history of the STAFH Project. Chapter Three describes the evaluation methodology. Chapter IV presents the findings and conclusions of the evaluation in relation to the key intermediate results, or project objectives, and assesses the degree to which they were achieved. Chapter Five discusses new project initiatives. Chapter Six evaluates the adequacy of project monitoring and evaluation. Chapter Seven appraises the implementation performance of the project's key participants. Chapter Eight discusses major factors that affected the achievement of project objectives. Chapter Nine describes implementation delays. Chapter Ten evaluates project design. Chapter Eleven analyzes the sustainability of project activities and benefits. Chapter Twelve assesses project outcome. The final chapter puts forward lessons learned and recommendations. The annexes contain lessons learned summaries on selected themes.

I. Country Context

A. History

4. Malawi became an independent nation in 1964 after 73 years of British rule. Hastings Kamuzu Banda, named Prime Minister in 1963, was elected President for life in 1971 and instituted authoritarian one-party rule. His control lasted until 1994, when he was defeated by Mr. Bakili Muluzi in the first multiparty elections held in Malawi. Mr. Muluzi and his United Democratic Front (UDF) party were re-elected in the country's second multiparty elections, held in

[1] See Statement of Work, Final Evaluation, Support to AIDS and Family Health (STAFH) Project, Project HOPE/Malawi, June 4, 2002.

June 1999. Local elections were held in the country for the first time in November 2000; the UDF won 70 percent of the wards, albeit on very low voter turnout.[2]

5. Malawi's economy prospered in the 1970s with the assistance of foreign aid and investment and grew at an annual rate of 6 percent. In general, though, 30 years of authoritarian rule did not spur significant and broad-based economic development. The new government, which has initiated an economic reform agenda, faces challenges on several fronts, among them a rapidly growing population, a high HIV/AIDS infection rate (about 14.9 percent), limited natural resources, high levels of inequality resulting from years of elitist development strategy, and the corrosive effects of recurring droughts, poor resource management, and environmental degradation.[3]

B. Economy

6. Malawi's economy is based largely on agriculture, which accounts for more than 90 percent of its export earnings, contributes 45 percent of gross domestic product (GDP), and supports 90 percent of the population. Malawi has some of the most fertile land in the region. Almost 80 percent of agricultural produce comes from smallholder farmers. Land distribution is unequal with more than 40 percent of smallholder households cultivating less than 0.5 hectares. The country's export trade is dominated by tobacco, tea, cotton, coffee, and sugar.[4] Malawi was the first country in Africa to grow tea on a commercial scale, beginning in the Victorian era, and has been responsible for the spread of tea production to the other East African states.[5]

7. The agricultural sector is dualistic, consisting of small-scale farmers and an estate subsector. The two subsectors have been distinguished historically on the basis of legal and institutional rules regulating land tenure, type of crops, and marketing arrangements. The smallholder subsector is based on a customary land tenure system and is primarily subsistence, providing the bulk of food production. The main food crop is maize, supplemented by rice, sorghum, pulses, cassava, and sweet potatoes. Since the mid-1990s, smallholders have been allowed to produce export/industrial crops, and this has generated great response in production, particularly of tobacco. Other cash groups include cotton, groundnuts, and pulses. The estate subsector comprises about 14,700 estates occupying some 850,000 hectares of leased land. The main crops are tobacco, tea, and sugarcane. Approximately 80 percent of the workforce is employed in the smallholder subsector and 11 percent on estates.[6]

C. Social Indicators

8. The 1998 Population and Housing Census enumerated a total population of 9.9 million (49 percent male and 51 percent female). The population growth rate was 2 percent per annum, based on the 1987 population of about 8 million. Forty-seven percent of the population lives in the Southern Region; 41 percent, in the Central Region; and 12 percent, in the Northern Region. Fifty-seven percent of the total population used Chichewa, which is the official language of Malawi,

---

[2] World Bank. Malawi, Country Brief, July 2002, p. 1
[3] Ibid., p. 1
[4] Ibid., p. 1.
[5] Source: www.teasourcingpartnership.org.uk
[6] Food and Agriculture Organization (FAO) and World Food Program (WFP), United Nations. Special Report, FAO/WFP Crop and Food Supply Assessment Mission to Malawi, Rome, 29 May 2002, p. 3

along with English, as their language of communication in their households. The literacy rate was 58 percent (64 percent male and 51 percent female). Of about 6.8 million persons aged 10 years or older, around 4.5 million or 66 percent were economically active. The majority (78 percent) were subsistence farmers. Sixty-nine percent of households were headed by males; one-fifth of urban households were female-headed, and one-third of rural households were female-headed. Sixty-six percent of the population lived in dwelling units that had thatched roofs with mud walls, or walls made of mud and wattle, i.e., traditional structures. Twenty-seven percent of the population had access to boreholes as their main source of drinking water; 25 percent got drinking water from unprotected wells. Seventy-three percent of the population had access to traditional pit latrines; 22 percent had no access to any toilet facility. The majority of Malawians (94 percent) used firewood as their main source of energy for cooking. About 50 percent of the population had access to at least one radio, and 41 percent had access to at least one bicycle.[7] According to UNICEF, Malawi has the eighth highest under-five mortality rate in the world.[8] MOHP reported a significant increase in the maternal mortality rate in recent years, which may be as high as 1200/100,000 live births. The Malawi Demographic Health Survey 2000 reported current use of modern contraceptive among women of all ages to be 26 percent, up from 14 percent in 1996; there was also an increase in the rural sector, which has comparatively lower rates of modern contraceptive use. Knowledge of at least one modern family planning method is universally high (95 percent or more) among all subgroups of currently married women and men in Malawi.[9]

9. HIV/AIDS. The HIV/AIDS epidemic in Malawi is one of the most severe in sub-Saharan Africa. HIV began to spread in Malawi in the early 1980s, primarily as a result of multiple partner sexual contact, low condom use, and high prevalence of sexually transmitted infections (STIs). At the end of 1999, the Government of Malawi estimated that about 15 percent of adults were currently infected with HIV, the virus that causes AIDS, which means that 740,000 women and men will develop or already have developed AIDS. Further, 65,000 children under age 15 are estimated to be HIV infected. About 75 percent of all AIDS cases occur among people in the most economically productive age group, 20-45 years.[10] The principal mode of HIV transmission in Malawi is heterosexual contact, which accounts for 90 percent of HIV infections in the country. Perinatal transmission accounts for nine percent of all HIV infections. It has been estimated that approximately 20 percent of babies born to HIV-positive mothers will be infected around the time of birth, and one-half of children infected perinatally will die before their fifth birthday. The children of HIV-infected parents who are not themselves infected are still at a great disadvantage, due to health and social consequences of losing one or more parents to AIDS. It is estimated that between 1990 and 2000, the number of Malawian children under 15 who are living without one or both parents grew from about 740,000 to 1.2 million, with most of the increase being the result of sharp rises in the rates of adult mortality.[11] All-cause mortality has risen by 76 percent among men and 74 percent among women age 15-49 during the 1990s; the age patterns of the increase are consistent with causes related to HIV/AIDS.[12] Life expectancy is estimated to have dropped from

[7] National Statistical Office. 1998 Malawi Population and Housing Census, Report of Final Census Results, December 2000, pp. viii-xix
[8] UNICEF. 1997 State of the World Report.
[9] National Statistical Office [Malawi] and ORC Macro. Malawi Demographic and Health Survey 2000, Zomba, Malawi and Calverton, Maryland, August 2001
[10] Ibid., p. 143
[11] Ibid., p. 143
[12] Ibid., p. xxi

52 to 42 years as a result of AIDS, and according to U.S. Census Bureau projections, it may fall well below 40 by 2010.

10. HIV/AIDS is also having a devastating effect on health services in Malawi. In 1996, the annual cost of treating persons with HIV/AIDS was estimated at almost US$2 million, or 7 percent of the MOHP 1995–1996 budget. According to the World Bank, half of all patients admitted to health institutions are infected with HIV. In addition, absenteeism, illness, and death from AIDS have exacerbated shortages of health care personnel. In the health and education sectors, annual personnel death rates are six times higher than they would have been without AIDS.[13]

D. Poverty

11. Malawi is one of the poorest countries in the world, ranked 151 of 162 countries in the 2001 UNDP Human Development Index.[14] In Malawi, 65.3 percent of the population—over six million people—lives in poverty, i.e., these individuals are unable to meet their basic needs. Poverty is worse in rural areas (66.5 percent) than in urban areas (54.9 percent). Nearly ninety percent of Malawi's poor live in rural areas. The Southern region is the poorest of the three regions (68.1 percent), followed by the Central region (62.8 percent) and the Northern region (62.5 percent).[15] Poor households are larger than non-poor households and have an average of 1.6 additional persons; this pattern is largely maintained in both rural and urban areas. Poor households have more dependents for every worker in the household. Relative to the non-poor, poor households have one extra dependent to support for every three members of working age (individuals aged 15 through 64). In 1999, per capita income was US$180 (Table 1).

E. Food Security Crisis

12. The Government of Malawi declared a national disaster due to actual and anticipated food shortages on February 27, 2002. The primary cause of the food security crisis is low production during the 2001/2002 growing season, which followed a mediocre 2000/2001 harvest. Another important cause of the crisis is poor government management. The World Food Programme (WFP) and the Food and Agriculture Organization (FAO) estimate that up to 3.2 million people will be affected by food shortages by the end of the coming year and anticipate a food aid requirement of 208,000 metric tons (MT).[16] There is a direct linkage between household food security and HIV/AIDS, including a loss of able-bodied labor within the household, loss of remittances from a working family member, adoption of orphans by the elderly, child-headed households, increased expenditures on health care and funerals, among others.[17] As survivors of HIV/AIDS victims, women, children, and the elderly are particularly affected due to their relative lack of opportunity for wage labor as compared with able-bodied men.[18]

---

[13] Source: www.usaid.gov/pop_health/aids/Countries/africa/malawi.html

[14] United Nations Development Programme (UNDP). Human Development Report 2001, Making New Technologies Work for Human Development, Oxford University Press, New York, 2001

[15] World Bank. The state of Malawi's poor: The incidence, depth, and severity of poverty, PMS policy brief No. 2 (revised), November 2000, p. 1

[16] U.S. Agency for International Development. Situation Report, Southern Africa Complex Drought Fact Sheet #6 (FY 2002), Southern Africa Complex Food Security Crisis, June 14, 2002

[17] FAO and WFP Special Report, op. cit., p. 14

[18] Ibid., p. 14

II. History of the STAFH Project

A. Background

13. Since 1990, Project HOPE has worked to improve health services for agricultural workers and their families in Malawi, beginning with a pilot project in eight agricultural estates that belonged to a single company. The project focused on improving sanitation and diarrheal disease control, in addition to limited family planning and HIV prevention efforts. In 1991, the project was expanded through a USAID Child Survival grant to include 39 additional estates who requested participation. The project trained clinical staff in existing estate health facilities and health surveillance assistants (HSAs) who provided health education talks, tracked the spread of disease in their communities, and delivered family planning services. The project also worked with estate management to ensure sustainability following the project's conclusion. In 1994, USAID awarded a second Child Survival grant to continue and expand project activities. Under this grant, the target population coverage grew by 50 percent with the inclusion of 19 new estates. The project focused on training HSAs to deliver health education and services, emphasizing quality of care; strengthening supervision systems, including the transfer of the major part of supervisory responsibilities to estate medical staff; expanding services to include increased family planning services, antenatal care, and under-five clinics; and working with estates to establish a local nongovernmental organization (NGO), Thandizani Moyo, that would take over project administration and supervision when Project HOPE's role was completed. In 1996, Project HOPE received a new grant from USAID for family planning and AIDS prevention through the Support to AIDS and Family Health (STAFH) project.

B. STAFH Project, 1996-1998

14. Goal and strategy. The goal of the first STAFH project was to decrease transmission of HIV/AIDS/STIs and reduce total fertility among private sector agricultural estate employees and their families through (a) improving STI prevention and treatment services, (b) encouraging behavior change to decrease HIV transmission, (c) increasing contraceptive usage, and (d) ensuring sustainability. The strategy was to assist the private agricultural estates to develop and maintain effective AIDS, STI, and family planning services, both in their estate clinics and in the compounds and communities where their employees live.

15. Activities. The project had four main activities: (a) improving STI treatment and quality of care by teaching health facility staff about the syndromic approach to STIs; (b) encouraging behavior change by training clinic staff, teachers and youth leaders in Training for Transformation (TfT) to reduce the transmission of HIV and increase community ownership of the problem;[19] (c) increasing contraceptive use on the estates by improving accessibility and acceptability of family planning (FP) services through community-based distribution of contraceptives and FP education; and (d) strengthening the primary health care infrastructure on the estates and developing mechanisms to ensure sustainability of STI and FP services.[20]

---

[19] Training for Transformation (TfT) is a participatory approach to community development that encourages community empowerment and is based on the belief espoused by Paolo Freire (1970) that communities themselves are powerful resources for problem-solving.

[20] Project HOPE. Technical Proposal, Family Planning and AIDS Prevention under support to AIDS and Family Health Project (STAFH), IFA No. 690-950A-002, Millwood, VA, January 1996, pp. 1-2

16. Target areas and populations. The target areas were 101 agricultural estates belonging to 15 estate companies and located in nine districts of Malawi. The estates ranged in size from a few hundred to 25,000 acres.[21] The total population (direct and indirect beneficiaries) expected to benefit from the project was 380,000 persons, including estate employees (permanent and seasonal) and their families. Of the 380,000 persons, 250,000 were associated with estates where Project HOPE had already been working, and 130,000, with estates with which Project HOPE would work for the first time.

17. Assessment. In 1998, the project was assessed in the areas of training, supervision/follow-up, equipment and supplies, reporting/record-keeping, research activities, and sustainability.[22] In order to take advantage of project strengths and ensure sustainability, the assessment recommended the following: (a) improved communication and relations between estate management and clinical personnel, (b) provide estate management with evidence that investment in health care for workers is beneficial, (c) improve supervision by Project HOPE staff and estate health employees and managerial staff, (d) address the shortage of drugs, in particular STD drugs, and the mismanagement of supplies, (e) adapt the levels and types of interventions to the current level of activities on the estate and the extent to which the estate is committed to the project, (f) consider a reduced number of states with a full gamut of activities, and (g) consider scaling back some types of training that do not appear to be cost-effective.[23] The assessment concluded that building upon a long and successful history of health interventions on private agricultural estates in Malawi, Project HOPE had provided important and necessary services to a large number of needy Malawians through interventions seen as unique approaches to providing health care in the private sector, opened the door for many similar activities in the region, and retained the best aspects of earlier grants, including the requirement for estate financing of salaries, medications, etc., and Project HOPE's demonstrably effective training and support.[24]

18. Project cost and financing. The total, planned project cost was US$979,825. The actual total cost was US$1,022,581. USAID provided 73 percent of project cost, and Project HOPE provided 27 percent in the form of gifts in kind (GIK).

C. First Follow-on STAFH Project, 1999-2001

19. Goals and objectives. The First Follow-on project supported USAID Strategic Objective 3: "increased adoption of measures that reduce fertility and risk of STI/HIV transmission among private agricultural estates," and within the USAID results framework, adopted the following intermediate results for which detailed indicators and activities were developed: (a) family planning, STI/HIV and child health services accessible and provided to Malawi's citizens; (b) increased participation of community members in activities that improve health; (c) improved knowledge of family planning, STI/HIV transmission and prevention, and child health practices; and (d) management capacity, practices, and systems improved within the private agricultural estates for continuing provision of health services.

---

[21] The districts were: Mulanje, Thyolo, Zomba, Machinga, Lilongwe, Mchinji, Kasungu, Nkhotakota, and Nkhata Bay.

[22] Erin Eckert. Family Planning and AIDS Prevention on Malawi's Private Agricultural Estates, An Assessment of the Project HOPE–STAFH Programme, 1996-1998, Measure Evaluation, USAID Cooperative Agreement: HRN-A-00-97-00018-00, December 11, 1998

[23] Ibid., pp. 12-14

[24] Ibid., p. 14

20. Activities. The project continued with the same activities of the first STAFH project: training estate health workers and volunteers in STI syndromic management, community-based distribution of FP services, TfT, HIV risk reduction counseling, participatory drama, and supervision skills training. Trained clinic staff, HSAs/HCWs, in-school youth, and estate volunteers provided FP, STI, and HIV/AIDS services to the estate communities and surrounding communities.

21. Target areas and populations. The target areas were 47 estates belonging to 13 estate companies in four districts, Thyolo, Zomba, Nkhotakota, and Nkhata Bay. The total population was estimated at 225,000 full-time and seasonal estate workers and their families.

22. Project cost and financing. The total planned project cost was US$910,986. The actual total cost was US$815,087. USAID provided 62 percent of total cost, and Project HOPE provided 38 percent in the form of GIK (pharmaceuticals and equipment).

23. Mid-term evaluation. A mid-term evaluation was conducted in late February 2001, which identified strengths and weaknesses in the areas of delivery of family planning and STI services and STI/HIV prevention education; capacity of the estate health system to sustain family planning, STI, and HIV/AIDS activities; the potential influence that participatory methodologies have on attitudes and behavior change within the estate communities; and project management capacity (para. 197).[25] The evaluation made detailed recommendations to improve the commitment of estate managers, improve the system of field supervision in order to raise the quality of interventions, increase the relevance of outreach work to increase behavior change, increase the reach of male and female employees, improve project monitoring, and improve the efficiency of program management and implementation.[26] The evaluation concluded that the First Follow-on project was making an important contribution to STI/HIV/AIDS prevention and family planning promotion in the target estates.

D. Second Follow-on STAFH Project, August 2001-July 2002

24. Goal and design. The goal of the Second Follow-on STAFH Project was the adoption of measures that reduce fertility and the risk of STIs and HIV among persons living in the private agriculture estates in Malawi through (a) improved knowledge and use of good reproductive health practices and own HIV status, (b) improved community participation in reproductive health care, and (c) expansion of the range and quality of reproductive health services for women, men, and youth in the target agriculture estates. The project was designed to strengthen family planning, STIs and HIV/AIDS interventions in the same impact area of the private agricultural estates of Thyolo, Zomba, Nkhotakota, and Nkhata Bay districts as the First Follow-on project. The project would consolidate the current FP, STI, HIV/AIDS activities and add new activities: adolescent reproductive health (ARH), community participation in HIV/AIDS and FP activities, prevention of mother to child transmission (MTCT) of HIV/AIDS, voluntary testing and counseling (VCT), and promotion of practices that prevent/control infection at health facility level.[27]

---

[25] Ruth Kornfield. Mid-term Evaluation of STAFH Project, March 2001

[26] Ibid., pp. 26-29

[27] Project HOPE. Second Follow-on Proposal on the Project HOPE Support to AIDS and Family Health (STAFH) Project for Private Agricultural Estate Employees in Thyolo, Zomba, Nkhotakota and Nkhata Bay Districts of Malawi, Request for Extension of Grant No. 690-0000-G-00-6056-00, November 1, 2000, p. 8

25. Target areas and populations. The target areas and population were the same as in the First Follow-on project: 47 estates belonging to 13 estate companies in four districts, with an estimated population of 225,000.

26. Project cost and financing. The total planned cost of the project was US$690,747. As of October 1, 2002, the provisional total cost was estimated at US$884,023, pending Project HOPE's official financial report to USAID. USAID provided an estimated 55 percent of total costs. Project HOPE provided an estimated 45 percent of total, distributed between GIK in the form of pharmaceuticals (98 percent) and cash (2 percent).

III. Evaluation Methodology

A. Selection Criteria for Site Visits

27. The STAFH Project was implemented in four districts with 13 estate companies and 47 participating agricultural estates. Five estates belonging to five estate companies in three districts were selected for site visits. The companies were I. Conforzi Tea and Coffee Estate Ltd., Naming'omba Tea Estates Ltd., and Makandi Tea and Coffee Estates Ltd. in Thyolo District; Dwangwa Sugar Estate Ltd. in Nkhotakota District; and Wallace Tobacco and Coffee Estate Ltd. in Zomba District. The selection criteria were: (a) "old" estates that previous to the STAFH Project had participated in the Child Survival projects, which were implemented by Project HOPE/Malawi; (b) "new" estates whose participation began with the STAFH Project; (c) estates whose health facilities represented the standard agricultural estate health model, a more complex model, e.g., Makandi estate, and a simpler model; (d) estates chosen to participate in the pilot activity for youth friendly services (YFS); and (e) estates that were supportive of the project and those that were less supportive. More estates were visited in Thyolo District because more estates there participated in the project. Wallace Tobacco and Coffee Estate Ltd. in Zomba District was the only participating estate in that district. Time constraints and proximity also influenced estate selection; the more distant estates in Nkhata Bay District could not be considered.

B. Evaluation Teams

28. Two teams acting in concert conducted the evaluation: the clinical team and the community/estate management team. The clinical team was comprised of the lead clinical evaluator and two research assistants. The lead community evaluator and two research assistants formed the community/estate management team. Both teams traveled together on site visits with an evaluation coordinator who was responsible for logistics, scheduling, and organization. At each estate, the clinical team visited health facilities, observed health care service delivery and conditions, and interviewed staff and clients. The lead clinical evaluator also met with Ministry of Health and Population (MOHP) central and district-level personnel. The community/estate management team conducted group interviews with members of the estate community and community volunteers. The lead community/estate management evaluator also interviewed estate management.

C. Clinical Evaluation

29. The clinical component of the evaluation took place from July 1-12, 2002 (Table 2). Prior to the site visits, the clinical team and project staff reviewed and finalized the evaluation instruments, including the health providers interview guide, District Health Officers (DHOs) interview guide, and the client-exit interview guide, which was translated into Chichewa. (See the separate document, Evaluation Instruments, for the clinical evaluation instruments.)

30. The evaluation of estate health facilities focused on the quality of reproductive health care, including the assessment of health providers' reproductive health knowledge and skills; the accessibility of contraceptives; drugs for the treatment of sexually transmitted infections (STIs); and infection prevention (IP) supplies. Where possible, client-provider interaction was evaluated by means of direct consultation observation. In order to obtain clients' perceptions of health services, client-exit interviews were carried out; one of the two clinical evaluation research assistants conducted the interviews in Chichewa. The client's consent was obtained prior to consultation observation and client-exit interviews. The clinical findings discussed in this report should not be generalized to the entire number of estates that participated in the project.

31. The evaluation of the partnership between the STAFH Project, MOHP, and agricultural estate health services, and of project sustainability consisted of ten in-depth interviews with central and district-level MOHP staff in three of the four districts where the project was implemented. Project staff were also interviewed. In order to complement the site visit data, numerous documents were reviewed, including technical project documents, evaluation reports, progress reports, training curricula, and resource documents such as technical manuals, among others.

D. Community Evaluation

32. The evaluation methodology for estate communities and community volunteer groups was participatory and consisted of meetings with the various groups, which were conducted according to thematic interview guides. For all five estates visited, a total of 542 persons (53 percent female) participated in 39 separate group meetings, as follows: (a) estate community groups, 194; (b) adult peer educators and counselors, 11; (c) adult drama groups, 24; (d) community-based distribution agents (CBDAs), 36; (e) health surveillance assistants (HSAs), 23; (f) school patrons who supervised youth groups, 11; and (g) youth groups, including Anti-AIDS clubs, youth peer educators and counselors, youth drama groups, and TfT youth leaders, 243 (Table 3). With the exception of HSAs, all other groups volunteered their services.

33. The thematic interview guides, based on planned project activities, were designed for each of the groups, reviewed by STAFH Project staff and the two community evaluation research assistants prior to the site visits, and minor adjustments were made during the course of the site visits. The guide for estate communities focused on the themes of challenges facing communities, estate health services, health education, drama groups, and community problem-solving. This guide was translated into Chichewa. The guides for the other groups—all of whom were trained under the project—dealt with training, outreach activities, supervision, materials and supplies, logistics and transportation, and communications and information, in addition to observed behavior change. The thematic interview guides for youth groups and CBDAs were also translated into Chichewa. (See the separate document, Evaluation Instruments, for the community group interview guides.)

34. Prior to beginning a group interview, the evaluation coordinator introduced the team, explained the purpose of the visit, and asked permission for note-taking. Next, the relevant interview guide was administered by one of the two research assistants. The other research assistant provided simultaneous translation of responses from Chichewa to English for the benefit of the community evaluator who took notes. Each group meeting lasted on average 45 to 60 minutes, and the total amount of time spent per estate averaged 8 hours, excluding travel time. As is customary, at the conclusion of each group interview, participants were given soft drinks and cookies, which were provided by the STAFH Project. No significant problems were encountered during the site visits; in fact, the evaluation met with great interest, cooperation, and patience.

35. With respect to data processing, all responses for each group interviewed were tabulated, i.e., the qualitative interview data were quantified in table form and reviewed for accuracy and completeness by the three-person community evaluation team plus the STAFH Project evaluation coordinator. Approximately 1,500 responses were recorded for the 39 separate group meetings held on the five estates.

E. Estate Management

36. Estate management from all five companies were interviewed, following a thematic interview guide whose principal themes were: (a) an evaluation of the project, including the assessment of major factors that affected the achievement of project objectives and of project sustainability, and (b) an appraisal of the partnership between the agricultural estates, MOHP, and the STAFH Project. The interviews with estate management averaged one hour in length. Follow-up interviews were conducted with estate management from two of the five companies. The estate management from two additional companies—Eastern Produce and Press Agriculture (Nantipwili estate)—were also interviewed for the purpose of supplementing information on the partnership arrangement. (See the separate document, Evaluation Instruments, for the estate management interview guide.)

F. Project HOPE

37. Project HOPE headquarters and Malawi staff were interviewed, using a thematic interview guide, which covered several topics in two large groupings: (a) an evaluation of the project, including the achievement of key intermediate results, major factors that affected the achievement of project objectives, project sustainability, project design, implementation delays, implementation performance, and monitoring and evaluation, and (b) an appraisal of the partnership between the agricultural estates, MOHP, and the STAFH Project. The interviews lasted on average two hours. (See the separate document, Evaluation Instruments, for the Project HOPE interview guide.)

G. Assessment of Project Outcome

38. The project outcome was assessed according to the achievement of key intermediate results, the sustainability of project activities and benefits at the conclusion of project financing, implementation performance, and the adequacy of monitoring and evaluation. Assessment ratings were defined for each category, based on document review, statistical data, interview data, and site visit findings.

IV. Achievement of Key Intermediate Results

The achievement of the project's three key intermediate results was to be measured by 40 key performance indicators (Table 4), which referred to 41 training activities (Table 5). The three key intermediate results were: (a) improved knowledge and use of good reproductive health practices and own HIV status, (b) improved community participation in reproductive health, and (c) expanded range and quality of reproductive health services for women, men, and youth in the target agricultural estates. This chapter assesses whether the three key intermediate results were substantially, partially, or negligibly achieved, based on analysis of the specific objectives, key performance indicators, and activities for each key intermediate result.

A. Improved Knowledge & Use of Good Reproductive Health Practices & Own HIV Status

39. The overall objective to improve the knowledge and use of good reproductive health practices and own HIV status was substantially achieved, based on the extent to which targets and training goals were met, as discussed in the following paragraphs.

40. Health care services on agricultural estates. In Malawi, health service provision on agricultural estates is not regulated by national policy. Thus, the criteria for its organization and the type and number of services and staffing varies and appears to be dependent primarily on the estate's financial situation and management's degree of social responsibility and motivation to contribute to a healthy workforce. In some instances, the provision of health services dates back to the estates' creation in the early twentieth century. However, the modern era of health services on the agricultural estates was reported to have been greatly influenced by the British-born, female physician, Dr. Miller. Dr. Miller was recruited by the tea estates in Thyolo District to help them determine the type of health services to offer with concomitant staffing. Dr. Miller also played a major role in Thandizani Moyo, a local NGO, which was involved in the project for a limited period (para. 212).

41. On the estates visited, health services were offered through clinics/dispensaries, health posts and community volunteers, the community-based distribution agents or CBDAs. Although health infrastructure did not appear to have a direct relationship with the estate population, the size of the estates did influence the number of clinics/dispensaries and health posts established. For example, the large Makandi Tea and Coffee Estate in Thyolo District had five clinic/dispensaries and two health posts (Table 7). The estates provided basic reproductive health (RH) services, which included family planning (FP) and STI diagnosis and treatment (Table 8). Antenatal care was not offered at all estate health facilities. Maternity services were rare among the estates, leaving child deliveries to traditional birth attendants (TBAs). In addition to basic RH, estate health services offered under-five clinics. Vaccinations, however, depended upon the availability of refrigeration. The estates had outpatient department (OPD) services that took care of the most frequent illnesses. Dispensaries/clinics were most often staffed by an enrolled nurse midwife (ENM) and RH provider, assisted by an HSA, dresser and cleaner. A dresser, who can perform as an auxiliary nurse for first aid purposes and malaria treatment, staffed health posts in most cases (Table 9).

42. Estate providers collected health facility statistics by age and by gender. The partnership between MOHP and the project made possible the monthly submission of the RHLMIS Form 06, which corresponds to contraceptives, STI drug supply, and other supplies. In so doing, the estates

obtained needed supplies, minimizing stockouts, and MOHP obtained vital data. In 2001, MOHP launched a new, revised Reproductive Health Logistics Management Information System (RHLMIS),[28] which integrates contraceptives, FP supplies, and STI drugs under Form 06. The RHLMIS and Form 06, in particular, appear to be the solution to the problem of STI drug stockouts. Form 06 is channeled to the FP/STI coordinator at the district level. Estate providers were recently trained in the use of the form. MOHP officials and estate service providers expect that on the completion of the training phase and the institutionalization of the form, a regular flow of necessary commodities will follow.

43. Local workers, both seasonal and permanent, along with their families, were the client-beneficiaries of estate health services. In addition, FP and STI services were extended to community members outside the estate, as were immunizations when sufficient vaccines were available. Further evidence of the partnership established between the estates and MOHP was that estate clinics were supplied with FP commodities, STI drugs, and child vaccines in exchange for the provision of estate clinic services to the neighboring communities.

1. Knowledge and use of family planning practices increased

44. The objective to increase knowledge and use of family planning practices was substantially achieved, based on the extent to which family planning services and goals were met.

45. The performance indicator for family planning (FP) methods expressed in couple years protection (CYP) by CBDAs and clinic staff was 12,000 CYP;[29] the achieved result was 7,002 CYP. The performance indicator for the number of individuals reached with family planning messages through TfT, drama, and counseling was 203,000; the achieved result was 58,474. It should be noted that the target number of 203,000 was an estimated five-year figure; the actual result of 58,474 is for one year. The performance indicator for the percentage of persons reporting having knowledge of available family planning methods on the estate clinic and CBDAs was 80 percent. Results were to be determined by means of a survey, which was not conducted; the needed technical assistance was not forthcoming (para. 193).

a. Estate clinics and clinic staff providing family planning services

(1) performance indicators

46. The performance indicator for the number of estate clinic providing family planning services was 27; the actual number achieved was 25. The performance indicator for the number of estate clinic staff providing family planning services was 45; the actual number achieved was 50.

(2) findings

[28] The RHLMIS is a system of inventory management, recording and reporting for drugs, contraceptives, and other medical supplies that is integrated with the MOHP medical supply system. See Republic of Malawi, Ministry of Health and Population, Reproductive Health Logistics Management Information System, A Procedures Manual, March 2001

[29] The CYP conversion factor: (a) pill = 15 cycles/couple/year; (b) Depo-Provera = 4 doses/couple/year; (c) IUCD = x 3.5 years/couple; (d) condom = 120 units/couple/year; (e) foam tablets = 120 tables/couple year.

47. Family planning acceptance in Malawi continues to rise. The Malawi 2000 Demographic and Health Survey (DHS) reported current use of modern contraception among women of all ages to be 26 percent, which represents a dramatic increase from 14 percent in 1996.[30] In the rural sector, where the agricultural estates are located, comparatively lower rates of modern contraceptive usage were reported; however, there was also an increase in contraceptive use. According to the survey, knowledge of at least one modern FP method was universally high (95 percent or more) among all subgroups of the currently married women and men in Malawi.[31] The number of providers interviewed for the evaluation was limited, but the survey corroborated interview findings. Specifically, providers were asked the question, "To what extent do you feel that the community (men and women) really understands the importance of RH services?" One representative response was: "They are understanding it now. Clients for FP are younger and with less number of children" (Conforzi estate, ENM-RH provider). Another typical response was: "The mentality has changed, before they had six children.... Now it is different" (Naming'omba estate, ENM-RH provider).

48. The largest investment of project resources was geared toward building reproductive health service capacity among estate staff in order to increase access to family planning clinical services. As of July 2002, 25 health estate health facilities were offering family planning services to the community of workers and their families, as well as neighboring communities, reaching 93 percent of the target populations. During the project, a partnership was established between the public and private sectors in which MOHP provides a continuous supply of family planning commodities in exchange for an expansion of family planning services by estate clinics to neighboring communities.

49. Family planning services were successfully institutionalized at estate health care facilities, which was reflected in an increased number of providers who were hired by the agricultural estates in response to a higher service demand. As of July 2002, the project achieved 111 percent of the targeted number of estate clinic staff providing family planning services. The estates visited offered family planning services on demand (OD). Interviews with providers, along with observational data gathered during field visits, indicated that the majority of clients seek services during morning hours. The FP methods offered were: hormonal contraceptives (combined oral contraceptives or pills, and progestin-only injectables in the form of Depo-Provera), barrier methods (male condom and spermicides), and the lactational amenorrhea method (LAM). Intra-uterine devices such as copper IUD380-A were not offered in all estate health facilities due to providers' limited skill and the small demand for this method. Clients for Norplant and surgical contraception (both male and female) were referred to public sector hospitals and/or to a local FP/RH NGO, *Banja La Mtsogolo* or BLM (Future Family.)

50. The increased number of estate family planning providers was the result of project capacity building through training. Knowledge among health care service providers increased following the family planning training and refresher courses provided by the project. The core content of training events that targeted professional staff, including enrolled nurse-midwives (ENMs) and medical assistants (MAs), focused on the following methods: (a) barrier (male condom) and spermicides; (b) combined contraceptives (combined oral contraceptives and combined three

[30] National Statistical Office and ORC Macro. Malawi, Demographic and Health Survey 2000, Zomba, Malawi and Calverton, Maryland, August 2001
[31] Ibid.

month injectable contraceptives); and (c) lactational amenorrhea method (LAM). Counseling knowledge and communication skills were integrated into each of the training events conducted.

51. Family planning training and refresher courses used national reference documents such as Family Planning Guidelines and, more recently, the National Reproductive Health Service Delivery Guidelines (RHSDGs). First published in 1996 under a different title, the RHSDGs were revised in 2001; the revised guidelines include the use of condoms as a preventive measure for STIs/HIV/AIDS, as well as pregnancy, which is therefore known as dual protection. Although the 2001 RHSDGs have yet to be published, the project's trainers have used the guidelines since January 2001 for their FP refresher courses. As a result of training, the agricultural estate providers' knowledge and practice was brought in line with the rest of Malawi's family planning providers. Trainees received a copy of the training/reference documents. Most of the family planning training events sponsored by the project were led by MOHP and/or invited trainers; project staff were responsible for training event coordination, which had the unintended effect of limiting their influence over training curricula and quality. Interviews conducted with providers and MOHP authorities at the district and central level indicated an overwhelming degree of satisfaction with the project's reproductive health knowledge and skills update. The project's contribution to the improvement of access and quality of reproductive health was widely recognized.

52. During the period, 1998-2002, the content of project-sponsored training focused mainly on family planning, including counseling, syndromic management of STIs, infection prevention (IP), youth friendly services (YFS), and prevention of mother to child transmission (PMTCT) of HIV/AIDS (Table 6). The core reproductive health content was updated during 2000 and 2001; YFS, PMTCT of HIV/AIDS, and IP training were offered toward the end of the project. Specifically, two months prior to project closing, a five-day training on youth friendly services (YFS) was conducted. The result of the training is a core of estate providers with an increased knowledge on youth needs and how to address them. It is hoped that providers' knowledge and motivation will be the catalyst for future YFS implementation. Although no HIV/AIDS specific training was conducted, HIV/AIDS risk assessment was integrated into the STI syndromic management training. To complement the reproductive health knowledge update, supervisory skills training was offered to a select number of estate providers. Infection prevention (IP) and PMTCT of HIV/AIDS training objectives, together with the rest of the curricula, were too ambitious for the number of training days allowed. Only three days were scheduled for IP and ten days for PMTCT of HIV/AIDS.

53. Progress achieved at the community level was, to some extent, due to the extensive and continued health education that HSAs conduct, as well as to the daily health talks given prior to a consultation. Family planning health talks were motivational, participatory, and culturally appropriate. In fact, the benefits of family planning for women's health, family economics, and children's health were the topics of songs, which are sung by both clients and HSAs. However, during consultations, misconceptions and rumors about family planning were not discussed, which meant that the opportunity to dispel them was lost. One example of such a misconception associated with Depo-Provera was brought up by a client during the consultation. She wondered if, within the content of the injection, foreign agents are introduced to make sexual intercourse less satisfying. She also said that women who use Depo-Provera become very thin. In spite of misconceptions, Depo-Provera is the FP method most widely accepted on the agricultural estates, which corresponds to the national trend. Providers interviewed indicated that the preference for

Depo-Provera was primarily due to the convenience of having an injection at three-month intervals. Consultation observations and interviews indicated limited knowledge of dual protection. Neither of the providers interviewed was able to verbalize the meaning of dual protection and/or importance on FP/RH.

54. Data from the site visits indicated that estate health care providers attended at least two training events per calendar year. During their absence, arrangements were made to have service provision coverage by another service provider, or clients were referred to the public health sector and/or neighboring estate clinic. In two of the estates visited (Wallace and Conforzi), the respective clinics were closed for the duration of the training events. The providers interviewed were well motivated and recognized that the project contributed significantly to their continued professional development.

55. Despite provider satisfaction with training, all of the persons interviewed identified the need to receive updated information and skills on safe motherhood. For example, the health service providers at four estates (Conforzi, Naming'omba, Wallace, Makandi) observed: "We are all doing antenatal care. Although there is not a maternity ward in the compound and most of the deliveries are at home attended by a TBA, we need to be refreshed on safe motherhood."

"The success has been that the Project HOPE STAFH has managed to train existing health workers and volunteers such as the CBDAs. The training went very well and the intention of the training was achieved."—Thyolo, District Health Officer and FP/STI Coordinator

"It has managed to provide skills and build the capacity of the estates**.** It has also increased knowledge among the youth especially in counseling, training for transformation, and interactive drama. Even myself (IEC coordinator), I've been trained in Training for Transformation and interactive drama and have contributed to the IEC coordinator development."—Thyolo IEC Coordinator

"Estate nurses have benefited a lot. The company is happy with services and the community [is happy] as well. It has been very useful."—Conforzi and Naming'omba RH providers

56. The providers felt that at present, they have the knowledge and skills to provide quality RH/FP services. However, they all expressed concerns about the future. They understand that the public sector, with its limited budget, addresses the needs of its personnel, relegating the private sector (including the agricultural estates) to a lower priority. There is consensus among providers that their training opportunities will be limited once the STAFH project closes.

57. Supervision. At the estate health facilities, supervision was carried out primarily by the project. Each training event was followed shortly afterward by project observation and supervision. Beyond this period, supervision was reported to be more sporadic. In some instances, supervision occurred on a quarterly basis; on more distant estates, supervision visits were even less frequent. In order to standardize the supervision visits, the project developed supervision checklists. However, it appeared that consultation observation, a mechanism to evaluate providers' skills, was seldom conducted.

58. MOHP supervision was perhaps even more sporadic. District health authorities identified the need to reach the private sector, including the agricultural estates, with supervision visits. However, access to transport and budgets for fuel were cited as important limiting factors. Although district health officials were grateful to the project for its supervision efforts, the data gathered reflected district-level interest in having joint evaluation visits. The FP/STI coordinator for Thyolo District offered the following observation: "The supervision is done under my work plan and depends on the availability of transport. Now days, we do not have transport because of budget cuts, but until last year it was okay. We got to supervise the CBDAs and the clinic staff. Supervision was done independently of the STAFH project. It was hard to coordinate, but it would have been good to do together." Similarly, the FP/STI coordinator for Zomba District said, "Maybe supervision has not been enough, so if there was transport, it would be easier."

59. The providers interviewed recommended more frequent supervisory visits, and as much as possible, they would like to keep a calendar of visits. Estate providers viewed supervisory visits as an opportunity to have an advocate for their needs. In addition, they welcomed observations and feedback on their daily routine.

60. Commodities. Over the course of the project, a major challenge for family planning service provision was the flow of necessary commodities. However, providers interviewed reported a significant improvement in the flow of commodities during the period, 2000-2002. Despite the improvement, sporadic condom stockouts were reported. District Health Officers (DHOs) and service providers interviewed attributed stockouts on the agricultural estates to the operation of the RHLMIS and communication difficulties, among others.

(3) conclusions

61. The increased number of estate clinics offering family planning services is the result of project investment in building capacity among estate service providers, which contributed to a significant increase in Malawi's contraceptive prevalence rate (CPR). In addition, the investment in training made an important contribution to providers' empowerment and pride, which has the potential to translate into improved quality of services. However, estate family planning providers may not continue to have their knowledge and skills updated following the conclusion of the project.

b. New and continuing family planning clients

(1) performance indicators

62. The performance indicator for the number of new family planning clients seen by CBDAs and clinic staff was 6,000; the actual number achieved was 5,604. The performance indicator for the number of continuing family planning clients seen by CBDAs and clinic staff was 20,000; the achieved result was 18,611.

(2) findings

63. The provision of family planning services reflected coordination and collaboration among estate clinics, health surveillance assistants (HSAs)/home craft workers (HCWs), and CBDAs. HSAs/HCWs and CBDAs were the real bridge between the community and family planning

services. They provided information and education. If a client accepted a modern contraceptive, the HSA oriented her on clinic services (i.e., location, schedules and methods available). At the clinic, HSAs continued client education through health talks, while the client waited for her consultation, and conducted follow-up at the community level. The trust and communication between the client and community volunteer was to some extent responsible for continuation rates. In addition, CBDAs were responsible for reminding clients to get method refills such as injectables. Despite significant progress in reaching new family planning clients, community and professional health providers still face challenges. On some estates, the limited number of HSAs leaves many community members without access to health services. Additionally, in spite of efforts made to increase family planning knowledge and skills among FP providers, supervisory skills training was not offered to professional staff, which left enrolled nurse midwives (ENM) and medical assistants (MA) inadequately prepared to perform their role as supervisors. ENMs and, in their absence MAs, are charged with supervising community workers such as HSAs/HCWs and CBDAs.

(3) conclusions

64. It was evident that coordination between estate clinics, HSAs/HCWs, and CBDAs resulted in an increased number of new family planning clients, as well as high continuation rates. In addition, it may also indicate the high level of family planning information reaching the community.

2. Increased Knowledge and Use of HIV prevention and STI prevention and treatment

65. The objective to increase the knowledge and use of HIV prevention and STI prevention and treatment was partially achieved, based on the extent to which the indicators and training goals were met.

(a) Estate clinics providing sexually transmitted infections (STIs) services (including counseling) through syndromic management

(1) performance indicators

66. The performance indicator established for the number of clinic staff providing STI counseling and treatment using syndromic management was 45; the actual number as of July 2002 was 36. The projected number of estate clinics providing STI syndromic management services was 28; as of July 2002, the actual number was 26.

(2) findings

67. Significant training efforts were made to increase access to diagnosis and treatment of STIs using syndromic management among estate health services. During the lifetime of the project, service providers participated in STI training and refresher courses. The number of providers to be trained was 45, the actual number as of July 2002 was 48. As with family planning, the project created a core of knowledgeable and skilled professionals to become the backbone of service

provision. STI and HIV/AIDS counseling content was integrated within the STI syndromic diagnosis and treatment.

68. A review of the number of cases of STI visits in each estate health facility visited showed that the number of cases treated is on the rise, leading to two hypotheses: (a) the incidence of STIs is increasing, and/or (b) more community members are seeking services at estate health facilities.

69. In order to streamline services and reduce stigmatization, STI diagnosis and treatment was integrated with other FP/RH services. In most cases, services were being offered by ENMs and/or MAs who are also trained in family planning. As previously mentioned, both sides welcomed the partnership between MOHP and the estate clinics, which aimed to increase access to diagnosis and treatment. Estate providers expected to improve quality of services because they now receive essential drug supplies, which were previously reported to be a barrier for service provision among agricultural estates. Providers interviewed indicated that estate managers and/or officials did not allocate a budget line item for STI drug procurement.

70. Drug supply was difficult for estate managers and clinicians to purchase and to maintain sufficient supplies for clients. Under a six-year program with the Department for International Development (DFID), British High Commission, MOHP is procuring the necessary drug supply, and in fact, the providers and health authorities interviewed stated that STI drug supplies had improved in the previous 12 months. Nevertheless, problems continued to exist due to communication and logistical issues between estate providers and district health personnel. Seven of 11 providers interviewed reported stockouts of STI drugs in the previous 12 months.

71. Counseling. Counseling was a core component in all FP training and refresher courses, as well as in STI syndromic diagnosis and treatment. Consultation observation found that providers were knowledgeable regarding the benefits and limitations of FP methods and that they were respectful of clients' rights, including the right to information, freedom of choice, confidentiality, and privacy. However, family planning providers did not assess clients' sexual behavior and therefore missed an important opportunity in terms of HIV/AIDS prevention and education. Dual protection was not routinely addressed.

72. According to the providers interviewed, there is an increasing number of "non-registered clients," in other words, "walk-ins" seeking condoms, which suggests that condom accessibility and acceptability have increased. However, clients who go to the clinics only seeking FP services were not encouraged to take condoms and use them. New Depo-Provera acceptors are encouraged to use condoms as a back up. However, instead of offering condoms to the women, providers recommended that the client's husband make a trip to the health facility to collect them, which made the process not only more cumbersome, but, most important, missed the opportunity to encourage condom use. When providers were asked the reason for this "peculiar" attitude, their response was, accordingly to Malawian culture, women were not allowed to take condoms home. If it is the case that such a cultural constraint exists, then there is an urgent need to conduct an in-depth analysis on ways to work with the community to overcome this constraint.

73. Counseling activities could be supported by the use of anatomical models such as hand-held uterus, penis models, and IEC material.

74. Although the number of consultation observations conducted for the present evaluation was very small, the findings seemed to indicate that providers have difficulty addressing issues of sexuality such as assessing HIV/AIDS risk behavior.

75. Client perceptions and knowledge. Although the number of women interviewed for the evaluation was small, their opinions provided important insights into community perceptions regarding estate health facilities and information given by providers during consultations. The women interviewed had similar demographic backgrounds; they were married to estate workers, had low educational levels (in two cases no education at all), and all of them had children. Three of the women interviewed were 21 years of age or younger, and the rest were between the ages of 22 and 33.

76. Knowledge about the transmission of HIV/AIDS seemed to be widespread among estate community members, serving as testimony to the efforts that estate health providers, community volunteers, and IEC campaigns have made in this arena over the years. However, the same cannot be said about women's' knowledge of STI preventive measures. Neither of the women interviewed was able to respond correctly to the following question: "Would you name three ways of preventing sexually transmitted infections?" Reported condom use among women interviewed was extremely low, which again corroborates the need to provide more education and skills training to married women in order to increase acceptance (Table 10). The women interviewed reported satisfaction with services received and declared that they would recommend the services to friends and sisters. Additionally, they would like to have the providers continue with "the good work they are doing."

(3) conclusions

77. The partnership between the project, MOHP, and agricultural estate health facilities strengthened efforts to improve access to diagnosis and treatment for traditionally underserved populations. It is also important to note that estates are making every effort to comply with partner notification and treatment, which, without a doubt, represents an improvement in quality of care and also contributes to the reduction of STI prevalence. Finally, by empowering clinic-based providers to address more freely issues of sexual behavior, fewer HIV/AIDS risk-reduction counseling opportunities would be missed.

b. Male condoms dispensed and STI partners treated

(1) performance indicators

78. The performance indicator for the number of couple years protection (CYP) for condoms dispensed at the estates was 200; the achieved result was 2,243. The performance indicator for the number of STI partners treated using a syndromic approach was 2,465; the achieved result was 816, or 33 percent of the projected number.

(2) findings

79. Significant progress was made in the last 12 months regarding male condom distribution, which was attributed to the improved logistics systems at the District Health Office and estate levels. HSAs/HCWs and CBDAs appeared to be responsible for the significant increase in

distribution. At the clinic level, service providers acknowledged that there was an increase in male condom demand from "non registered clients," meaning men who do not seek consultations.

80. In regard to the number of STI partners treated, the achieved results were low. One reason was that prior to MOHP allocation of STI drug supply for service exchange, most partners who were not members of the estate were not allowed to receive STI services from estate clinics. Another reason was culture, which stigmatizes and condemns sexually related illnesses. There is a need to secure clients' privacy and confidentiality and to reduce treatment barriers such as drug stockouts and long waiting periods for service provision.

(3) conclusions

81. It appeared that much progress took place at the community level. At the clinical level, there was a need to explore more in-depth the factors that influence providers' attitudes towards condom distribution. There was also a need to work at the community level to address issues of dual protection in order to increase the use male condoms to protect against STI/HIV/AIDS infection. It is also imperative to work with the community of providers and potential clients in order to reduce stigmatization.

B. Improved Community Participation in Reproductive Health

1. Estate community participation in family planning promotion and STI and HIV prevention activities increased

82. The objective to increase estate community participation in family planning promotion and STI and HIV prevention activities was substantially achieved, based on the extent to which performance indicators and training goals were met, and the impact of project activities on the target population.

a. Community-based distribution agents (CBDAs)

(1) performance indicators

83. The performance indicator for the number of community-based distribution agents (CBDAs) providing family planning services to estate communities was 100; the actual number as of July 2002 was 115. The planned number of practicing CBDAs and their primary supervisors who would receive refresher training in family planning was 80; the actual number was 75. The planned number of new CBDAs and their supervisors who would be trained in community family planning services was 100; the actual number was 96.

(2) findings

84. CBDAs are community volunteers whose job is to promote information, education, and communication on family planning, STIs, and HIV/AIDS within communities to individuals, couples, and community groups, and to recruit and maintain family planning acceptors.[32] CBDA job responsibilities are to make at least 30 contacts with clients per month; distribute pills, foaming

[32] National Family Planning Council of Malawi (NFPCM) and MOHP. Guidelines for Community Based Distribution of Contraceptives in Malawi, June 1998, Annex 4, p. 45

tablets, and condoms to eligible clients; recruit at least six new acceptors per month; fill in the Client Register and Tally Sheet; and follow-up on clients, among others.[33] Since 1994, the project trained a total of 119 CBDAs. Of the total number, 114 are still active and providing family planning services, and five are inactive.[34] It should be noted that MOHP does not have CBDAs; the role of the CBDA was created by NGOs.

85. The project provided 75 CBDAs and their primary supervisors with refresher training in family planning, which covered the topics of combined oral pills, mini pills, spermicides/condoms, prevention of mother to child transmission (PMTCT) of HIV/AIDS, education on HIV/AIDS/STI, organizing and conducting group talks, client follow-up, fears and rumors and how to overcome them, counseling and screening of potential clients, record keeping, community assessment, and filing RHLMIS Form 01.[35]

86. The project provided 96 new CBDAs with training, which covered the same topics listed above for CBDA refresher training and included others such as the background to family planning in the Malawi CBDA program, population dynamics, benefits of family planning, family planning policies, primary health care, anatomy of male and female reproductive organs, menstrual cycle, traditional methods of family planning, introduction to modern family planning methods, combined oral contraceptives, progestin only pills, hormonal checklist, male and female condoms, lactational amenorrhea method (LAM), Norplant, injectable contraceptive, IUCD, vasectomy, natural methods, STI/HIV/AIDS prevention, knowing and understanding your community, referral system, record keeping, use of visual aids in family planning, communication, counseling, and development of learning objectives.[36]

87. Group interviews were conducted with a total of 36 CBDAs (34 women, 2 men). CBDAs from all five estates reported that their training was very important but that one week was not sufficient to learn and absorb the course content. CBDAs from three estates stated that they needed a refresher course; others said that they needed additional training in PMTCT of HIV/AIDS and safe motherhood. With respect to outreach activities, the majority of CBDAs made daily household visits to individual clients and visited different compounds on the estates. Clients also visited CBDAs in their homes. The most effective approach mentioned was individual counseling in client homes. The average number of clients per CBDA was 40.

88. The major challenges that CBDAs faced were transport and the transient nature of the estate populations. For example, on Dwangwa estate, there are a total of 10 CBDAs for 12 compounds with an average population of 2,300 persons per compound. The CBDAs cover one compound each and share the remaining two compounds among themselves. To reach their clients, they must often walk long distances over difficult terrain. Estate populations vary widely according to peak and non-peak seasons. For example, the population of Makandi estate was 6,000 during the peak season and 4,000 during the non-peak season. At the close of the peak season, workers, including CBDA clients, are dismissed and leave the compounds. At the beginning of the

[33] Ibid., p.45
[34] STAFH Project. Training Events by Date, Content, Participant, and Number of Training Days, July 2002. Also see NFPCM, MOHP, and STAFH Project. Interpersonal Communication and Counseling: A Training Manual for Family Planning Providers, September, 2001
[35] Ibid.
[36] Ibid.

peak season, new workers and their families arrive, signaling a new group of clients. CBDAs try to refer clients who are moving to another CBDA or clinic facility.

89. Observed behavior change. CBDAs were asked if they had observed any change in behavior among persons living in their communities since they began work. Based on frequency of response,[37] the observed changes reported were: understanding, acceptance and use of family planning, including more clients seen daily, people having fewer children and able to live freely, and husbands and wives are very happy, 52 percent; request for family planning services and use of condoms by youth, 33 percent; and other, including women asking about the side effects of family planning, 5 percent, limited behavior change, 5 percent; and initial problems with headmen (community leaders) about family planning who later changed their minds, 5 percent (Table 11). With regard to youth (boys and girls) requesting condoms, most of the CBDAs said that the youth go to the CDBAs' homes to get condoms in order to preserve their anonymity and because they are shy. One group of CBDAs noted that youth go to their homes for condoms only, not counseling, and thus they would like to formulate a drama on youth and condoms.

90. Materials and supplies. CBDAs on two estates reported that they were using the old Tally Sheet forms, as opposed to the new ones, which are required in the RHLMIS. CBDAs on another estate said they had not had Tally Sheets for two months. Tally Sheet completion and timely submission is key to having an adequate supply of contraceptive methods. Moreover, this is an area to which the project gave much attention during quarterly meetings with CBDAs and one that may require further attention.[38] CBDAs on two estates had no problems in obtaining contraceptive supplies sufficient to meet demand. In regard to materials, many CBDAs used the highly favored "*Kabanja*" book, which is a motivational booklet on family planning about a man who plans his family, and the "*Kulera*" book, which is a family planning booklet that lists all family planning methods. The CBDAs said they had sufficient instructional materials with the exception of CBDAs at Wallace estate Malawi who cited the need for a demonstration penis in order to show proper condom use.

91. Incentives for participation. The CBDAs interviewed expressed the view that as volunteers, they needed incentives in recognition of and encouragement for their work. All of the CBDAs cited the need for soap because they wanted to be presentable to clients and further suggested that soap could be distributed to them at the quarterly meetings. Other proposed incentives were plastic shoes, bicycles, uniforms, a credit scheme, staff privileges at estate health clinics, and ballpoint pens. With regard to the latter, one group of CBDAs reported that they had received two ballpoint pens when they were trained in 1997, needed new pens every three months, and had asked the clinic nurse to forward a request for pens to estate management, which never responded.

92. Supervision. CBDAs reported to their primary supervisors, HSAs/HCWs and, more recently, to CBDAs trained as CBDA supervisors. The CBDA secondary supervisor is the estate

---

[37] Frequency of response is a technique used for the interpretation of qualitative data that has been quantified. First, each response is recorded, and this constitutes the "raw" data. Second, similar responses are grouped in like categories, the number of responses in each category is summed, and the frequency of responses is expressed as a percentage of total responses.

[38] STAFH Project. CBD Quarterly Meeting held at Chombe October 2001; CBD Quarterly Meeting held on 25 May 2002, Wallace Estate, Zomba; and CBD Quarterly Meeting, Sorrento Club, Conforzi Estate, 18 April 2001

health clinic-in-charge. The project also had supervisory and training follow-up responsibilities for CBDAs, including quarterly meetings with CBDAs and their supervisors. The total number of planned quarterly meetings was 16, compared to the actual achievement of 15.[39] CBDAs interviewed on four of the five estates reported that they had good relations with the clinic-in-charge, and those on three estates described HSA/HCW supervision as very effective. CBDAs on three estates cited problems with STAFH project supervision, whereas those on one estate said that communication with the project was good. Due to the high number of training events, the low number of trainers, geographic coverage, transport problems, and otherwise, project supervision and training follow-up were deficient.

(3) conclusions

93. CBDAs substantially contributed to the achievement of the objective to increase estate community participation in family planning promotion. They can largely be credited with the introduction of family planning on agricultural estates, which did not exist prior to Project HOPE/Malawi interventions. They are a highly dedicated group of individuals, as evidenced by the fact that 97 percent of trained CBDAs are still working. The importance that CBDAs attached to the training experience and the quarterly meetings cannot be overstated, and this is an indication of the high quality of training. In contrast, the quantity of training may not have been sufficient. Project HOPE/Malawi may wish to review the amount of time allocated to CBDA and other types of training—other groups also expressed the need for more training time. The CBDAs' desire for refresher training is compelling because they and other community volunteer groups hear about new training topics and very much want to be up-to-date. The CBDAs also see refresher training as an incentive because they are volunteers.

94. Incentives for participation are everywhere critical to the sustainability of project activities; more attention should have been paid to incentives, as well as to keeping CBDAs properly supplied with the materials they need in their work. Supervision is also an incentive insofar as volunteers are assisted and encouraged in their work. At the conclusion of project financing on July 31, 2002, it is uncertain whether the MOHP District Health Office in the person of the family planning coordinator will be able to provide adequate supervision of CBDAs, especially continuing with the quarterly meetings and/or refresher training. However, it is expected that the CBDAs' primary supervisors, HSAs/HCWs and CBDA supervisors, will continue their supervisory function.

b. Adult drama groups

(1) performance indicators

95. The performance indicator for the number of estate adult drama groups conducting drama performances for the estate communities was 10 (each group = 10 members); the actual number was 8 groups. The planned number of adult drama group members trained in theater for development was 20; the actual number trained was 40. The performance indicator for the number of persons attending drama performances that contained HIV, STI, and family planning information was 45,000; the actual number was 24,611. Project staff noted that HSAs/HCWs are responsible for reporting the number of persons attending drama performances and may be under-reporting the actual number because they are not familiar with methods for estimating group numbers. The performance indicator for the percentage of estates providing family planning and

[39] One meeting per district per quarter was planned x 4 districts x 4 quarters = 16.

STI and HIV information through drama performance was 50 percent; the actual achievement was 47 percent.

(2) findings

96. Twenty-four members of adult drama groups (7 women, 17 men) were interviewed, and two drama group performances were observed (Makandi and Dwangwa estates). The drama groups assessed their training as very important. They learned different ways to approach people, stage dramas depending on community needs, and deliver health education messages through drama. They said that they also learned a lot about their own culture. The drama groups performed several times a month on estate compounds, at schools, in surrounding communities, and sometimes outside the estate. The drama groups stated that the most effective approaches were to have a concert or conduct a comedy before the drama performance and that topics of most interest to the community were STI/HIV/AIDS prevention, family planning, good sanitation, well baby care, how to take care of orphans, and how to take care of terminally ill AIDS patients. Most of the drama groups prepared performances based on their training, but the doctor at the Matiki health clinic, Dwangwa estate, gave the drama group—many of whom were clinic staff—specific health education messages, and the group developed a drama for each message. The doctor and the drama group thought this way of working together was very effective. The Matiki clinic also provided transport for the drama group in one of the two clinic ambulances; the doctor occasionally gave drama group members small allowances drawn from the estate health budget.

97. The drama performance observed at Makandi estate was a play about a husband and wife (played by a man) who were both unfaithful. Each of them in turn would pay their "houseboy" for his silence. At first, the houseboy was glad to have the extra money. He later realized that if the husband and wife—his employers—died of AIDS, he would not have a job, so he told each one that the other was being unfaithful. When the husband and wife met, they argued and fought over the other's infidelity but in the end reconciled and pledged to be faithful. The central character in the play was the houseboy.

98. When the children saw the man who would play the houseboy walking across the soccer field with a small bag containing his costume, they started shouting his name and ran to sit down in front of the area that would be the stage. The performance attracted more than 100 women, men, youth, and children who laughed and applauded throughout. It was obvious that the drama group was very much appreciated.

99. Children and adults met the drama performance observed at Dwangwa estate with the same high level of enthusiasm. The performance was singing and dancing in the style traditional to the area. The singing told a story about the dangers of STI/HIV/AIDS and how to prevent them.

100. Observed behavior change. The drama groups were asked if they had observed any changes in behavior since they began performing. Based on frequency of response, observed behavior changes were: progress in family planning, including a better understanding of family planning, increased acceptance of family planning, and a reduction in childbirths due to family planning, 44 percent; positive behavior change in general, including a reduction in sexual behavior due to HIV/STI messages and the marriage of some unmarried men, 33 percent; better sanitation due to drama messages, 11 percent; and a better understanding of what drama groups do to the extent that they are now invited to perform, 11 percent (Table 11).

101. Materials and supplies. The drama groups said a major problem was the lack of materials for drama. They needed costumes and props, including dolls. Following performances, some groups reported that they were asked for condoms, which they did not have. Another need was materials to make posters in order to publicize upcoming performances.

102. Logistics and transportation. All of the drama groups reported that transportation was a problem because the distances to some compounds were great. A few estates provided occasional, not regular, transportation. Some drama groups indicated that they would like to travel beyond the estate to perform—and some groups have done so—but the lack of transportation was a constraint.

103. Supervision. The drama groups stated that their supervision by HSAs/HCWs was very effective.

104. Incentives for participation. The groups acknowledged that they lacked needed support from the estate companies and Project HOPE. They would like to have uniforms (t-shirts, caps) so that they could be readily identified as drama group members.

(3) conclusions

105. The drama groups substantially contributed to the achievement of the objective to increase estate community participation in family planning promotion and STI and HIV prevention activities. Of all the project activities, drama performances were by far the favorite; the drama groups provided education and entertainment, which is lacking on the estates. In fact, the other community groups interviewed reported that reaching people with health education messages through drama was an extremely effective approach. The sustainability of drama group activities appeared to be likely because of the tremendous response to them; however, the lack of incentives for participation might jeopardize their sustainability.

c. Adult peer educators and counselors

(1) performance indicators

106. The performance indicator for the number of adult peer educators and counselors providing family planning and STI and HIV information at the workplace was 60; the actual number was 42. The planned number of estate adult volunteers in peer education and counseling to be trained in family planning promotion and STI and HIV prevention was 30; the actual number was 40.

(2) findings

107. The role of the adult peer educator and counselor is to influence behavior change on HIV/AIDS and STI and to promote family planning among peers by means of providing information and counseling to peers at the workplace and other venues. Eleven peer educators and counselors (2 women, 9 men) from five estates were interviewed and all concurred that their training was very important. The six-day training topics were interpersonal communication, basic education on STI/HIV/AIDS, effective use of condoms, the concept of communication in peer education and counseling, the role of values, knowledge and skills of care and support in managing persons infected and affected with HIV/AIDS at the workplace, planning and designing peer

education and counseling activities, basic counseling skills, and leadership skills in HIV/AIDS, STI, family planning, and tuberculosis education.[40] The peer educators and counselors interviewed expressed the need for more individuals to be trained (only two were trained per compound) because they are few in number, and there are many people to reach. They also stated the need for additional training, e.g., on PMTCT of HIV/AIDS, and for refresher training.

108. Among the activities of peer educators and counselors were: providing peer education on Sunday afternoons, in the compounds after work, during breaks and lunch at the workplace, in compounds other than the one in which they live, at group meetings, at the under-five clinic, before or after drama performances, and wherever people gather. They organized meetings to give health education talks, which sometimes lasted three to four hours. Some of the peer educators and counselors interviewed reported that people seek their services all the time and that some people visit them in their homes. The majority found that individual and group counseling were equally effective. Another effective approach mentioned was to start with a joke then introduce a family planning message. Peer educators and counselors on three estates reported that the estate company did not assist them or provide a chance for them to talk to people and that sometimes their activities were not well-received.

109. Observed behavior change. The peer educators and counselors were asked if they had observed any changes in behavior since beginning work. Based on frequency of response, the changes were: now people understand more about HIV and know how to prevent HIV/AIDS through condom use, 33 percent; youth want to learn more about STIs, and there has been a decrease in STIs among youth, 22 percent; increase in condom use (previously not many people came to them for condoms and now many do), 22 percent; provision of family planning services and awareness and use of family planning, 11 percent; and one response was that it is very difficult to know if behavior change is taking place, but people are beginning to understand things such as HIV/AIDS, 11 percent (Table 11).

110. Materials and supplies. Most of the peer educators and counselors said the supplies (books, pencils, posters) they received in the beginning were exhausted; they needed posters and other materials. Others reported that condom supplies were sometimes delayed on account of transportation. One pair of peer educators and counselors observed that women would like to have female condoms to keep in their houses; another pair needed a demonstration penis to show correct condom use.

111. Logistics and transportation. Peer educators and counselors on four of five estates found transportation to be their greatest problem because they travel on foot and cannot cover the distances to reach all estate compounds.

112. Supervision. The peer educators and counselors on three estates assessed their supervision by HSAs/HCWs and, in one case, by an environmental health assistant, as satisfactory. However, one pair of peer educators and counselors on a different estate reported that the HSA did not know how to supervise their work, so they went to the clinic nurse who also did not know how to supervise their work, but told them to just keep on working. This same pair kept their report forms up-to-date and wanted someone to look at them.

[40] STAFH Project. Peer Education and Counseling Training Curriculum, n.d.

113. Incentives for participation. With respect to incentives, the peer educators and counselors expressed the need for uniforms (t-shirts, caps) so that they could easily be identified, bicycles in order to reach more people, lunch allowances because they travel to far areas, and bags and umbrellas.

(3) conclusions

114. Although few in number relative to the estate populations they cover, the adult peer educators and counselors substantially contributed to the achievement of the objective to increase community participation in family planning promotion and STI and HIV prevention activities. In many ways, theirs is the most difficult work of all the volunteer groups because it focuses on the workplace, where time for education and counseling is limited, and estate management support may not be forthcoming. The lack of support on the part of estate management makes supervision and incentives for participation more important; it also places the sustainability of peer counselor and educator activities in jeopardy.

d. Health surveillance assistants (HSAs)/Home craft workers (HCWs)

(1) performance indicators

115. The performance indicator for the percentage of estate compounds provided with family planning and STI and HIV information by HSAs/HCWs using TfT methodology was 100 percent; the actual achievement was 100 percent.[41] The planned number of new estate outreach staff trained as HSAs was 20; the actual number trained was 12.

(2) findings

116. The HSA is a health worker who serves as a link between fixed district health services and the community. The HSA works directly with community leaders in identifying and providing health and health-related services in the community, among others. Specifically, the HSA conducts community assessments within his or her coverage area, works with the community in solving health and health-related problems, assists the community in promoting hygiene and sanitation by conducting regular inspections and giving feedback to the community health committee, trains health committee members on appropriate sanitation technologies, gives health education talks to individuals, families, and communities, in addition to other functions.[42] In the context of the agricultural estates, some HSAs/HCWs are salaried employees of the estate—a unique achievement of Project HOPE/Malawi. Some HSAs working on agricultural estates are government employees.

117. HSA/HCW training consists of an 8-week course, designed by MOHP.[43] In addition to this training, the project provided TfT training. The goal of the TfT training was to equip HSAs/HCWs

---

[41] Home craft workers existed before the position of HSA was introduced. Many HCWs were subsequently trained as HSAs.

[42] H.R.D.C. Mgengo-Mbewe. The current job description of health surveillance assistants in Malawi, 12.09.97

[43] The MOHP training course covers the following modules: orientation to primary health care, family health, nutrition, growth monitoring, immunization, communicable diseases, community water supply, vector

with knowledge of and skills in a health education participatory approach to estate communities in order to influence behavior change in preventing HIV/AIDS, STI, and promoting family planning methods.[44] The TfT training covered communication, team building, family planning and HIV/AIDS/STIs, assessment of felt needs, health and development, life planning skills of adolescent reproductive health in relation to HIV/AIDS/STI prevention and family planning promotion, proper condom use, the identification of behavior, attitude, and beliefs that put people at risk of contracting HIV/STI, the psycho-social method (TfT), participatory ways of teaching about HIV/AIDS/STIs and family planning, leadership, group reflection, empowerment versus dependency, and planning.[45]

118. Twenty-three HSAs/HCWs (14 women, 9 men) were interviewed, representing five estates. Three groups of HSAs/HCWs assessed the training as important because it showed how people can participate in education and was easy to understand; they thought TfT was a good method for reaching people and changing behavior. Two groups of HSAs/HCWs reported that the amount of training time (one week) was insufficient—there was too much to learn, and some HSAs/HCWs could not finish the training. All HSAs/HCWs expressed the need for refresher training in STI/HIV/AIDS education and counseling and TfT, and the need for additional training in PMTCT of HIV/AIDS, HIV testing, and STIs. One group of HSAs/HCWs who were trained in CBDA supervision stated that the training was very good but too short.

119. The HSAs/HCWs interviewed prepared work plans, began each day at the estate health clinic and worked in the estate compounds in the afternoon. HSAs/HCWs provided information and counseling on family planning, taught health education in groups, talked to female estate workers in their dormitories, went house-to-house in compounds looking at sanitation, occasionally visited the workplace to give health education talks to men during the lunch hour, and in one case, combined forces with the drama group. The HSAs/HCWs from one estate reported spending 50 percent of their time on individual counseling and 50 percent, on group counseling. Among the most effective approaches in reaching people were individual discussions, seeking out workers at the workplace and single persons, in their dormitories. New workers were targeted during the lunch hour. The TfT method was considered to be effective. Four of five HSA/HCW groups agreed that drama performances were a very important means of reaching people with health education messages, especially messages on family planning. Lecturing was identified as the worst approach.

120. HSA/HCW supervision of CBDAs. The HSAs/HCWs assessed their own supervision of CBDAs as effective. Three of five HSA/HCW groups rated CBDA performance as highly satisfactory and also noted that it had improved greatly.

121. Supervision of HSAs/HCWs. Three HSA/HCW groups were satisfied with project supervisors because they gave good advice and worked hand-in-hand with the HSAs/HCWs. One group noted a conflict between some CBDAs and project supervision. HSAs/HCWs were also satisfied with clinic-in-charge supervision. With respect to MOHP supervision, the HSAs/HCWs said that they needed more supervision and guidance from MOHP, which did not conduct regular supervision visits.

---

control, village sanitation, food hygiene, village inspection, community assessment, formation and training of village health committees, health education, health information system, and planning health activities.

[44] STAFH Project. Training for Transformation, Curriculum for HSA/HCW, n.d

[45] Ibid.

122. Observed behavior change. The HSAs/HCWs interviewed were asked if they had observed any changes in behavior since they began work. Based on frequency of response, the reported changes were: increase in the knowledge and use of family planning, including condom distribution and use, 35 percent; behavior change resulting from HIV/AIDS education, including a decrease in the number of STIs, possibly fewer HIV positive persons, and some people being tested for HIV, 35 percent; decrease in sexual behavior, 9 percent; good health education and attendance at health education meetings resulting in no cholera, good family planning, and good condom distribution, 7 percent; behavior change on account of drama performances, 5 percent; no behavior change for men seeking sex at women's dormitories or women who do not have money having sex to get money, 5 percent, and other, 4 percent (Table 11).

123. Materials and supplies. Three of five HSA/HCW groups said they did not have materials such as posters, so they just talked and gave examples. One group reported that the IEC materials were good, for example, the poster on breast-feeding. Some of the HSAs/HCWs had the highly favored *Kabanja* book, but others did not.

124. Logistics and transportation. The project provided 33 bicycles for HSAs/HCWs, which facilitated transport. The arrangements for bicycle maintenance were to be agreed with the individual estate companies. One estate company provided a bicycle repair and maintenance allowance, which was recently raised from 60 *kwachas* per month to 150 *kwachas* per month, but the HSAs/HCWs said this was not sufficient. One estate company provided bicycles to HSAs through a purchase plan, deducting a monthly sum from salaries until full payment was made. One group of HSAs/HCWs thought that the estate was supposed to pay for bicycle maintenance and had not; the HSAs/HCWs asked the clinical officer to forward their request for maintenance repair costs to the estate, but no response was received.

125. Incentives for participation. The HSAs/HCWs expressed the desire for uniforms (t-shirts, caps) in order to be readily identified.

(3) conclusions

126. The HSAs/HCWs substantially contributed to the achievement of the objective to increase estate community participation in family planning promotion and STI and HIV prevention activities. Along with the CBDAs, they are largely responsible for bringing family planning to the agricultural estates. As salaried estate employees, the sustainability of their activities is likely. Whether they will have the opportunity in future for additional and/or refresher training is uncertain because estate companies may not be willing to finance training costs.

2. Estate youth participation in adolescent sexual and reproductive health care increased

127. The objective to increase estate youth participation in adolescent sexual and reproductive health care was substantially achieved, based on the extent to which performance indicators and training goals were met, and the impact of project activities on the target population.

128. Target population. Youth under 15 years of age make up half of Malawi's population. The project targeted youth ages 11 to 14 (grades 5-7) for health education, especially HIV/AIDS

prevention messages and information, because very little HIV infection is found in this age group,[46] which is called the "window of hope" in combating the AIDS epidemic in Malawi and for whom prevention messages are a priority.

129. Youth living on agricultural estates. The youth who live in the compounds on agricultural estates and surrounding communities are for the most part isolated from the larger society due to the large size of many of the estates, lack of transportation, and poverty. Recreational activities for youth on the estates visited were minimal or non-existent. Most of the schools had a soccer field, but there were no balls. In one school, a wadded up sheet was used as a ball. The schools themselves were in deteriorated condition, lacking electricity, school desks, chairs, books, and other educational materials. Classrooms were severely overcrowded; the average ratio of teacher to students was 1:74 on the estates visited. One school that was built for a maximum capacity of 500 students had over 1,000 students attending classes.

130. Major challenges and problems faced by youth on agricultural estates. Group interviews were conducted with 243 youth (42 percent female) in five primary schools and one secondary school, where the project had provided training to anti-AIDS clubs, youth drama groups, youth peer educators and counselors, TfT youth leaders, and school patrons who supervised the youth groups.[47] Based on frequency of response, the youth interviewed stated that the major challenges and problems they face are: poverty, 15 percent; forced marriage/early marriage, 12 percent; drug and alcohol abuse, 12 percent; orphans, 11 percent; teenage pregnancy, 9 percent; STIs and HIV/AIDS, 9 percent; child abuse and child labor, 9 percent; rape, 8 percent; sexual activity and behavior, 8 percent; and illness, 5 percent (Table 12). Grouped together, the problems that would place youth at risk of STIs and HIV/AIDS accounted for 46 percent of responses. Hence, the need for health education, including adolescent sexuality and reproductive health information, is critical.

131. The tragedy and enormity of the phenomenon of orphans—boys and girls who have lost one or both of their parents to AIDS—is difficult for someone from outside Malawi to comprehend. At each of the six schools visited, the orphans themselves and their friends discussed the plight of orphans. Among the consequences of being an orphan is having to drop out of school. Orphans fail to go to school because they are sent to take care of others. Because their parents died and they have no money, they must go to work in the fields and thus miss classes. Orphans are pressed, or compelled by circumstance, into child labor. One small boy said he was made to do work that did not fit his size and age. Orphans are also abused; the abuse of orphans was reported in two of the schools visited.

b. Anti-AIDS clubs

(1) performance indicators

[46] UNICEF. A Handbook for Primary School Anti-AIDS Clubs, Ages Eleven to Fourteen, Edzi Toto, Basic Information on HIV and AIDS, p. 1

[47] The schools were Naming'omba Primary School, Conforzi estate; Naming'omba Primary School, Naming'omba estate; Thunga Parish Primary School, Makandi estate; Matiki Primary School and Majiga Community Day Secondary School; Dwangwa estate; and Makoka Primary School, Wallace estate. The smallest number of youth (10) was interviewed at Matiki Primary School because the day of the visit coincided with Education Day, and the majority of youth were occupied with the Education Day events.

132. The performance indicator for the number of youth Anti-AIDS clubs that would have developed adolescent reproductive health programs was 10 schools (7 primary and 3 secondary schools); the actual number achieved was 19. Project staff reported that Anti-AIDS club executive committees were trained on how to develop a program of HIV/AIDS activities and develop a plan accordingly (para. 176). Nineteen estate schools (15 primary and 4 secondary) developed plans; however, the project was not able to help the clubs implement their plans. The performance indicator for the number of HIV/AIDS campaigns organized and conducted by the schools and estates was 4 school and 13 estate campaigns. At the time of the final evaluation, no campaigns had been conducted, but one was planned at the district level for the end of July 2002.

(2) findings

133. Anti-AIDS clubs are organized for the purpose of motivating young people to change their behavior through peer education in recognition of the fact that community-based prevention and control activities are the most effective way of reaching young people with appropriate prevention messages.[48] An estimated 10 to 20 percent of primary school students in the participating agricultural estates are members of Anti-AIDS clubs. The Anti-AIDS club at Majiga Community Day Secondary School, Dwangwa estate, reportedly had the most members—100 students. Club members observed that their training was very important. Among others, they learned how to prevent and to teach others how to prevent STI/HIV/AIDS, how to care for and teach others to care for persons with AIDS, how the human body works, how to change behavior, and the dangers of early pregnancy. Five of the six Anti-AIDS clubs expressed the need for additional training.

134. Club activities included teaching youth how to prevent STIs and HIV/AIDS and to care for persons with AIDS, counseling youth and estate compound (community) members on STI/HIV/AIDS prevention, delivering HIV/AIDS prevention messages at school assemblies, teaching girls to say no to boys who proposition them for sex, and assisting persons suffering from HIV/AIDS with bathing, food, and blankets. The Anti-AIDS club at Thunga Parish Primary School, Makandi estate, helps orphans: they play with orphans, motivate them to join the club, and share money with them.

135. Most of the Anti-AIDS clubs held weekly meetings and recorded their activities in a notebook. The most effective approaches in reaching youth were deemed to be drama (effective in getting messages across and changing behavior), comedies, song, and counseling individuals in private. Among the topics of most interest to youth were adolescent reproductive health and development, how to take care of orphans, and how to have a good future. Future plans included abstaining from sex and not marrying until finishing school, being a teacher, stopping sexual behavior in order to have a brighter future and good marriage, helping friends who are orphans, staying in school, continuing to teach people about the danger signs of HIV, and wanting to wipe out HIV/AIDS because the youth view it as their responsibility to see that HIV/AIDS is gone completely.

[48] UNICEF, op. cit.

(3) conclusions

136. The youth Anti-AIDS clubs substantially contributed to the achievement of the objective to increase estate youth participation in adolescent sexual and reproductive health care. The club members are highly motivated and demonstrate an impressive seriousness of purpose in their efforts to combat HIV/AIDS and ensure a good future. In addition to the youth's own determination, energy, and creativity, their success owes to the school patrons who supervise their activities and, more important, help guide them on a safe path to the future.

Comedy skit

Aida: Hi Precious.
Precious: Hi Aida.
Aida: Did you meet your boyfriend yesterday?
Precious: A boyfriend? I don't even have one.
Aida: You don't? You must have one to move with.
Precious: My parents say casual sex may lead to transmission of sexually transmitted diseases and early pregnancies.
Aida: What are these diseases?
Precious: They are diseases like gonorrhea, syphilis, bubo, and HIV/AIDS.
Aida: What are the dangers then?
Precious: To us the youth we may leave while young, our future is doomed or else we may die.
Aida: Then I shall stop going about with James.
Precious: Yes, you have to, because the best way is to abstain.

Anti-AIDS Club, Naming'omba Primary School
Naming'omba Tea Estates Ltd.
Thyolo District, Malawi

c. TfT youth leaders

(1) performance indicators

137. The performance indicator for the percentage of estate schools provided with adolescent sexuality and reproductive health information by youth leaders using TfT methodology, drama, and counseling was 100 percent; the actual achievement was 100 percent, i.e., all 19 participating schools. The planned number of youth leaders trained in TfT and Anti-AIDS club management skills was 40; the actual number trained was 38. The six-day training covered basic information on HIV/AIDS/STIs, family planning, communication, team building, needs assessment, health and development, community social analysis, participatory approach through the TfT method, four worlds (process of change), leadership, empowerment versus dependency, group reflection, planning, and application of the TfT method in a listening survey.[49]

(2) findings

138. Sixteen TfT youth leaders were interviewed. With respect to training, they said it was very important: they learned how to care for others, and that if the youth can improve, the whole country can change; how to improve future plans; how to teach others to abstain from sexual intercourse; identify problems; prevent HIV/AIDS; and they learned about behavior change and family planning. Their activities as TfT youth leaders included teaching friends about HIV/AIDS, counseling friends at school, motivating friends to join Anti-AIDS clubs, teaching about

[49] STAFH Project. Table of Training Events, Duration, and Content, July 2002. Also see Ann Hope and Sally Timmel. Training for Transformation, A Handbook for Community Workers, Book 2, Mambo Press, n.d.

HIV/AIDS at other schools and some churches, and meeting weekly and announcing their meetings at school assemblies. The most effective approaches were identified as individual counseling, songs or very short plays, and for people who were difficult, approaching them by using the TfT coding system. The topic of most interest to youth was HIV/AIDS prevention. Among their future plans were, on finishing school, to train others to prevent HIV/AIDS in the future and to learn more about how to teach friends.

(3) conclusions

139. The TfT youth leaders contributed substantially to the achievement of the objective to increase estate youth participation in adolescent sexual and reproductive health care. Like the other youth group members, they are enthusiastic and committed to their work.

d. Youth drama groups

(1) performance indicators

140. The performance indicator for the number of youth drama groups conducting drama performances was 10; as of July 2002, the actual number was 8. The planned number of youth trained in participatory drama was 20; the actual number trained during the period, August 2001-July 2002, was 60 (10 per school). The six-day training covered basic information on STIs, HIV/AIDS, family planning, and HIV/AIDS/STIs predisposing factors; peer influence and behavior change; decision-making and problem posing; social issues and community assessment; participatory drama, story line and theme development; debates; drama creation; song and dance development; and performance preparation.[50]

(2) findings

141. Twenty-five youth drama group members were interviewed. All reported that their training was very important. They learned how to form a drama group, prepare a drama script, and perform participatory drama and motivate others to participate, and assess community needs and stage a drama accordingly. Drama activities were to perform for the whole school; call meetings on the school playground and have a drama fest; call meetings in communities and have a drama fest; teach adults about HIV/AIDS through drama, followed by a question and answer session; teach friends about HIV/AIDS and discuss how to prevent HIV/AIDS with friends during school breaks; and teach how to care for people with HIV through drama. Other drama themes included prevention of pregnancy, family planning, how to say no to sexual proposals, and children should not travel at night to prevent rape. The youth drama group at Dwangwa estate had competed in Ministry of Education (MOE)-sponsored competitions and won first, second, and third place on different occasions. Transportation was a problem for the Dwangwa drama group. This group cited the need for an income-generating activity such as the sale of ballpoint pens to raise funds for transportation; however, the group lacked the capital needed for the initial investment.

(3) conclusions

[50] See The Story Workshop. It's Time for Change! A Training Manual for Drama Groups, Using Village Drama for Behavior Change, n.d.

142. The youth drama groups contributed substantially to the achievement of the objective to increase estate youth participation in adolescent sexual and reproductive health care.

e. Youth peer educators and counselors

(1) performance indicators

143. The performance indicator for the number of in-school and out-of-school peer youth educators and counselors providing sexuality and reproductive health education was 56 percent; the actual number was 19 schools (15 primary and 4 secondary schools). The planned number of in-school and out-of-school youth trained in peer education and counseling skills for sexual and reproductive health was 50; the actual number trained was 38. The six-day training topics were interpersonal communication, basic education on HIV/AIDS, adolescent growth and development, sexuality, gender, relationships, preventing pregnancy, family planning, planning for the future, STIs, and personal, family and community values.[51]

(2) findings

144. Project staff reported that one training session for youth peer educators and counselors was not held. Furthermore, the project did not reach any out-of-school youth. Initially, it was contemplated that the project would reach out-of-school youth because some are employed on the estates and some are at home and that out-of-school youth would be targeted separately from in-school youth. However, due to time constraints, out-of-school youth were not reached; the project focused on in-school youth. At the same time, the best strategy identified for reaching out-of-school youth was a "youth corner," a place that could be anywhere as long as it had a youth-friendly environment, where youth could go and learn about adolescent sexuality and reproductive health and other matters of interest to them.

145. Eleven youth peer educators and counselors were interviewed. They found their training to be very important. They learned how to prevent and teach their friends to prevent STI/HIV/AIDS, abstain from sexual intercourse and change behavior, and plan for the future, among others. Their activities included teaching friends about HIV/AIDS and to not drop out of school, talking about HIV/AIDS at school assemblies, going to other schools to teach youth, motivating youth to join Anti-AIDS clubs, and discussing the dangers of early pregnancy. The youth reported that the most effective approaches in reaching other youth were individual, confidential counseling; group meetings; and meeting friends during school breaks. Topics of most interest to youth were how to prevent HIV/AIDS, how to prevent early pregnancy and stay in school, adolescent development, human rights, sanitation and hygiene, and traditional behaviors that can lead someone to have HIV/AIDS.[52] Future plans of youth peer educators and counselors were to continue to encourage

[51] STAFH Project. Table of Training Events, Duration, and Content, July 2002. Also see National Family Planning Council of Malawi (NFPCM). Life Planning Skills, A Training Manual for Young People in Malawi, 1999

[52] The community evaluation team research assistants reported that the youth interviewed identified two traditional behaviors that can lead someone to have HIV/AIDS: *Chokolo* (wife inheritance by deceased husband's brother) and *Fisi* (when a girl reaches menarche, her parents employ a man to have sexual intercourse with her).

friends to prevent HIV/AIDS and therefore defeat AIDS and, for the peer educators and counselors at Wallace estate to establish youth clubs in the surrounding communities.[53]

(3) conclusions

146. The youth peer educators and counselors contributed substantially to the achievement of the objective to increase estate youth participation in adolescent sexual and reproductive health care.

f. Observed behavior change and project impact

147. The youth interviewed were asked if they had observed any changes in behavior that could be attributed to the activities of the different youth groups. The reported observed behavior changes, based on frequency of response, were: a decrease in sexual activity and behavior, 44 percent; decrease in teenage pregnancies, early marriages, school dropouts, STIs, and reduction in multiple marriages, 20 percent; increased knowledge about HIV/AIDS/STIs and how to prevent them, 9 percent; home care of persons with HIV/AIDS, 7 percent; reduction in alcohol consumption and marijuana smoking, 7 percent; women requiring the use of condoms, 4 percent; friendship and assistance to orphans, 4 percent; a disputed reduction in boys propositioning girls for sex, 2 percent; and no behavior changes observed outside Anti-AIDS club membership, 2 percent (Table 11).

148. In light of the reported behavior changes, the impact of the project on youth living on agricultural estates was significant. In addition to positive behavior change through training and health education, the project has given the youth who were trained the opportunity to see the world outside the confines of the agricultural estate and to meet other youth at the training events and, thus, to know that they are not alone.

g. Supervision of youth groups by school patrons

149. All youth groups interviewed reported that their supervision by the school patron(s) was very effective, which indicates that the selection of teachers to serve as school patrons was quite good. The youth said that their school patrons encouraged them to continue teaching others, provided information, corrected them when they made mistakes, and came to their rescue when they failed in responding to questions. One school patron reportedly used his own money to support youth group activities.

h. Materials and supplies

150. All of the youth groups needed materials and supplies, including books and leaflets on human development and other subjects, posters, notebooks and pencils, soccer balls, and costumes for the drama groups. All of the youth groups cited the need for uniforms (t-shirts, caps) in order to be readily identified as a member of a youth group, which would be an incentive for their participation. It is noted that the technical proposal stated that it would be important to provide (Anti-AIDS clubs) with resources needed to support their activities such as sports uniforms, balls,

[53] The NGO, Inter-Aide Water Supply Project, was reported to be very active in the communities surrounding Wallace estate and had organized youth clubs for out-of-school youth, which was the only activity encountered for out-of-school youth.

t-shirts, trophies, and some indoor games.[54] The project should have taken into account the expressed needs of the youth groups.

i. Sustainability

151. In the short-term (0 to 12 months), the sustainability of youth group health education activities is likely, given the enthusiasm of the youth and the support of the school patrons. However, there is a natural attrition rate of students trained by the project who graduate and leave school. In the absence of continued youth training, the sustainability of activities would most probably diminish over the medium-term (1 to 2 years). The positive impact of health education activities on behavior change is evident in the self-reported behavior changes identified by both youth and school patrons. The sustainability of these benefits over time cannot be predicted.

j. School patrons

(1) performance indicators

152. The planned number of school patrons (teachers) trained as trainers of adolescent sexual and reproductive health programs was 25; the actual number trained was 38.

(2) findings

153. Eleven school patrons (3 women, 8 men) were interviewed. They assessed training as above average, noting that more patrons need to be trained and that training for youth and patrons should be scheduled outside school hours in order for students not to miss classes. The school patrons confirmed youth group observations, e.g., drama and child-to-child peer counseling were among the approaches that work best, and topics of most interest to youth included HIV/AIDS prevention and adolescent reproductive health and human development. The school patrons also corroborated the behavior changes reported by youth by means of their own observations and observed additional behavior changes in connection with youth participation, the results of training youth, and changes in the school curriculum.

154. Observed behavior change and project impact. Based on frequency of response, behavior changes among youth observed by school patrons were: good behavior change, including change in moral behavior and changed behavior of youth trained under the project and youth not trained under the project, 31 percent; decrease in teenage pregnancy and school dropouts due to early pregnancy, 28 percent; decrease in sexual activity and behavior, including decrease in rape, 16 percent; increased participation in Anti-AIDS clubs, 9 percent; children have learned how to teach friends, especially about HIV/AIDS, and now children can protect themselves against it, 9 percent; sex education has been incorporated into the curriculum, 3 percent; and decrease in school dropouts, 3 percent (Table 11). One of the most striking examples of behavior change reported by both youth and school patrons occurred at a school where truck drivers used to stop to pick up girls for sex and no longer do so on account of girls changing their behavior and refusing to go with the truck drivers.

155. The behavior changes in youth observed by school patrons agreed with the changes reported by the youth themselves and thus confirmed that the project has had a tremendous impact

[54] Project HOPE. Second Follow-on Proposal, op. cit., p. 13

on youth in terms of raising awareness of HIV/AIDS and teenage pregnancy, in particular, and reducing high risk behavior.

156. Supervision. The supervision of school patrons was uneven. One group assessed their supervision by the district Primary Education Adviser (PEA) as good; another group reported that the PEA had been supervising them but was transferred to another district; a third group said they had received no officials or motivation from the district; and a fourth group believed that the PEA was not involved because the project activities were not part of a government program.[55]

157. Evaluation of STAFH Project. School patrons were asked to assess the project, in particular, the objective to increase estate youth participation in adolescent sexual and reproductive health care. Fifty-seven percent of responses indicated that the project was highly satisfactory because some of the youth changed their behavior, youth participation increased, patrons and students received training, contests were held for the youth, the project sensitized a lot of people, and community members were involved in different activities to prevent HIV/AIDS. Thirty-five percent of responses concerned project continuity. School patrons thought the gains to date might slip if the project stopped, that although the project has contributed to the community, the need remains for the project to continue in order for people to change their behavior, and that it is important for the project to continue in order to achieve all of its objectives. One school patron reflected on what could be accomplished in three to four more years under the project.

(3) conclusions

158. The school patrons contributed substantially to the achievement of the objective to increase estate youth participation in adolescent sexual and reproductive health care. Without the support and encouragement of school patrons, the different youth groups would not have met with the successes that they have realized to date. Again, the sustainability of project activities aimed at youth is uncertain over the medium-term because of the need for training new groups. It is not known whether the office of the PEA or District Youth Officer (DYO) would assume this responsibility.

k. Communities

159. Group meetings were conducted with a total of 144 community members (66 percent female) on four of the five estates.[56] The general purpose of the meetings was to learn about the estate communities. The specific objectives were to explore the community's knowledge about project health education activities, including their assessment of same, and to obtain the communities' views on estate clinic health services.

160. In general, living conditions on the estate compounds were poor. The four community groups interviewed cited poverty, poor housing, lack of sanitation, inadequate water supply, unsafe

[55] Unfortunately, time did not permit interviewing PEAs in order to learn their views on youth group project activities and school patron supervision of youth groups. This omission is regretted.

[56] Although a community group meeting was planned for Makandi estate, the drama group performed prior to the scheduled community meeting and drew an audience of over 100 persons. Following the performance, it was not possible to hold a community meeting of the kind conducted on the other four estates because of the large number of people.

drinking water, and illness and disease (malaria, diarrhea, tuberculosis, HIV, bilharzia,[57] upper respiratory infections, STIs) as the major problems they faced. School infrastructure was deteriorated; the quality of education was questionable, given classroom overcrowding and lack of educational materials and supplies. Whereas most estates had standard primary schools (grades 1-8), one estate school visited only offered grades 1-5. The community groups variously expressed the desire for home craft workers (HCWs) to come and teach them skills; income-generating clubs; adult literacy classes; a cinema to show films; a maize mill; and activities for children and youth who have nothing to do.

161. Health education. Three of the four communities visited reported that they received a lot of information and education on family planning, STIs, cholera management, well baby care, malaria, and good sanitation. Health information and education was presented at both informal and formal meetings. In particular, women received health education talks when they went to the estate clinics. With respect to the assessment of health education activities, three of four community groups felt strongly that health education should continue to be provided because they compare themselves with other communities that do not receive health education. Three community groups stated that health education on HIV/AIDS and family planning improved the health status of the community and of the family. Two community groups found that health education programs had helped to improve their lives. The CBDAs at Wallace estate were singled out for special mention because they were said to be very effective. With regard to drama, all four community groups felt strongly that drama was very important because they learned a lot from drama performances. Two groups reported that the most important messages received from drama groups concerned HIV/STI, prevention of diseases, family planning, how to care for the sick, and sanitation.

162. Two community groups reported that health education was inadequate, and in one group, the men said that men had not received any health education messages in three to four years. Three community groups observed that women were privileged in relation to health education because they received health education during the day when the men estate employees could not attend. With respect to the men who had not received health education messages, it should be noted that their community was not on the estate proper, where the estate-financed HSA worked, but rather was a neighboring community. The reported lack of health education messages suggests the need for more HSAs (para. 220).

163. In relation to children and youth, community groups wanted for children to have a separate place for health education; health education materials; recreation equipment (soccer ball); books about the reproductive system; health education on hygiene, sanitation, toilets, safe water, family planning; and a committee to mobilize youth activities. One community group said that it would like for youth to learn about health education but felt that it was the parents' responsibility to educate youth, and therefore wanted someone to come and teach the parents.

[57] Gumboots and gloves can protect workers from bilharzia (schistosomiasis), which is a disease caused by parasitic worms that live in certain types of snails; infection occurs when skin comes into contact with contaminated fresh water. For people who are repeatedly infected for many years, the parasite can damage the liver, intestines, lungs, and bladder. An estate health care provider said that the treatment for bilharzia is one pill costing K400 (US$5.30); in July 2002, the cost of one pair of gumboots at Bata shoe store in Blantyre, Malawi was K700 (US$9.28).

164. Estate health services. Three of four community groups said that the most important problem at estate health clinics was an inadequate supply of drugs, although two of the groups observed that family planning methods were always available. Three community groups assessed clinic services as good, and two of these groups singled out under-five and outpatient services as good. On the other hand, several problems with clinic services were identified. Two community groups said transport to the hospital was lacking because clinics only had one ambulance to serve the entire estate population. Two community groups reported that their respective clinics did not provide a shelter for guardians (patient's family or visitors) who had to sleep outside the clinic in the cold and had nowhere to prepare meals for the patient. One community group that did not live on the estate compound but in a nearby community said that when they tried to go to the estate clinic, they were questioned by the estate guard at the entrance gate. One community group observed that pregnant women who were about to deliver were treated shabbily by clinic nurses.

165. In sum, project health education activities did reach the target communities. Generally speaking, the communities viewed the activities as positive and beneficial. Health education through drama was for the community groups, as well as the other groups interviewed, the most effective means of conveying health education messages. The observation that women receive more health education than men is worth pursuing further. Although adult peer educators and counselors are specifically tasked with providing health education at the workplace, their numbers are few, and workplace opportunities for health education talks are limited; thus, a new strategy may be necessary in order to reach men. The community groups interviewed made very little mention of project health education activities that are directed at children and youth, e.g., Anti-AIDS clubs, which coupled with the observation that someone is needed to teach health education to parents so that they can teach their children, suggests that child and youth health education activities should be promoted within communities as well as in the school setting.

C. Expanded Range & Quality of Reproductive Health Services for Women, Men, and Youth in the Target Agricultural Estates

1. Management capacity, practices, and systems improved

166. The objective to improve management capacity, practices and systems was substantially achieved but with some shortcomings, notably, the lack of time to complete all planned activities.

a. Estate clinics experiencing STI drug and contraceptives stockouts

167. The performance indicator for the number of estate clinics experiencing STI drug/contraceptive stockouts was 20 percent; the actual achievement was 8 percent. At the end of the First Follow-on project, 50 percent of estate clinics experienced stockouts. Project staff reported that as of July 2002, three of a total of 25 clinics were experiencing stockouts due to lack of communication between the estate and the District Health Office (DHO) and logistical problems with central medical stores. In 2001, DFID agreed to supply STI drugs to MOHP for a period of six years. STAFH Project management lobbied very hard with the MOHP Reproductive Health Unit to have estates included in the DFID program. As of July 2002, some but not all estates, depending on the district, were able to obtain STI drugs from MOHP.

b. Estate companies with health plans and HIV/AIDS workplace policies

168. The performance indicator for the number of estate companies with health plans and an HIV/AIDS workplace policy in place was 13; as of July 2002, five companies reportedly were in the process of developing an HIV/AIDS workplace policy. The Kawalazi estate company in Nkhata Bay had a health policy, and an HIV/AIDS workplace policy was under preparation. The Tea Association of Malawi—whose membership includes the tea estates in Thyolo district—had begun the process of preparing an HIV/AIDS workplace policy. The medical doctor at Matiki clinic, Dwangwa estate, serves on the committee that is developing an HIV/AIDS workplace policy for agricultural estates, which is part of the HIV/AIDS Education and Policy in the Workplace Programme being implemented by the Ministry of Labor and Vocational Training in partnership with Project HOPE.

169. As a result of decentralization, districts in Malawi have new planning responsibilities, including the preparation of district health plans. All health plans come under the purview of the District Assembly and not the District Health Office. Members of the District Assembly are not necessarily knowledgeable in health matters and need to be trained. The project worked with district commissioners to inform them about estate health activities; however, the districts need technical assistance in order to help the estates prepare their own health plans. It is likely that estate health plans might not be prepared or taken into account by the respective districts, with the consequences that planned estate health activities would not receive district supervision, and drugs and other medical supplies would not be purchased.

c. District AIDS Coordinating Committee HIV/AIDS program

170. The performance indicator for the number of district AIDS coordinating committees (DACCs) with a district HIV/AIDS program was 2; the actual number was 4. The planned number of DACC members who would receive training in the management and coordination of district HIV/AIDS activities was 30; the actual number was 46. DACC members are not health care professionals and are not well-versed in HIV/AIDS. The project assisted DACC members in all four districts and provided them with information on HIV/AIDS. Workshops were held on DACC leadership and management skills, including planning. The specific workshop assignment was to prepare a one-year plan under the five-year plan, National HIV/AIDS Strategic Framework, 2000-2004.[58] Project staff asked the National AIDS Commission (NAC) for technical and financial assistance to implement the one-year plans.

171. The lesson learned with regard to both District Assemblies and DACCs was that if a district does not have sufficient technical capacity, it cannot support the agricultural estates. The larger lesson learned is that MOHP must be involved as a key stakeholder at the beginning of the process of project design; otherwise, there is no sense of "ownership," and with nothing at stake, the ministry's interest in and response to a project may be minimal.

d. Estate companies and youth centers

[58] Government of Malawi. National HIV/AIDS Strategic Framework, 2000-2004, Strategy Planning Unit, National AIDS Control Programme, Ministry of Health and Population, October 1999

172. The performance indicator for the number of estate companies that would have established youth centers was 6; as of July 2002, no youth center had been established. However, 15 health clinic staff from 10 estates were trained in youth friendly services (YFS) services in June 2002 (Annex B).

e. Estate management quarterly meetings

173. The performance indicator for the percentage of planned quarterly estate management meetings was 100 percent or 52 meetings; the actual percentage of quarterly meetings held was 38 percent, or 15 meetings. A meeting with estate management to wind up the project was to be held by the end of July 2002. Project staff reported that the quarterly meetings were uneven. Senior management did not always attend but sent mid-level managers who did not have decision-making authority. Because of the drought, the tea industry in particular has not done well, and estates are reported to have cut back on health expenditures and laid off a high number of workers. In addition, the project learned that individual meetings with estate general managers were more productive than the quarterly group meetings.

f. District health coordination meetings

174. The performance indicator for the percentage of planned district health coordination meetings, which included HSAs/HCWs and clinic staff, was 100 percent, or 16 meetings; the actual achievement was 75 percent, or 12 meetings. The meeting scheduled for December 2001 was not held due to the number of other activities being implemented by the project.

g. District quarterly CBDA meetings

175. The performance indicator for the percentage of planned district quarterly CBDA meetings was 100 percent, or 16 meetings; the actual number of quarterly meetings held was 15. This is the only meeting held in conjunction with the District Health Office. The district's family planning coordinator attends, solves problems, and is encouraged to supervise the CBDAs.

h. District quarterly youth meetings

176. The performance indicator for the percentage of planned district quarterly youth meetings was 100 percent, or 16 meetings; the actual number of quarterly meetings held was four, which were conducted in each of the four districts during the third quarter. No meetings were held in the first or second quarters because youth training activities were implemented instead. Initially, there were no quarterly meetings with youth. However, youth members of the executive committees of the Anti-AIDS clubs who are responsible for, among others, overseeing other youth groups, suggested that youth meet quarterly as did the CBDAs. At the quarterly meeting, agreement was reached that a strategy for youth officers would include estate school youth officers in the respective districts, a supervision plan for youth activities was finalized, and it was agreed that estate youth would be included when district youth events took place. For example, in the Nkhata Bay District, the AIDS Day event included youth drama groups from the estates.

2. Range and quality of reproductive health services for women, men, and youth expanded in the target agricultural estates

177. The objective to expand the range and quality of reproductive health services for women, men, and youth in the target agricultural estates was substantially achieved, as evidenced by training activities implemented and additional support.

a. Estate clinics reporting stockouts on infection prevention supplies and percent of clinics practicing infection prevention

(1) performance indicators

178. The performance indicator for the percentage of estate clinics (25 clinics) reporting stockouts on infection supplies was 75 percent; the achieved result was 12 percent, or 3 clinics. The performance indicator for the percentage of estate health clinics practicing infection prevention was 50 percent; the achieved result was 85 percent, or 21 clinics. The planned number of estate clinic and outreach staff to be trained in infection prevention and quality assurance was 20; the actual number trained was 38.

(2) findings

179. Two 3-day training events created a core of estate providers with updated infection prevention (IP) knowledge. At the time of the evaluation visit, providers' knowledge was reflected in safer IP practices such as proper elimination of sharp objects, health facility cleaning, instrument cleaning, and disinfection. Providers were apparently knowledgeable about safe practices in waste disposal. One hundred percent of health facilities visited were disposing of hazardous waste, such as syringes and sharp objects, appropriately, thus safeguarding their own health as well as the health of the community. Despite providers' awareness of the importance of hand-washing, only 50 percent of providers were observed practicing it. The other 50 percent blamed the absence of hand-washing facilities in the consultation room for their inability to incorporate this IP practice.

180. To facilitate the adoption of appropriate IP practices, the project donated to each estate the minimum essential supplies for IP, including JIK (Chlorine solution), buckets, hand-washing basins, heavy duty gloves, aprons, Sharp containers, black bags, soap, detergent, and hand towels (for each of the trainees). A knowledge update on IP was carried out during the last six months of the project, but time for follow-up and support to recently trained providers was very limited. The adoption of safe IP requires more time since, in some instances, providers' need to change their behavior, e.g., hand-washing. In addition, more time is needed to motivate and educate estate managers and/or financial officers on the importance of IP practices in order to have them contribute financially to the purchase of supplies needed to protect health workers and their clients. The providers interviewed recognized the project's significant contribution in the area of IP, but they were in doubt that they would have access to the supplies needed to continue observing appropriate IP practices once the project closed. At the time of the site visits, providers reported that gumboots for field workers most likely would not be replaced. In some instances, the amount of JIK (Chlorine solution) given by the project was already diminished.

181. Although it is evident that there has been achievement on the objective related to infection prevention, it is important to note that neither the project nor the estate clinics had a specific list of the IP practices that had been introduced or changed by the time the project began to phase out. A final guiding document, recommending specific changes, is still needed for each of the clinics and would be of assistance to the providers who have been trained and will carry on. Additionally,

given that appropriate IP practices require financial commitment from estate managers, a projection of costs would have been useful for both providers and estate management.

(3) conclusions

182. The project contributed significantly to the improvement of infection prevention practices in estate health facilities as well as within the community. The complete institutionalization of newly acquired practices will depend on the estates' commitment to provide necessary supplies. Support from District Health Offices through additional follow-up and technical assistance will be essential. Finally, there was no performance indicator given for the number of types of available family planning methods, including LAM, which were not used by estate family planning users. However, three methods were reported not to be used regularly by estate clinics: sterilization, Norplant, and IUCD. At the time of the evaluation visit, IUCD was offered by the Matiki clinic, Dwangwa estate. LAM is offered at all estate health facilities. For surgical methods (male and female sterilization), women and men are referred to BLM, Malawi's largest NGO offering family planning, and/or to district hospitals. Information, education, and counseling on surgical methods was provided at estate health facilities prior to the referral.

V. New Initiatives

A. Voluntary Counseling and Testing Services

183. The present state of the HIV/AIDS epidemic in Malawi requires a national response, utilizing a set of interventions that could potentially avert a large number of future infections, and could contribute to reversing the course of the epidemic. In Malawi, access to HIV testing is very limited throughout the country, but is especially unavailable to residents of the rural sector. Although there is a known need to increase access to HIV voluntary counseling and testing (VCT), the absence of a national policy to guide its implementation is delaying progress. As a regulatory agency, MOHP has yet to approve the use of rapid testing and finalize the document that will provide guidelines for VCT counseling.

184. It is important to also make clear that VCT centers go beyond ensuring access to HIV testing. They intend to offer a constellation of services to clients who seek testing. First and foremost, the testing should be done only after a counseling session, where issues of confidentiality and privacy are discussed and guaranteed. The counselor should be well trained to provide information in an empathetic and non-judgmental fashion. If the client chooses to be tested, results should be provided with a post-test counseling session in which discussions are held on how to maintain his/her sero-negative status or, if the result is positive, provide counseling, offer information on health care, and set up referrals.

185. At the time of the evaluation, none of the estates visited had a VCT center.[59] Dwangwa estate was the only estate that offered pre- and post-test counseling for HIV testing in their largest facility. Two Enrolled Nurse Midwives on staff were reproductive health providers trained in HIV/AIDS counseling by MOHP. Clients were walk-ins, as well as patients from the in-patient ward. The counseling session was conducted in the same FP/RH consultation room, and testing was done in the same facility. However, at the time of the visit and, according to providers'

[59] When the project was designed, it was contemplated that VCT centers would be established. A number of performance indicators were delineated accordingly; however, VCT was not initiated.

interviewed, the Dwangwa estate health facility had yet to set up support groups for clients who are HIV negative or positive.

B. Prevention of Mother to Child Transmission of HIV/AIDS

186. During the later part of the project, and in order to build even further greater capacity among agricultural estates, a 10-day training event on prevention of mother to child transmission (PMTCT) of HIV infection was carried out with 18 participants, two short of the 20 projected. Although the aim of having providers trained in PMTCT of HIV/AIDS could be justified, the timing and the content should have been analyzed more critically in light of providers' desired performance and estate program implementation capacity and capability. As is the case with VCT, the Malawian government is in the process of making recommendations and setting guidelines on breast-feeding, which will have implications for implementation of such a program. In addition, there are a number of other issues that need to be addressed such as access to health care and support groups.

187. Although the introduction of VCT and PMTCT of HIV/AIDS was included in the technical proposal, no implementation strategy or timetable was provided.[60] Estate capacity building via training was implemented three months prior to project closing, leaving insufficient time for follow-up and support. In reviewing the training objectives and content to be presented for PMTCT of HIV/AIDS, it was clear they were too ambitious. Some of the material covered, although important academically, is unnecessary in an initial training. Program designers and implementers need to remember that training should be relevant, well-timed, and targeted to achieving selected skills. Furthermore, these new initiatives—VCT and PTMTC transmission on HIV/AIDS—are challenging given the content and its implications at the community and health services level.

188. At the time of the evaluation visit, none of the sites visited was offering services related to PTMTC. Despite providers' enthusiasm and pride in being trained in a complex issue such as PTMTC, program implementation requires more than training. It is hoped that the initial project contribution will be taken further once the necessary conditions, such as government regulations and estate commitment, are in place.

VI. Monitoring and Evaluation

189. Project monitoring and evaluation was satisfactory with some shortcomings, including inadequate monitoring of financial data and insufficient supervision of community activities in the latter part of the project. The project gave particular attention to forwarding all monitoring data to relevant government entities.

A. Project HOPE Center

190. Project HOPE Center made scheduled supervision visits, although few in number. Supervision in the form of technical assistance was uneven because it varied in quantity and quality

[60] Second Follow-on Proposal on the Project HOPE Support to AIDS and Family Health (STAFH) Project for Private Agricultural Estates Employees in Thyolo, Zomba, Nkhotakota and Nkhata Bay Districts of Malawi, Request for Extension of Grant No. 690-0000-G-00-6056-00, August 1, 2001-July 31, 2002 (draft), Milwood, Virginia, November 1, 2000

over the lifetime of the project. Technical assistance provided to Project HOPE/Malawi in the area of proposal development was assessed as good, owing to teamwork.

191. Project HOPE Center provided training to Project HOPE/Malawi staff in the areas of basic information on reporting policies and procedures and finance. With regard to the latter, in 1999, Project HOPE Center installed a new financial reporting system in order to improve decision-making at all levels of the organization. Subsequently, the focus was placed on standardizing and automating the field accounting systems to better capture local data needs, while training field staff to interact with the central database through Internet links for real-time processing, analysis, and performance feedback. The new financial reporting system was introduced to the field staff in May 2000, with implementation scheduled for July 1, 2000. The Project HOPE/Malawi finance and administration manager was trained at Project HOPE Center in the "upload" template in October 2001. In May 2002, the Assistant Regional Director, Finance-Africa, provided training to Project HOPE/Malawi finance and administration staff in the QuickBooks 2002 financial system, which feeds into the new financial reporting system through the use of a template that uploads the information from one system to another.[61]

192. A serious shortcoming in project monitoring (the basis of which could not be determined) was the apparent lack of adequate financial monitoring, including the lack of critical financial information on the part of project staff. For example, the project manager did not have information on actual project expenditures and was not aware until January 2002 that the project was underspent relative to the time remaining. Moreover, the budget documents provided by Project HOPE Center reportedly did not disaggregate budget amounts according to planned project activities; therefore, the project staff did not know the amount of funds allocated for each activity or the actual expenditures per activity. Budget allocations by activity and regular (monthly) statements of planned versus actual expenditures are a routine part of the financial monitoring of projects. Had project management been aware that the project was underspent, needed adjustments could have been made in project implementation activities and staffing. In addition, expenditures per activity are a useful way of calculating unit costs, which is a key feature of budget preparation and project evaluation. In lieu of a unit cost system, the calculation of expenditures per activity would have permitted the analysis of, for example, the unit cost of refresher training per CBDA, and would also have permitted the analysis of the cost per estate of project interventions, which would be highly useful data in promoting a similar project to agricultural estates in the future. Without an adequate management information system (MIS), covering both project and financial data, it is very difficult to make timely, informed management decisions.

B. Project HOPE/Malawi

193. The Country Director provided technical assistance to the STAFH Project to the extent that her responsibilities for the country project portfolio would permit. The technical proposal for the project stated that a full-time technical support manager would be recruited to support the monitoring and evaluation activities of all programs, including the STAFH Project. The position of technical support manager was filled in July 2002, and thus the project did not benefit from this assistance. The project did not receive needed support in technical monitoring, especially in the area of behavioral surveillance, which was important due to the project's strong focus on behavior change. Attempts to identify consultants with expertise in behavioral surveillance were unsuccessful.

[61] Project HOPE Center, personal communication, September 17, 2002

C. STAFH Project

194. STAFH Project monitoring and evaluation were based on the project's three key intermediate results that were to be assessed according to a total of 40 key performance indicators, which in turn referred to a total of 41 activities to be implemented during the 12-month project implementation period. The key performance indicators were duly monitored and reported on in the project's quarterly reports. Technical staff prepared required project training and supervision reports. Data processing was burdensome because the project did not have a computerized system for monitoring project data. The office assistant or technical staff entered project data in Microsoft Word, which was an inefficient use of technical staff's time; next, the project secretary would enter the same data in Excel, which was altogether a very long process. The project's technical proposal had a line item for a part-time data entry person, but no one could be found to fill the position part-time. A full-time person could not be hired because he or she would have to be trained, and there was no MIS person to do the training. Because project data was not computerized and the project did not have a data management system, it is not easy to access project data or to manipulate it for analytical purposes except by hand. The cost-effectiveness of the project could not be determined due to lack of data.

195. It is strongly recommended that Project HOPE/Malawi consider a better system for the management of financial and project data.

196. Monitoring for family planning was adequate. Estate clinic family planning staff, HSAs/HCWs, and CBDAs completed required RHLMIS forms, which were sent directly to the District Health Office (DHO). With regard to STIs, the government had not finalized the tool for monitoring services as of July 2002, although there was a form for STI drugs. As of July 2002, the project continued to use the form designed by John Snow International for monitoring STI services. The need may exist to update the MOHP system with respect to the syndromic management of STIs because not many MOHP staff are trained in syndromic management. MOHP does not have a monitoring system in place for health education. The project developed its own monitoring system and a consolidated monitoring form for all health education activities, which is sent to the DHO. The project also has a new monitoring system for youth activities. Youth record their activities in notebooks, e.g., youth peer educators and counselors record data on counseling, and school patrons consolidate this data on a single form, which is sent to the district health and education offices and the STAFH Project. The school patrons did not have resources for monitoring activities but decided to monitor until an agreement is reached on how to support this activity. The assumption is that primary education advisers (PEAs) are collecting this information from the school patrons and using it at the district level, along with the District Youth Officer. Finally, with regard to adolescent health monitoring, as of July 2002, the Ministry of Gender, Youth, and Community Services had not informed the project whether or not an adolescent health monitoring system had been developed.

197. The mid-term evaluation of the First Follow-on project was delayed for a period of nine months. The process of consultant selection began in May 2000, a consulted was selected in July 2002 and was scheduled to conduct the evaluation in September 2000. The evaluation was undertaken in February 2001; the evaluation report was completed in March 2001, by which time it was too late to use the results in the preparation of the Second Follow-on project. The lesson learned here is that for projects of short duration (0-3 years), mid-term evaluations are not effective

monitoring instruments because of unforeseen delays; consequently, the results are not useful in terms of making improvements and remedying problems. A more useful mechanism is an annual review, which has the same function as a mid-term evaluation, or a semi-annual review.

VII. Implementation Performance

198. Implementation performance was satisfactory overall, based on the performance of the major participants. The performance of community volunteers was highly satisfactory; theirs was the more difficult work, and they did it very well.

A. Project HOPE Center

199. The performance of Project HOPE Center was satisfactory. The Regional Director for Africa changed three times over the course of the project, affecting continuity of attention. Communication and information exchange was less than desirable at all levels—Project HOPE Center, Project HOPE/Malawi, the STAFH Project, MOHP, agricultural estate management, and community volunteers. STAFH Project management did not receive critical financial information, which would have permitted better project monitoring. Project HOPE Center did not receive sufficient project input on needs regarding gifts in kind (GIK). The flow of information and communications was constrained; the lack of e-mail access for staff at Project HOPE/Malawi and the STAFH Project hampered communications. The issue of e-mail access should be addressed at the earliest possible opportunity.

200. One effective means of communicating about a project—including its objectives, activities, budget, implementation schedule, coordination and partnership arrangements, and monitoring and evaluation arrangements—is a project launch workshop to which all interested parties are invited. Project HOPE may wish to consider such an activity for its projects in the future. Otherwise, frequent and regular communications with everyone concerned, including MOHP and estate management, are recommended to increase project efficiency, transparency, and accountability.

201. The STAFH Project reported some problems with GIK, i.e., some items were not deemed suitable for Malawi, some items did not correspond to the service level of estate clinics, some drugs were close to their expiration dates, and the STI drugs on the MOHP drug list were not available in the United States and, therefore, could not be supplied. These observations on GIK largely reflect poor communications among Project HOPE Center, Project HOPE/Malawi, and the STAFH Project because, on the face of it, better communications would have avoided the problems. At the same time, the project did not plan for the distribution of GIK, nor was the distribution cost budgeted, which was a significant oversight. Project HOPE/Malawi does not have a GIK monitoring and distribution system and would greatly benefit from such a system.

B. Project HOPE/Malawi

202. The performance of Project HOPE/Malawi in project implementation was satisfactory. Project HOPE/Malawi—including the STAFH Project—is held in very high regard by all project participants, including government, estate companies, and communities. Project HOPE/Malawi's reputation is based on a strong record of working to improve health services on agricultural estates and the health condition of estate workers and their families. Project HOPE/Malawi and the STAFH Project have successfully brought health concerns to the attention of the agricultural

estates and brought health concerns on agricultural estates to the attention of MOHP, which are unique achievements. At the government policy level, not much is known about the agricultural estate communities; the estates have not been involved in policy-making. Project HOPE/Malawi and the STAFH Project have worked with both sides on policy development.

203. Management and staff provided guidance and assistance to the project, which was well-received. As previously noted, one area in need of improvement is financial project monitoring. Project monitoring could have been stronger on the part of both Project HOPE/Malawi and Project HOPE Center.

204. With regard to staffing, the need exists to review the salary/compensation package regularly, e.g. every six months, including the possible introduction of an inflation clause.[62] Although Project HOPE/Malawi is one of the largest NGOs in the country and is a recognized leader on the HIV/AIDS issue, competition for qualified, experienced staff in all sectors is high. Project HOPE/Malawi has lost staff to smaller NGOs that have better salary/compensation packages. Staff development at all staffing levels is another area in need of attention, e.g., improvement of technical staff computer skills would increase efficiency.

205. Finally, the idea of "transition funding" should be explored as a means of retaining competent staff in the transition period between projects or during a lapse in project funding.[63] The STAFH Project experienced such a period lasting nine months in 1998-1999; no funds were available between the end of the original STAFH Project and the beginning of the First Follow-on project. During this period, some staff were deployed to other Project HOPE/Malawi projects; some staff could not be supported due to lack of funding and left the project. The staff turnover rate in 1998 was 46 percent (Tables 13-14).

C. STAFH Project

206. The STAFH Project was implemented by 15 persons: project manager, accountant/administrator, four technical officers, and nine support staff, including a secretary, office assistant, two drivers, five security guards, and one gardener (Table 15). The performance of management in project implementation was highly satisfactory but with the shortcoming that the project manager was also the project manager for the Project HOPE/Malawi HIV/AIDS in the Workplace Project. The performance of project staff was highly satisfactory. Project staff consistently performed well, despite an overwhelming workload, logistical difficulties, and the absence of a computerized project monitoring system. The four-member technical staff organized and participated in the very well-regarded training activities whose positive results largely accounted for the achievement of project objectives. All staff made significant contributions to the project.

207. In the larger context of Project HOPE/Malawi's work with agricultural estates, the project served as liaison between MOHP and the agricultural estates, which produced many positive results. For example, the project trained estate health staff using government training and trainers, which worked very well.

---

[62] The inflation rate was 16.7 percent in June 2002, down from 28 percent in August 2001, as reported by the Commercial Bank of Malawi (CBM) in Highlights of the Malawi Economy, Issue No. 50.

[63] Save the Children reportedly has a mechanism in place for transition funding to support staff during transition periods.

D. MOHP

208. The performance of the MOHP in project implementation was satisfactory but with some shortcomings. Joint supervision with the District Health Management Team (DHMT) was partially successful; it proved difficult to combine the project and DHMT monitoring strategies because the DHMT goes out as a team to look at several interventions, the STAFH Project had only three interventions, and schedules were not always compatible. In addition, the district-level MOHP was severely constrained by lack of resources, e.g., fuel for vehicles. MOHP supervision was desired in part because estate management did not have a health background and could not, for example, evaluate clinical performance. Project design did not incorporate MOHP as a full partner with a well-defined role and responsibilities, and this omission had a negative effect on MOHP project participation. MOHP provided the training curriculum for HSAs, family planning, and STIs. Lead clinical trainers were from MOHP, and MOHP training centers were used for training events. In the end, MOHP played a very important supportive role; the ministry always responded when called.

E. Agricultural Estates

209. The performance of agricultural estate health providers was satisfactory. The performance of estate management was somewhat deficient due to lack of involvement on the part of the majority of senior managers. For example, very few managers consistently attended the quarterly management meetings, provided support beyond the minimum required, or monitored the project from a management of view. However, estate management was not involved in project design as a key stakeholder, did not have a specified role or responsibilities in project implementation, and the partnership arrangement was not governed by a Memorandum of Understanding or any other formal document, all of which would have contributed to greater estate management involvement. In addition, project staff assumed a certain level of knowledge and understanding on the part of management as regards reproductive health, STI/HIV/AIDS, and other crucial health issues. Over time, it became clear that estate management was not fully cognizant of the issues that the project addressed, and the project should have provided more support in this area.

F. Community Volunteers

210. The performance of community volunteers—CBDAs, adult peer educators and counselors, adult drama groups, youth peer educators and counselors, youth drama groups, TfT youth leaders, and youth Anti-AIDS clubs—in project implementation was highly satisfactory. The project successes would not have occurred without the wholehearted dedication of the volunteers who gave freely of their time and abilities on a daily basis; their participation was of immeasurable value to the project. In fact, it is because of community volunteer reporting on their activities that project achievements could be measured and that particular project activities could continue, e.g., reporting on the needs for contraceptive methods.

G. USAID

211. The performance of USAID in project implementation was satisfactory. There were no funding problems; USAID funds were always timely. USAID identified and discussed key issues and contributed to project monitoring.

H. Thandizani Moyo

212. The performance of Thandizani Moyo in project implementation was deficient. The planned role of Thandizani Moyo, a local NGO, was to coordinate the procurement of low-cost drugs on the estates in Thyolo District, supervise estate health workers, and monitor health activities on the estates. Project HOPE/Malawi established relations with Thandizani Moyo during implementation of the earlier Child Survival project. The NGO's founder, Dr. Miller, helped to coordinate and promote estate participation in the STAFH Project. Many estates subscribed to Thandizani Moyo services on a fee-for-service basis, which was determined by the size of the estate population. Thandizani Moyo was able to purchase drugs at lower costs, which were then purchased by the agricultural estates; drug purchases covered a variety of pharmaceuticals and not just those of interest to the project. Dr. Miller left Malawi on the occasion of her husband's retirement from Eastern Produce Malawi, and the Thandizani Moyo network largely disappeared. As of July 2002, most estates had dropped out of the arrangement with Thandizani Moyo.

I. Others

213. The performance of the National Family Welfare Council (NFWC) was satisfactory. In order to ensure that government norms and regulations were met, the NFWC required that it be present at CBDA training and, in fact, was present at all CBDA training events. The performance of the National AIDS Commission was satisfactory, although the promulgation of some policies and guidelines, e.g., for VCT and PMTCT, has been delayed.

VIII. Major Factors that Affected the Achievement of Project Objectives

A. Factors not Subject to Government Control

214. For the past five years, climatic changes (drought and floods) adversely affected agricultural production in Malawi, including the tobacco and tea estates that participate in the project. The climatic changes had a partial, negative effect on the achievement of project objectives. Whereas many participating estates provided workers with lunch (and sometimes breakfast), family members suffered from lack of food, which had a deleterious impact on the estate as a whole. Losses attributed to drought decreased estate profits, resulting in an increasing number of workers being dismissed each year, which created hardships for families.

B. Factors Subject to Government Control

215. The change in government in 1994 from a single to multi-party system had a positive effect on the achievement of project objectives. The change in government occasioned changes in policies in all government departments; the process of changing policies has taken five years in part because people's attitudes toward democratic culture are still being nurtured. In July 2002, many new policies were being promulgated at the same time, e.g., health, child labor, and human rights. Policies and guidelines on health changed, e.g., the policy on how to manage HIV, which is still in draft form but is being implemented. Some of the new policies would support estate management for the betterment of workers.

216. Beginning in 2000, the government began a process of decentralization, which has had both positive and negative effects on the achievement of project objectives. On the positive side,

the District Health Officer (DHO) has more power to control health services (HIV/AIDS, health education, environmental health, transport, etc.), and the DHO mandate includes both the public and private sectors, whereas under the centralized health system, agricultural estates were not part of the district coverage area. Decentralization also mandated that district-level institutions are responsible for government, namely, the District Assemblies. On the negative side, District Assemblies do not have sufficient technical capacity to meet their new responsibilities, and neither do DHOs. Many DHOs do not have proper training in district health management; they are overwhelmed with work, dissatisfied with their salaries, and are leaving the country. The turnover rate for DHOs was reported to be every six months, which meant that project staff were continually introducing and promoting the project to DHOs.

C. Factors Subject to Project HOPE Center Control

217. Inadequate staffing levels had a substantial negative effect on the achievement of project objectives. Inadequate staffing was related to proposal preparation, which was shaped by the availability of donor funding and eligible funding categories. Although donor funding for staff costs is traditionally limited, the project needed additional staff on account of the heavy workload but found it difficult to persuade Project HOPE Center (and donors) that staffing levels should be increased. All of the project staff were overworked; at the end of the project, staff were expected to have a high number of compensatory days. During proposal preparation, it should have been evident to all concerned that four technical staff could not undertake the proposed number of training activities and conduct supervision on 47 agricultural estates located in four districts of Malawi during the 12-month implementation period. Another result of inadequate staffing was crisis management rather than planned management.

D. Factors Subject to Project HOPE/Malawi Control

218. Project HOPE/Malawi uses the business management software program, QuickBooks, to capture financial data. This program was updated in 2001, but as of July 2002, the project accounting/administration staff had not been trained in the software, which had a partial and limited negative effect on the achievement of project objectives.

E. Factors Subject to STAFH Project Control

219. The lack of transport for each of the project's two technical teams—the reproductive health training team and the community health education training team—had a partial, negative effect on the achievement of project objectives. During the latter part of the project, only one vehicle was available (the second vehicle needed repair); thus, it happened at times that one of the two teams could not undertake scheduled training and/or supervision activities because the other team was using the vehicle.

F. Factors Subject to Agricultural Estate Control

220. Agricultural estates exercise complete control over the financing of estate health services, with the exception of government-provided contraceptives and STI drugs. Estate management released from work those persons who attended project training events, which had a substantial positive effect on the achievement of project objectives. Project staff reported that, according to MOHP, some estate clinics did not meet MOHP standards and were asked to update clinic services

and infrastructure in order to meet ministry standards. Estates also have control over health staff, and a shortage of health staff, e.g., HSAs, was reported on some estates. The MOHP policy is one HSA per 2,000 population, which changed in June 2002 to one HSA per 1,000 population. No estate approximated the MOHP ratio.

IX. Implementation Delays

221. The nine-month implementation delay between the conclusion of the original STAFH Project (1996-1998) and the First Follow-on STAFH Project (1999-2001) had a partial, negative effect on the continuity of project activities and on project staff who were let go due to lack of funds. When the original project ended in September 1998, some project staff were deployed to other projects, and others were let go. Project HOPE received notification from USAID that another grant would be awarded. The proposal writing for the First Follow-on project grant took nine months; the First Follow-on project began in August 1999.

222. The delay in the start-up of the Second Follow-on project had a substantial, negative effect on project implementation. The USAID grant agreement was signed in July 2001 and finalized in August 2001. Project HOPE/Malawi delayed the start-up of project implementation until mid-October 2001, waiting for a copy of the fully executed grant agreement. That is, rather than having a full 12 months for project implementation, the actual execution period was about 10.5 months. Accordingly, the project activities that were to be implemented over a 12-month period were compressed into a 10.5 month period, which resulted in some cases in poor execution and reduced supervision of project activities.

223. Implementation delays caused by delayed funding flows had a partial, negative effect on project implementation. The project received funds from Project HOPE Center every month. When funding for a particular month was delayed, all planned activities could not take place. Hence, instead of spreading out activities as planned, they were compressed, especially in the last quarter of the project. The locus of the funding flow delay could not be ascertained; however, together Project HOPE Center, Project HOPE/Malawi, and the STAFH Project may wish to consider how such delays can be avoided in the future.

X. Project Design

224. The design of the project was inadequate for achieving project objectives. The design did not provide for a sufficient number of technical staff relative to the proposed number of activities, geographic coverage, and project duration. The design did not provide for an adequate (computerized) monitoring and evaluation system. The design did not take into account the time and cost involved in the distribution of GIK or provide for a GIK monitoring system. The design did not provide for the "consolidation of interventions started in 1996," as stated in the technical proposal. However, the design did provide for new initiatives (e.g., voluntary counseling and testing and prevention of mother to child transmission of HIV/AIDS), which was in direct contradiction to the aim of consolidating earlier interventions over the relatively short period of 12 months. Moreover, project design included the new initiative of voluntary testing and counseling (VCT) when MOHP had not (and of July 2002, still had not) approved the use of rapid testing or finalized guidelines for VCT counseling.

225. The most serious design flaw was the complete lack of attention to the sustainability of project activities and benefits at the conclusion of project financing. The project did not have an exit strategy in the event that it succeeded or failed. The design did not take into account sufficient incentives for local participation (i.e., community volunteers), which are key to sustainability. The design did not provide for activities from the outset that would ensure estate commitment and MOHP commitment, which are essential for sustainability. The design did not provide for a transition phase in which MOHP and the agricultural estates together would plan for and reach agreement on how best to sustain project activities and benefits when the STAFH Project ended. The design did not provide for the hand-over of the project to MOHP and the agricultural estates at the conclusion of financing. It is noted that project reports did not address the issue of sustainability.

226. The responsibility for poor project design is shared by USAID, Project HOPE Center, and Project HOPE/Malawi.

227. Project design was adequate in terms of how well the criteria—the performance indicators—for judging the achievement of project objectives were quantified in the technical proposal.

XI. Sustainability

228. The sustainability of project activities and benefits is uncertain. The sustainability of some activities and benefits is likely, and for others, unlikely or uncertain. The sustainability of family planning and STI services on agricultural estates is likely because these are well-established interventions. The sustainability of health education activities is likely because the estates have hired HSAs. The sustainability of infection prevention in estate health clinics is uncertain because it is not known if estates will continue to purchase the necessary supplies when the project-provided supplies are exhausted. The sustainability of other new initiatives such as youth friendly services (YFS) and PMTCT of HIV/AIDS is uncertain because the activities and support surrounding these initiatives were not significant. The sustainability of community volunteer activities is uncertain because community volunteers are motivated in large part by refresher training, which the estates may not provide. One exception is Naming'omba Tea Estates Ltd., which already has a plan for HSA/HCW and CBDA refresher training, including funds budgeted for that purpose. The sustainability of STI drug supplies at the conclusion of the DFID program is uncertain; it is not known whether the estates will purchase STI drugs in the future. The sustainability of the estates' financial support for health-related activities is uncertain because of the uncertainty surrounding the estates' profitability.

229. The sustainability of project activities and benefits was seriously jeopardized by the lack of a planned, transition phase for MOHP and the estates and the lack of a planned hand-over of the project to MOHP and the estates. Toward the end of the project, management met with MOHP and estate management to inform them of project closing. Additional follow-up is recommended in order to make MOHP and estate management aware of project achievements and, in particular, to maintain the successful relationship that Project HOPE enjoys with the agricultural estates, which should continue in support of improved health for estate workers and their families.

230. With regard to MOHP, the sustainability of project activities and benefits is negatively affected by District Health Officers (DHOs) who have a high turnover rate. On the other hand,

some MOHP central and district-level authorities interviewed expressed optimism in relation to the potential for sustainability. The District Health Officer for Thyolo District said that if there were problems in sustaining activities, the district would assist and, further, that the decentralization of the ministry, including that of budget authority, meant that districts would be able to help the agricultural estates. Other MOHP authorities interviewed were less optimistic.

XII. Assessment of Outcome

231. The project's outcome was highly satisfactory. The project attained its major objectives with only a few shortcomings, based on the degree to which the performance indicators were met, implementation performance, monitoring and evaluation, and sustainability (Table 16). The project addressed very difficult objectives through working with intermediary groups. Project partnerships with MOHP, the estate companies and their health service providers, and community groups made the achievement of objectives more complicated—unlike other projects where project staff have direct control over inputs, processes, and outcomes. When Project HOPE began work on the agricultural estates, family planning services were non-existent, and today they have become institutionalized. In fact, the project's major accomplishment is that health services are available that were not available before, e.g., family planning, counseling, and STI diagnosis and treatment. The major shortcoming was the seeming assumption that project activities would continue, therefore, there was no need to work out a follow-on plan. The lack of planning for and execution of a transition phase was the main deficiency.

232. The impact of project activities on behavior change was highly significant, as reported by HSAs/HCWs, CBDAs, adult peer educators and counselors, adult drama groups, youth groups, including Anti-AIDS club members, TfT youth leaders, youth drama groups, and youth peer educators and counselors, and school patrons. For example, youth groups reported a decrease in sexual activity and behavior; a decrease in teenage pregnancies, early marriages, and school dropouts; and increased knowledge about HIV/AIDS/STIs and how to prevent them, among others.

233. Project activities also had a positive, unintended impact on the participating tea estates. The Tea Sourcing Partnership of the United Kingdom (UK) aims to understand how tea is sourced and to validate conditions on estates and factories by credible, independent monitoring.[64] The partnership, which includes some of the UK's best-known tea brands, looks at five areas and assesses whether estates and factories comply with local laws and national union agreements for each area: (a) employment, including minimum age and wage levels, (b) education, (c) maternity, (d) health and safety, and (e) housing. Estates and factories are given an in-depth questionnaire to complete on their policies and procedures in these areas. The estates' responses are then validated by an independent, on-site audit. If the estates/producers are identified as not complying with the relevant legal requirements, and if they do not achieve the improvement that the Tea Sourcing Partnership seeks, then after due process members of the Tea Sourcing Partnership will cease trading with them, which is very much a last resort. Estate management interviewed reported that project activities contributed in an important way to the findings of the independent audit of their estates and factories.

XIII. Lessons Learned and Recommendations

[64] Source: http://www.teasourcingpartnership.org.uk/

A. Project Design

234. The project design was overly ambitious in relation to the scope of activities, including new initiatives, and geographic coverage relative to the number of staff and the project duration of 12 months. The lesson learned is that a project must be properly sized, i.e., the project dimension should fit the proposed activities and staffing level in the planned time frame. In hindsight, it might have been better for the STAFH Project to have focused exclusively on the agricultural estates in Thyolo District, where the greater part of project estates were concentrated.

235. The project design did not adequately provide for building the partnerships on which the project would depend at its conclusion. Specifically, the preparation of the project did not include the active participation of MOHP or estate management, define each partner's roles and responsibilities, provide for strengthening the capacity of the partnership, identify the measures by which the partnership would be maintained, develop a communications strategy, assess the costs and benefits to each partner, or formalize the partnership arrangement through a Memorandum of Understanding or similar type of document. As a consequence, the project partnership with both MOHP and estate management was weak. The lesson learned is that all key stakeholders should be involved in project preparation; Project HOPE may wish to develop a consultation mechanism for that purpose.

236. The project design did not plan for sustainability with the result that the sustainability of project achievements is uncertain because no provision was made to develop and implement a transition plan that would hand-over the project to MOHP and participating estates at the conclusion of project financing. The lesson learned is that every project designed and supported by Project HOPE should have an exit strategy and plan. The exit strategy should address the questions of what happens if a project succeeds, especially to the beneficiaries, and what happens if a project fails, especially to the beneficiaries? The dilemma that Project HOPE now faces is what to do, given that the STAFH Project succeeded and project financing ended.

237. Planning for sustainability in the design phase of a project is not simply identifying an exit strategy. In order for project achievements to be sustainable, certain factors must be taken into account in the design phase, including incentives for local participation, management effectiveness, the project's technical and financial viability, social impact, and the commitment of project partners. The sustainability of project achievements is jeopardized because these factors, in particular, incentives for local participation and partner commitment, were not considered. The lesson learned is that every project designed and supported by Project HOPE should take into account the major factors upon which sustainability depends.

B. Reproductive Health Capacity Building

238. Strengths. The project has many strengths in the area of building reproductive health capacity. It has successfully built reproductive health capacity in estate health services. Through the recruitment of MOHP and other national trainers, as well as the use of national reference manuals, the project has adhered to and supported national policies, and in so doing, has contributed to the standardization of local knowledge and practice. Training events among participating estates were also standardized. The project's training system allowed service providers to keep their knowledge and skills up-to-date. The new project initiatives—youth friendly services (YFS), prevention of mother to child transmission of HIV/AIDS, and updates on

infection prevention (IP) knowledge and practices were direct responses to needs that were identified by the communities and health facilities.

239. Weaknesses. The project design did not include an analysis of the expected outcomes for providers' reproductive knowledge and skills, nor was there a system in place for evaluating achievements. It was not clear if a system for prioritizing interventions was established in collaboration with estate management and district health officials. New initiatives should be implemented only when the interest and commitment exists to ensure appropriate support. Implementation of two of the three new initiatives required training human resources, e.g., YFS and IP, and a budget for minimum essential supplies, which was not vouchsafed prior to training. In addition, capacity building for new initiatives was implemented in the later part of the project (six months prior to closing), which left no time for appropriate follow-up and support necessary for implementation.

240. The evaluation findings show that there is a need to prioritize interventions and tailor them more closely to the needs on the ground and to collaborate more closely with all stakeholders. Training objectives and content were too ambitious for the number of training days allotted. Training objectives and the number of training days should be tailored specifically to the knowledge and skills that are expected to be achieved in order to provide services. Training content should be more timely, relevant, and less ambitious. Although capacity building through training was amply demonstrated, it is necessary to look into other factors as well, such as building strong partnerships that would provide needed logistical and financial support, e.g., the purchase of essential supplies and equipment. Finally, Project HOPE/Malawi projects would benefit from capacity building for its own staff, which would allow for more control of the quality of training interventions, among others.

C. Reproductive Health Service Provision

241. Strengths. The project made a significant contribution to increased access to family planning (FP) and reproductive health (RH) services on agricultural estates and neighboring communities. The partnership between the project, MOHP, and the estates should be considered as a model for increasing access to FP and RH services, albeit a model that needs to be strengthened. The project helped to eliminate barriers to family planning services such as physical examinations and lengthy follow-up visits. Health providers were highly motivated and enthusiastic about the expansion of reproductive health services. Contraceptive stockouts as well as STI drug supplies appeared to have been less of a problem the last 12 months of the project. Providers welcomed project supervision visits.

242. Weaknesses. The absence of MOHP regulations governing agricultural estate health services and the lack of regular ministry supervision were limiting factors on improving and/or expanding estate health services. Estate management's apparent limited understanding of health conditions on the estates, including the importance of a healthy workforce, was an obstacle in terms of financial support, e.g., a line item budget allocation for minimum essential supplies for service provision. No supervisory system was established on the estates, leaving behind a weak supervision capacity. The integration of HIV/AIDS prevention into family planning services was limited. In relation to the RHLMIS, periodic support in the form of training and follow-up was not established between the estates and the district-level MOHP, which delayed implementation of Form 06.

243. Provider attitudes, beliefs, and poor communication skills may hamper good communication with clients, especially in the area of sexuality. To improve service provision, strategies should be identified to avoid missing opportunities for STI/HIV/AIDS prevention. Also, it is essential to work more closely with community members (men and women), as well as providers, to reverse traditions/beliefs that present barriers for condom accessibility/use in dual protection.

D. Monitoring and Evaluation

244. Project monitoring and evaluation, including the provision of technical assistance, took place at several levels, Project HOPE headquarters, the Malawi country office, and the project office, with varying degrees of success. One of the principal stumbling blocks to effective monitoring and evaluation was the inadequacy of financial and project data management. Another stumbling block was communications. Hence, the lesson learned is that good monitoring and evaluation depends on a data management system that fits the needs of all three Project HOPE entities and on efficient and transparent communications between and among management and staff at all three levels. It is recommended that data management needs be reviewed and the data management system improved accordingly. It is also recommended that communication on all levels be frequent and regular.

E. Partnership Model

245. The partnership model of project implementation worked in spite of its shortcomings and holds considerable promise for the future. The evaluation documented numerous benefits enjoyed by both MOHP and estate management as a result of the project, including the fact that the partnership between MOHP and estate management was strengthened by virtue of the project. Central and district-level MOHP authorities and estate health providers concurred that their public/private sector partnership resulted in increased access to and the quality of reproductive health services. Although the project kept MOHP informed of interventions taking place at estate health facilities, and results were reported to MOHP, there was a very limited sense of project "ownership" on the part of MOHP and estate management. The quarterly meetings with project staff and the District Health Officer (DHO), in addition to joint supervision/follow-up visits, would have been excellent opportunities to actively engage DHOs and estate management.

246. The partnership between the project and community volunteers was highly successful, and most probably the benefits to the project far outweighed the cost of training and supervising the volunteers. The needs and recommendations of the community volunteers were not given sufficient consideration, which resulted in them not being able to do as good a job as they would have liked and were trained to do. Most volunteer groups reported the need for IEC materials and supplies such as pens and notebooks, in addition to suggested incentives for their participation. The lesson learned is that community volunteers should be supported to the fullest extent possible. In the future, Project HOPE should make every effort to improve communication with community volunteers, including consultation on training activities, and to provide incentives in recognition of their work.

247. Finally, the partnership model that Project HOPE/Malawi has developed can, with some adjustments, be replicated for scaling-up across the agricultural estate sector. In order to do this, it

would be necessary to prepare a document on the model that describes the purpose, activities, and costs of health interventions and the partnership arrangement, including roles and responsibilities, and the costs and benefits of participation. The model could then be used to promote improved health services on non-participating estates and to promote the sustainability of project activities on participating estates. Furthermore, Project HOPE/Malawi could engage industry associations such as the Tea Association to adopt the model as an effective and efficient means of improving worker and family health in fulfillment of industry social responsibilities. To be effective and meaningful, Project HOPE/Malawi would need to conduct close consultations with MOHP and estate management, and perhaps also the Ministry of Agriculture, in the preparation of the model. It is recommended that Project HOPE consider such an undertaking in view of its remarkable role to date in improving health services on agricultural estates and the potential for greater successes.

Bibliography

Author unknown

Integrated Baby Friendly Hospital Initiative (BFHI) in the Context of HIV/AIDS. Training Material, Lusaka, Tanzania, 13-28 May 2002

Eckert, Erin

Family Planning and AIDS Prevention on Malawi's Private and Agricultural Estates, An Assessment of the Project HOPE-STAPH Programme, 1996-1998, Measure Evaluation, USAID Cooperative Agreement: HRN-A-00-97-00018-99, December 1, 1998

Family Planning Association of Malawi

Youth Friendly Health Services: Handbook For Health Care Providers, Trainers of Trainers, 18-22 March 2002

Food and Agriculture Organization (FAO) and World Food Programme (WFP), United Nations.

Special Report, FAO/WFP Crop and Food Supply Assessment Mission to Malawi, 29 May 2002

Franco, Ciro et al.

Employer-Based Programs in Maternal and Child Health, Project HOPE's Strategy for Attaining Long-Term Sustainability of Health Promotion in Malawi, BASICS, Arlington, VA, 1997

Government of Malawi

Draft Malawi Policy on HIV/AIDS in the Workplace, prepared by the HIV/AIDS related Workplace Policy Task Force under the HIV/AIDS Education and Policy in the Workplace Programme being implemented by the Ministry of Labor and Vocation Training in partnership with Project HOPE, October 2001

Guidelines for Community Based Distribution of Contraceptives in Malawi, National Family Planning Council of Malawi (NFPCM) and MOHP, June 1998

Interpersonal Communication and Counseling: A Training Manual for Family Planning Providers, NFPCM, MOHP, and STAFH Project, September 2001

Life Planning Skills, A Training Manual for Young People in Malawi, National Family Planning Council of Malawi (NFPCM), 1999

Malawi, Demographic and Health Survey 2000, National Statistical Office, Zomba, Malawi, and ORC Macro, Calverton, Maryland, August 2001

Malawi National Reproductive Health Service Delivery Guidelines, MOHP, JHPIEGO Corporation, and USAID, October 2001

National HIV/AIDS Strategic Framework, 2000-2004, Strategy Planning Unit, National AIDS Control Programme, Ministry of Health and Population, October 1999

National HIV/AIDS Strategic Framework, 200-2004, Annex A, The Agency for Action, Strategy Planning Unit, National AIDS Control Programme, Ministry of Health and Population, October 1999

Profile of Poverty in Malawi, 1998, Poverty Analysis of the Malawi Integrated Household Survey, 1997-1998, National Economic Council (Poverty Monitoring System), November 2000 (revised)

Reproductive Health Logistics Management Information System, A Procedures Manual, MOHP, March 2001

Sentinel Surveillance Report 2001, HIV/Syphilis Seroprevalence in Antenatal Clinic Attendees, Monitoring and Evaluation, National AIDS Control Commission, n.d.

Service Provider Handbook: Managing People with Sexually Transmitted Diseases in Malawi, National AIDS Control Program, MOHP in conjunction with John Snow International (JSI) and the STAFH Project (USAID), First edition, 23 June 1998

National HIV Prevalence Estimates from Sentinel Surveillance Data 2000, Monitoring and Evaluation, National AIDS Commission, n.d.

Youth Friendly Health Services: Training Manual for Service Providers in Malawi, National Youth Council of Malawi (NYCOM), 2001

1998 Malawi Population and Housing Census, Report of Final Census Results, National Statistical Office, December 2000

Hope, Ann and Sally Timmel

Training for Transformation, A Handbook for Community Workers, Book 2, Mambo Press, n.d.

Johns Hopkins Bloomberg School for Public Health

Infection Prevention Course Handbook: Guide for Participants, October, 1997

Kornfield, Ruth

Mid-Term Evaluation of STAFH Project, December 2000

Makwakwa, J.M., F.F. Sota, and L.J. Uta

A Report on RH Refresher Course for Enrolled Nurses and Medical Assistants. 15th to 28th July 2001

Mwenziwina, Jane and Olive Mtema and Mrs. Gamechi

Family Planning Refresher Training Held at Nali Motel. January to March, 2001.

Project HOPE

A Follow-on Proposal on the Project HOPE Support to AIDS and Family Health (STAFH) Project, Request for Extension of Grant No. 690-0000-G-00-6056-00, May 1, 1999-April 30,2001, Milwood, Virginia, February 1999

Second Follow-on Proposal on the Project HOPE Support to AIDS and Family Health (STAFH) Project for Private Agricultural Estates Employees in Thyolo, Zomba, Nkhotakota and Nkhata Bay Districts of Malawi, Request for Extension of Grant No. 690-0000-G-00-6056-00, August 1, 2001-July 31, 2002 (draft), Milwood, Virginia, November 1, 2000

STAFH (Family Planning and AIDS Prevention on Malawi's Private Agricultural Estates) Program, Review of Midterm Evaluation Recommendations (1998, 2000), February 14, 2001

Statement of Work, Final Evaluation, Support to AIDS and Family Health (STAFH) Project, Project HOPE/Malawi, June 4, 2002

Technical Proposal, Family Planning and AIDS Prevention Under Support to AIDS and Family Health Project (STAFH), IFA No. 690-95-A-002, January 1996
Trip Report, Malawi, Virginia M. Lamprecht, February 3-16, 2002

STAFH Project, Project HOPE/Malawi

A report on STD Syndromic Management Service Providers Course for Estate Health Workers. Project HOPE, STAFH Program, Mzuzu, Northern Region, 1-12 May 2000

A report on STD Syndromic Management Service Providers Course for Estate Health Workers. Project HOPE, STAFH Program. Thyolo, Southern Region, 10–21 April 2000

CBD Training Follow-up, 9-14 March 2001

CBD Training Report for CBDAs and CBDA Supervisors held at Cherda Hotel from 13-24 May 2002

CBD Quarterly Meeting held at Chombe October 2001

CBD Quarterly Meeting held on 25 May 2002,Wallace estate, Zomba

CBD Quarterly Meeting, Sorrento Club, Conforzi Estate, 18 April 2001

CBDA/Supervisors Training held at Cumberland Motel, Bvumbwe, Thyolo from 12-30 March 2001

Eighth Quarterly Report for the Period April-June 2001, Family Planning and AIDS Prevention Under Support to AIDS and Family Health (STAFH) Project, Grant No. 690-0000-G-00-6056-00, Limbe, Malawi, July 2001

End-of-Year Report for the Period July1999-December 2000, Family Planning and AIDS Prevention Under Support to AIDS and Family Health (STAFH) Project, Grant No. 690-0000-G-00-6056-00, Limbe, Malawi, February 2001

End of Year Two Report for the Period July 2000-July 2001, Family Planning and AIDS Prevention Under Support to AIDS and Family Health Project, Grant No. 690-0000-G-00-6056-00, STAFH Follow-on Programme, Limbe, Malawi, January 2002

Estate Adult Peer Education and Counseling Supervision for Nkhotakota and Nkhata Bay from 4-9 February 2002

Fifth and Sixth Quarterly Report for Period (July-December 2000), STAFH Program, Limbe, Malawi, n.d.

First Quarterly Report for the Period October-December 2001, Family Planning and AIDS Prevention Under Support to AIDS and Family Health (STAFH) Project, Grant No. 690-G-00-99-00230-00, Second STAFH Follow-on Programme, Limbe, Malawi, January 2002

Infection Prevention Training Report from 16-18 January 2002

Infection Prevention Training Report from 13-15 March 2002

Infection Prevention Training Curriculum

Initial HSA Training Report, June 2002

In-school EDZI TOTO Club Supervision for Nkhotakota and Nkhata Bay from 4-9 February 2002

Integrated baby friendly hospital initiative, infant feeding and prevention of mother to child transmission on HV/AIDS training report, 12-25 May 2002

Minutes of the CBDA Quarterly Meeting held on 18 December 2001 at Thyolo Catholic Hall

Peer Education and Counseling Training Curriculum, n.d.

Report on CBDAs and Their Supervisors Refresher Training held at Nali Motel, 20-25 May 2001

Report on Refresher Course for CBD Agents from Thyolo Estates and ZombaWallace estate held at Cumberland Motel Bvumbwe from 5-9 February 2001

Second Quarterly Report for the Period January-March 2002, Family Planning and AIDS Prevention Under Support to AIDS and Family Health (STAFH) Project, Grant No. 690-G-00-99-00230-00, Second STAFH Follow-on Programme, Limbe, Malawi, April 2002

Seventh Quarterly Report for the period January-March 2001, Family Planning and AIDS Prevention under Support to AIDS and Family Health (STAFH) Project, Grant No. 690-0000-G-00-6056-00, Limbe, Malawi, April 2001

Supervision Visit Report for Schools in Nkhotakota and Nkhata Bay from 4-9 February 2002

Table of Training Events, Duration and Content, July 2002

Training Events by Date, Content, Participant, and Number of Training Days, July 2002

Training for Transformation, Curriculum for HSA/HCW, n.d.

United Nations Children's Education Fund (UNICEF)

A Handbook for Primary School Anti-AIDS Clubs, Ages Eleven to Fourteen, Edzi Toto, Basic Information on HIV and AIDS, n.d.

United Nations Development Programme (UNDP)

Human Development Report 2001, Making New Technologies work for Human Development, New York, 2001

United States Agency for International Development (USAID)

Southern Africa – Complex Drought Fact Sheet #6 (FY 2002), Bureau for Democracy, Conflict, and Humanitarian Assistance (DCHA), Office of U.S. Foreign Disaster Assistance (OFDA), Southern Africa Complex Food Security Crisis, 14 June 2002

The Story Workshop

It's Time for Change! Using Village Drama for Behavior Change, A Training Manual for Drama Groups, n.d.

World Bank

Better Health Outcomes from Limited Resources, Focusing on Priority Services in Malawi, Africa Region Human Development Working Papers Series, 24132, April 2002

The state of Malawi's poor: The incidence, depth, and severity of poverty, PMS policy brief No. 2 (revised), November 2000

Annex A: The Quality of Family Planning Services

According to the 2000 Malawi Demographic Health Survey (MDHS), thirty one percent of currently married women are using a family planning method. Twenty six percent of women reported using a modern contraceptive method, representing a dramatic increase from seven percent in 1992 and fourteen percent in 1996. This significant increase (almost doubling every four years) is without a doubt the result of a national effort to reduce Malawi's fertility rate.

Malawi's achievements could be seen as the result of a human resource development process by which providers at the clinic and at the community levels (in both the public and the private sectors) have been trained to reduce accessibility barriers with a significant improvement in quality of services as well. Traditionally, the Ministry of Health and Population (MOHP) has focused on building capacity within the public sector and has not viewed the private sector, including the agricultural estates, as part of their jurisdiction or their responsibility. As a result, the private sector was left very much on their own until recently.

Since 1998 Project HOPE Malawi, with USAID/Malawi financial support, implemented a "Family Planning and AIDS Prevention under Support to AIDS and Family Health (STAFH) Project". One of STAFH's main objectives is "to increase contraceptive usage on the agricultural estates by improving the accessibility of FP services and by increasing the acceptability of modern methods, including the condom." In order to meet this objective, STAFH has built the capacity among service providers within the agricultural estates. Capacity building is one of Project HOPE's major strengths and is done through training. Over the life of the STAFH program a significant number of training events have been conducted, especially in the area of FP. And, in order to keep providers' as up to date on FP knowledge as possible, the STAFH program offered refresher courses.

Though counseling was not the subject of any specific training, its content was integrated in all the FP and STIs training and refresher events. The reference material used for this purpose was a counseling manual developed by Malawi's Family Planning Council that uses the globally known GATHER approach to counseling.

During the evaluation field visits opportunities to observe FP first consultations were very limited. Nevertheless, the two that were observed showed a provider who is knowledgeable of clients' rights to information, freedom of choice, privacy and confidentiality. The providers observed offered accurate information on each of the methods (e.i. benefits as well as limitations) available at that health facility. Additionally, the client is educated briefly on the female reproductive system and the ovulation process. During the consultation the providers treated clients with the utmost respect. However, neither of the providers observed inquired about the client's sexual history (i.e. number of partners, if husband/partner has more than one partner, etc.). In Malawi polygamy continues to be accepted. Overall, 17% of currently married women are in polygamous unions (that is, one or more co-wives), and it is more common in rural areas (19%) than in urban areas (9%). In addition, given the trends in HIV infections among married women, it is imperative that providers discuss issues of sexual behavior during a FP consultation and explore with clients STI/HIV/AIDS risk-behavior. Condom use was discussed in only 27 percent of cases and dual protection was not discussed at all.

The quality of counseling was also assessed during FP follow-up visits. On average, the time spent during this type of visit ranged between 2 to 3 minutes, and was primarily dedicated to exploring potential method limitations. Very little time was spent on discussion of the clients' satisfaction with her chosen method. And, as in the first consultation, no questions were asked about clients' and/or partner sexual behavior. No issues related to condom use were discussed either.

Though providers demonstrate a positive and warm attitude, the client-provider interaction observed does not encourage clients to ask questions; therefore the counseling session becomes in most cases a one-way conversation.

Where available, Information, Education and Communication (IEC) materials can support the information given during the consultation. However, field visits indicated that their use is limited. Though providers have all received a FP flip chart, two of the four sites visited had put them away. Providers interviewed did indicate that they use the flip chart when they have a client. Unfortunately, they do not have anatomical models such as a hand-held uterus for the women to visually familiarize with female anatomy, nor do they have penis models to demonstrate appropriate condom use.

The fact that increasing numbers of women and men from the agriculture estates are seeking FP services may be an indicator of satisfaction with the information given through counseling. However, observations indicate that each of the consultations is a "missed opportunity" to address crucial issues directly related to STI/HIV/AIDS prevention such as sexual behavior, condom use and dual protection.

In summary, Project HOPE has made a significant contribution to the improvement of access and quality of FP services among the rural population of the agricultural estates. In the future, STAFH investment should be the basis on which to build communication skills aimed at the reduction of "missed opportunities" regarding STI/HIV/AIDS prevention. In addition it would be important to address the empowerment of women and men to improve their own communication as couples.

Annex B: Youth Friendly Services

Young people in Malawi have a heightened awareness of reproductive health issues such as contraception, Sexually Transmitted Infections (STIs) and HIV/AIDS. A recent study of revealed that 96.3% and 94.9% of adolescent females and males (respectively), ages 15-19, are knowledgeable about modern contraceptive methods. However, anecdotal information indicates that the number of youth seeking RH services is still low. In Malawi, the median age at first birth is 19.3 years, a "modest increase of 0.4 years over the median age reported in Malawi's 1992 Demographic Health Survey (MDHS)." There is a small variance in the median age at first birth between urban women (19.7 years) and rural women (19.0 years). 66.4% of adolescents ages 15 to 19 have begun childbearing. Among those, 27.1% are urban dwellers and 34.2% live in the rural sector. Median age at first intercourse has remained constant at just under 17 years but by age 19 more than half have had sexual intercourse.

While significant progress has been achieved regarding adolescent RH awareness, young people in Malawi have not been able to access reproductive health services. Providers' attitudes and limited knowledge on adolescent health successfully discourage the youth from seeking services. In addition to a traditional adolescent sense of invulnerability, local culture minimizes adolescent capacity and ability to make RH decisions. In Malawi, as in many other countries around the world, public policy is seeking to reverse this trend. Therefore, to address an increasingly unmet need for adolescent RH services and, following February's 2002 Ministry of Health and Population (MOHP) Reproductive Health Policy report declaring that: "all SRH services shall be youth friendly and adolescents shall be provided with accurate and relevant information on SRH and substance abuse" Youth Friendly Services are being actively promoted.

The STAFH Project Youth-Friendly Services Initiative

Project HOPE STAFH's second cost-extension (August 2001 – July 2002) proposes to pilot Youth Friendly Services in three agricultural estates (Makandi, Dwangwa and Kawalazi).

Though STAFH did not outline a strategy in support of the establishment of YFSs, the Project Hope document (Lamprecht, V., Trip Report, March 2002) mentioned that YFS includes "prevention and protection from early pregnancy, HIV prevention, and management of STIs. It also includes the provision of clinic services at special times, as well as provision of recreational activities." At the close of the program a total of 20 estate providers had participated in a five-day YFS training conducted in June, 2002. (Clinical Evaluation: Annex 3 for content, and participant list.) The material used during the training provides a very good background on options for YFS services (i.e. integrated versus stand alone) presenting the limitations as well as the benefits in regard to costs, potential for sustainability, etc. They also address barriers related to providers' attitudes. However, the content did not address the need for special communication skills among providers to promote interaction with adolescents. It is commendable that the training program included the elaboration of an action plan for each of the estates represented at the training event.

Though training is a key component for any new initiative that alone is not enough. Success of the initiative requires motivation and support among stakeholders such as estate managers, financial officers and health officials (including the medical director in the case of Dwangwa). In addition, successful YFS include the participation of youth in the design and implementation of services targeting community members of their age.

Presently, the agricultural estate health facilities have not incorporated adolescent-friendly service hours, nor have they developed recreational activities to engage adolescents and to promote healthy behaviors. The ideal is to delay sexual initiation and, for those who are sexually active, to reduce the number of partners and increase the use of contraceptives and condoms. In Makandi estate, despite provider interest, accessibility to additional resources for the purchase of "minimum essentials" (i.e.. soccer balls, table games, books/magazines, etc) for recreational activities is hindering efforts to launch the estate's youth corner. In Dwangwa estate, though there is a core of human resources sensitive to adolescents needs and equipped with updated RH knowledge, YFS are still on the drawing board.

Despite STAFH project's good intentions, success has been compromised by the absence of a strategy that goes beyond training, the lack of time for activities such as motivation of estate stakeholders, limited or no youth participation, and failure to establish a sustainability mechanism. The program is closing after making a significant contribution in regard to building capacity among service providers and creating a sense of responsibility to address the needs of the youth. Much needs to be done in order to continue with the process leading towards real implementation of YFS. It is clear that provider motivation alone will not be enough.

Provider interest in implementing their individual action plans will be an important factor in negotiations with estate managers and financial officers to obtain resources needed for the establishment of recreational activities. At Conforzi estate there is a motivated provider, supported by socially responsible estate managers, who is seeking to establish a "youth corner" sometime in the very near future. At the time of the evaluation the provider's expectation was to launch the youth corner by August. Youth only health services will be offered on Saturdays. The Conforzi estate provides a good example of youth participation in the process. According to the provider, youth have been part of the decision-making regarding the "youth corner" location and they participated in the elaboration of minimum essentials. Providers, managers and youth must be encouraged to create a climate of communication where an open flow of information and a sense of ownership will be the catalysts for attitudinal change among adolescents as well as providers. This would ultimately contribute to increasingly healthy behavior among youth.

Annex C: The Youth of Malawi: Confronting the HIV/AIDS Epidemic

Introduction. The HIV/AIDS epidemic in Malawi is one of the most severe in sub-Saharan Africa. At the end of 1999, the Government of Malawi estimated that about 15 percent of adults were currently infected with HIV. In response to the epidemic and to the need to improve health conditions on agricultural estates in Malawi, Project HOPE implemented the Support to AIDS and Family Health (STAFH) Project from 1996 to July 2002. The project aimed to improve health services for agricultural estate workers and their families and to provide HIV/AIDS education to adults and youth, among other activities.

The project was evaluated in July 2002,[65] and during the course of the evaluation, 243 youth (42 percent female) participated in group interviews that were held at five primary schools and one secondary school located on participating agricultural estates. One of the most compelling findings of the evaluation concerned what youth are doing to confront the HIV/AIDS epidemic, which owes to the training they received under the project and, beyond that, to their overwhelming compassion and generosity of spirit.

The STAFH Project. The project's target areas were 47 agricultural estates under the management of 13 companies in the districts of Thyolo, Zomba, Nkhotakota, and Nkhata Bay. The target population for all estates was estimated at 225,000 agricultural workers and their families. The project specifically targeted youth ages 11 to 14 (grades 5-7) for health education, especially HIV/AIDS information and prevention messages, because very little HIV infection is found in this age group, which is called the "window of hope" in combating the AIDS epidemic, and for whom prevention messages are a priority.

In 2001-2002, the project provided training to 138 youth who would, in turn, educate and inform other youth on the subjects of adolescent growth and development, the dangers of early pregnancy, sexually transmitted infections (STIs) and HIV/AIDS, and planning for the future, among others. The youth were trained as peer educators and counselors, youth leaders, and members of drama groups. The project strengthened youth Anti-AIDS clubs through leadership and club management training; it also trained the schoolteachers who were patrons of the different youth groups.

Youth living on agricultural estates. The youth who live in the compounds on agricultural estates and surrounding communities are for the most part isolated from the larger society due to the size of many of the estates, lack of transportation, and poverty. Recreational activities for youth (and adults) are minimal or non-existent. While most estate schools have soccer fields, very few have soccer balls or other sports equipment. School infrastructure is badly deteriorated. The majority of estate schools lack electricity, school desks, chairs, books, or other educational materials. Classrooms are severely overcrowded. One school, which was built for a maximum capacity of 500, had over 1,000 students. The quality of education suffers from all of these deficiencies.

---

[65] See Graciela Salvador-Davila and Anna Kathryn Webb. Final Report, Final Evaluation of the Support to AIDS and Family Health (STAFH) Project for Private Agricultural Estate Employees in Thyolo, Zomba, Nkhotakota, and Nkhata Bay Districts of Malawi, Second STAFH Follow-on Project-USAID Grant No. 690-G-00-99-00230-00, August 1, 2001-July 31, 2002, San Antonio, Texas, October 2, 2002

Major challenges facing youth. According to youth, the major challenges they face are: poverty, forced marriage/early marriage, drug and alcohol abuse, orphans, teenage pregnancy, STIs and HIV/AIDS, child abuse and child labor, rape, sexual activity and behavior, and illness, e.g., malaria. The tragedy and enormity of the phenomenon of orphans—boys and girls who have lost one or both of their parents to AIDS—is difficult for someone from outside Malawi to comprehend. One of the consequences of being an orphan is having to drop out of school. Orphans fail to go to school because they are sent to take care of others. Or because their parents died and they have no money, they must work in the fields. Orphans are pressed, or compelled by circumstance, into child labor. They are also abused. One small, orphaned boy said he was made to do work that did not fit his size and age. Between 1990 and 2000, the estimated number of Malawian children under 15 who are living without one or both parents grew from 740,000 to 1.2 million, with most of the increase being the result of sharp rises in the rates of adult mortality.

STAFH project training helped youth to meet the difficult challenges they face through the activities of Anti-AIDS clubs, peer educators, drama groups, and youth leaders.

Anti-AIDS clubs. Anti-AIDS clubs are organized for the purpose of motivating young people to change their behavior through peer education. About 10 to 20 percent of primary school students on the agricultural estates are members of Anti-AIDS clubs. Club activities include teaching youth how to prevent STIs and HIV/AIDS and to care for persons with AIDS, counseling youth and community members on HIV/AIDS and STI prevention, delivering HIV/AIDS educational messages at school assemblies, teaching girls to say no to boys who proposition them for sex, and assisting persons suffering from HIV/AIDS with bathing, food, and blankets. One Anti-AIDS club decided to focus on helping orphans: club members play with orphans, motivate them to join the club, and share money with them. Club members said that the most effective means of reaching youth with health education messages are drama, comedies, song, and counseling individuals in private.

Arise

Boys and girls arise to fight AIDS.
AIDS is the killer of my friends.

Boys arise, girls arise, see how people are dying.
AIDS is the killer of my friends.

If you can't abstain, use a condom.
AIDS is the killer of my friends.

Let us join our hands and fight AIDS.
AIDS is the killer of my friends.

Schoolchildren's song
Anti-AIDS Club, Naming'omba Primary School
Naming'omba Tea Estates Ltd.
Thyolo District, Malawi

Youth peer educators and counselors. Youth peer educators and counselors were trained to provide HIV, STI, and family planning information to their peers and to promote the adoption of behaviors that reduce the risk of HIV and STIs. They teach friends about HIV/AIDS, discuss HIV/AIDS at school assemblies, and sometimes go to other schools to talk about HIV/AIDS. They counsel fellow students to stay in school and motivate them to join Anti-AIDS clubs. The youth peer educators found that the most effective approaches in reaching other youth are individual, confidential counseling, group meetings, and chatting with friends during school breaks. According to the peer educators, the majority of youth want to learn how to prevent HIV/AIDS and how to prevent early pregnancy and

stay in school, in addition to learning about adolescent development, human rights, sanitation and hygiene, and traditional practices that can lead someone to have HIV/AIDS.

Youth drama groups. Youth drama group members were trained in basic information on HIV/AIDS and STIs, family planning, peer influence and behavior change, and how to assess community needs and stage a drama accordingly. They were also taught how to form a drama group, prepare a drama script, and perform participatory drama and motivate others to participate, as well as song and dance development.

Youth drama groups perform dramas and comedy skits for their schools, gather students together on school playgrounds and hold a drama fest, call people together in communities and have a drama fest, and discuss how to prevent HIV/AIDS during school breaks. Drama themes include how to care for people with AIDS, prevent pregnancy, say no to sexual proposals, and how children should not travel at night to prevent rape.

Comedy skit

Aida: Hi Precious.
Precious: Hi Aida.
Aida: Did you meet your boyfriend yesterday?
Precious: A boyfriend? I don't even have one.
Aida: You don't? You must have one to move with.
Precious: My parents say casual sex may lead to transmission of sexually transmitted diseases and early pregnancies.
Aida: What are these diseases?
Precious: They are diseases like gonorrhea, syphilis, bubo, and HIV/AIDS.
Aida: What are the dangers then?
Precious: To us the youth we may leave while young, our future is doomed or else we may die.
Aida: Then I shall stop going about with James.
Precious: Yes, you have to, because the best way is to abstain.

Anti-AIDS Club, Naming'omba Primary School
Naming'omba Tea Estates Ltd.
Thyolo District, Malawi

TfT youth leaders. Training for Transformation (TfT) is a participatory approach to community development that encourages community empowerment and highlights communities' abilities to solve their own problems. Youth leaders were trained in TfT to provide them with the knowledge and skills necessary to influence other youth to their change behavior. TfT youth leaders guide discussions with other youth on the subjects of adolescent growth and development, the importance of preventing HIV/STI, how to care for people with AIDS, how to change behavior, how to abstain from sexual intercourse, and what to do in order to have a good future. They talk to friends on the way to and from school, present information at school assemblies, and visit estate compounds. According to the youth leaders, the topic of most interest to youth is how to prevent HIV/AIDS. They agreed that the most effective approaches in reaching youth are individual counseling and songs or very short plays.

Supervision. All youth groups interviewed reported that their supervision by the school patron(s) was very effective, which indicates that the selection of teachers to serve as school patrons was quite good. The youth said that their school patrons encouraged them to continue teaching others, provided information, corrected them when they made mistakes, and came to their rescue when they failed in responding to questions. One school patron reportedly used his own money to support youth group activities.

Volunteerism and incentives for participation. All of the youth were enthusiastic, highly motivated, dedicated volunteers who gave freely of their time and energy to help children, youth, and their communities combat HIV/AIDS. All of the youth groups expressed the need for materials and supplies, including books and leaflets on human development, posters, notebooks and pencils, soccer balls, and costumes for the drama groups. Furthermore, they cited the need for uniforms (t-shirts, caps) in order to be readily identified as a member of a youth group, which would be an incentive for their participation. One drama group wanted to undertake an income-generating activity (selling ballpoint pens) to pay transport costs to other schools, but lacked start-up capital. The project proposal noted the importance of providing Anti-AIDS clubs with the resources necessary to support their activities such as sports uniforms, balls, t-shirts, trophies, and some indoor games, but such resources were furnished sporadically, if at all.

Impact of youth activities. Youth activities had a significant impact on changing behavior. The youth interviewed—79 percent of whom were not trained by the project but received information and educational messages from the trained youth—reported having observed behavior changes, which are contrasted below with behaviors that can lead to HIV/AIDS and STIs.

Behaviors that can lead to HIV/AIDS and STIs:

- sexual relationship with boy/girl
- teenage pregnancy
- rape
- forced marriage/early marriage
- traditional practices
- selling sexual favors to buy things
- alcohol and drug abuse

Observed behavior change:

- sexual abstinence
- decrease in talk about sex
- decrease in sexual activity
- women require use of condoms
- reduction in rape
- decrease in multiple sex partners
- boys quit chasing girls
- girls quit dressing to attract boys
- decrease in teenage pregnancy
- decrease in using school fees to buy alcohol and drugs

The training that the youth received had a wider impact on their lives. First, youth from different schools attended training events at venues outside the estates, which gave them an opportunity to see something of the larger world and to exchange views and make friends with other youth and, in so doing, learn that they are not alone. Second, project training provided the youth with a way to plan for a positive, hopeful future. Among the future plans cited by youth were abstaining from sex and not marrying until they finished school, staying in school, finishing school and training others to prevent HIV/AIDS, establishing youth clubs in surrounding communities, traveling to see what their friends are doing in far-away schools, learning more about how to teach friends, helping orphans, being a teacher, and wanting to reach the "heights of drama" and be like prominent actors.

Moreover, the project training appeared to have had a profound effect on the youth as regards the HIV/AIDS epidemic. Some said they would continue to encourage their friends to prevent HIV/AIDS and, therefore, defeat AIDS. Others said they would like to wipe out HIV/AIDS and that it is their responsibility to see that HIV/AIDS is gone completely. Still others said that if the youth can improve, the whole country can change.

Lessons learned. The positive lessons learned, applicable to other Project HOPE endeavors, are: (a) when properly trained, youth are very effective in reaching other youth with appropriate health education messages; (b) with the right approach and message, youth can change their behavior to avoid health risks; (c) training can have a positive impact on youth and society beyond its content and purpose, which may be more important over the long-term; and (d) STAFH project activities aimed at youth can be replicated.

The negative lessons learned are: (a) despite excellent training and supervision, children and youth are powerless to prevent rape, child abuse, or child labor, especially in the case of orphans; (b) the lack of necessary materials, supplies, and asked-for incentives in all likelihood will jeopardize the sustainability of youth activities; and (c) the natural attrition of trained youth due to their graduating from school, coupled with the project closing in July 2002, most probably will result in a decrease and eventual cessation of the activities that proved to be so highly successful.

Annex D: A Partnership Model for Health Care on Private Agricultural Estates in Malawi

Introduction. The unique feature of Project HOPE's work on agricultural estates in Malawi is the partnership approach. Since 1990, Project HOPE, estate management and health care providers, community volunteers, and the Ministry of Health and Population (MOHP) have worked together to build, improve, and expand health services on the estates. The most recent collaboration was the Support to AIDS and Family Health (STAFH) Project. The project was evaluated in July 2002, and one of the key findings concerned the efficacy of the partnership model for the implementation of health projects in the private, agricultural sector.[66] The purpose here is to review the partnership model and identify lessons learned that would be applicable to future Project HOPE endeavors.

This document is based on the findings of the July 2002 evaluation, which included interviews with Project HOPE management and technical staff, estate health care providers and clients, community volunteers, and the management of seven estate companies that participated in the STAFH project.

Background. For the past 12 years, Project HOPE and its respective partners have worked to improve health services for agricultural workers and their families, beginning in 1990, when Project HOPE and one estate company decided to build on already existing estate and government health services to benefit the populations of eight estates under the company's management in Thyolo District. The one-year pilot project, funded by the United States Agency for International Development (USAID), focused on community outreach of health education services to improve knowledge and behaviors related to child survival, primarily through training health surveillance assistants (HSAs) and estate compound (community) volunteers. Previous to this project, the position of HSA did not exist on agricultural estates.[67]

The pilot project's success led to a three-year, child survival grant (1991-93) from USAID to cover 39 estates in Thyolo District. The prerequisite for the estates' participation was their willingness to hire HSAs for community outreach and prevention activities, contribute toward recurrent project costs, make available their facility-based curative health providers for training purposes, and continue the project at the conclusion of external funding. This project trained clinical staff in existing estate health facilities and HSAs who provided health education talks, tracked the spread of disease in their communities, and delivered family planning services. At the end of the three years, a second, three-year child survival grant (1994-97) was funded by USAID, which included an additional 19 estates in Mulanje District. This project focused on training HSAs to deliver health education and services, strengthened supervision systems, transferred the major part of supervisory functions to estate medical staff, and expanded health services to include increased family planning services, antenatal care, and under-five clinics.

STAFH Project. For the period 1996-98, Project HOPE received a new grant from USAID through the Support to AIDS and Family Health (STAFH) Project, which aimed to assist estates to

[66] See Graciela Salvador-Davila and Anna Kathryn Webb. Final Report, Final Evaluation of the Support to AIDS and Family Health (STAFH) Project for Private Agricultural Estate Employees in Thyolo, Zomba, Nkhotakota, and Nkhata Bay Districts of Malawi, Second STAFH Follow-on Project-USAID Grant No. 690-G-00-99-00230-00, August 1, 2001-July 31, 2002, San Antonio, Texas, October 2, 2002

[67] Traditionally, the HSA is a health worker who serves as a link between fixed MOHP district health services and the community.

develop and maintain effective HIV/AIDS, sexually transmitted infection (STI), and family planning services in their clinics and develop outreach activities in the compounds, schools, and surrounding communities, where estate workers and their families lived. The targets areas were 101 agricultural estates belonging to 15 companies in nine districts of Malawi. The First Follow-on STAFH Project covered the period, 1999-2001, and continued the activities of the original project: training estate health workers and volunteers in STI syndromic management, community-based distribution of family planning services, and HIV risk reduction counseling, among others. The target areas were reduced to 47 estates under the management of 13 companies in four districts; the target population for all estates was estimated at 225,000 agricultural workers and their families. The Second Follow-on STAFH Project covered the period August 1, 2001-July 31, 2002. This project aimed to strengthen family planning and STI and HIV/AIDS interventions in the same impact areas as the First Follow-on project and added new activities such as adolescent reproductive health, voluntary counseling and testing, and prevention of mother to child transmission of HIV/AIDS. Both follow-on projects were supported by USAID grants.

Project outcome. The STAFH project's outcome was highly satisfactory; it substantially achieved its main objectives with a few shortcomings. The major accomplishment was that health services are available on private agricultural estates that were not available before.

The agriculture sector and the economy. Malawi's economy is based largely on agriculture, which accounts for more than 90 percent of its export earnings, contributes 45 percent of gross domestic product (GDP), and supports 90 percent of the population. Malawi has some of the most fertile land in the region. Almost 80 percent of agricultural produce comes from smallholder farmers. Land distribution is unequal with more than 40 percent of smallholder households cultivating less than 0.5 hectares. The country's export trade is dominated by tobacco, tea, cotton, coffee, and sugar.[68] Malawi was the first country in Africa to grow tea on a commercial scale, beginning in the Victorian era, and has been responsible for the spread of tea production to the other East African states.[69]

The agricultural sector is dualistic, consisting of small-scale farmers and an estate subsector. The two subsectors have been distinguished historically on the basis of legal and institutional rules regulating land tenure, type of crops, and marketing arrangements. The smallholder subsector is based on a customary land tenure system and is primarily subsistence, providing the bulk of food production. The main food crop is maize. Since the mid-1990s, smallholders have been allowed to produce export/industrial crops, and this has generated great response in production, particularly of tobacco. The estate subsector comprises about 14,700 estates occupying some 850,000 hectares of leased land. The main crops are tobacco, tea, and sugarcane. Approximately 80 percent of the workforce is employed in the smallholder subsector and 11 percent on estates.[70] Throughout the 1990s, agricultural production was characterized by marked swings, mainly due to droughts. Agricultural estates suffered financial hardships in 2001-2002 due to drought, a drop in world market prices, and inflation.[71]

---

[68] World Bank. Malawi, Country Brief, July 2002, p. 1.
[69] Source: www.teasourcingpartnership.org.uk
[70] Food and Agriculture Organization (FAO) and World Food Program (WFP), United Nations. Special Report, FAO/WFP Crop and Food Supply Assessment Mission to Malawi, Rome, 29 May 2002, p. 3
[71] The inflation rate deceased from 28 percent in August 2001 to 16.7 percent in June 2002. See Commercial Bank of Malawi (CBM). Highlights of the Malawi Economy, Issue No. 50.

Health care on agricultural estates. In some cases, the provision of health services on private agricultural estates dates back to the estates' creation in the early 1900s; however, the modern era of estate health services was greatly influenced by the British-born, female physician, Dr. Miller. Dr. Miller was recruited by the tea estates to help them determine the type of health services to offer with concomitant staffing. MOHP does not regulate agricultural estate health services, although clinics that do not meet MOHP standards are asked to update services and infrastructure to meet standards. Estates exercise complete control over financing health staff and services, with the exception of government-provided contraceptives and STI drugs.

Estate health services are offered through clinics and/or dispensaries, health posts, and community-based distribution agents (CBDAs). Estates provide basic reproductive health services, which include family planning and STI diagnosis and treatment, and under-five clinics. Childhood immunizations depend upon the availability of refrigeration. Antenatal care is not offered at all estate health facilities. Maternity services are rare, leaving deliveries to traditional birth attendants. Estate outpatient departments take care of the most frequent illnesses. The clinics and/or dispensaries are most often staffed by an enrolled nurse midwife (ENM) and reproductive health provider, assisted by an HSA, dresser, and cleaner. A dresser, who can perform as an auxiliary nurse for first aid purposes and malaria treatment, staffs health posts in most cases. To some extent, the type and number of health facilities and services is a function of the size of the estate. In general, larger estates have a main clinic(s) and satellite health posts, whereas smaller estates have a single clinic. Most estates have one vehicle designated as an ambulance. The client-beneficiaries are the estates' permanent and seasonal workers and their families, and in some cases, members of neighboring communities.

Social Welfare Policy and Practice:
The Case of Naming'omba Tea Estates Ltd.

The Naming'omba company in Thyolo District, founded in 1928, operates three estates, which have a total of 43 compounds and a workforce of about 6,700. The company has provided health services since 1939; it has one dispensary and 12 satellite clinics, although half of the satellite clinics were closed due to workers moving off the estate.

For decades, and as a matter of policy, the company has provided free medical care to an estimated 20-25,000 persons who live in two communities that border two of the three estates. The relationship with the communities was initiated years ago by a community leader who sought the company's assistance with health services because the government hospital was far away and many of the estate workers were (and are) community residents. The company also maintains the communities' roads and bridges, which are not used in estate work. The company values the relationship with the neighboring communities and, through the provision of health care, believes it has achieved a good standard. The only limitation in extending health services to the communities is the cost of additional drugs.

The company monitors social indicators such as the national pass rate at its primary and secondary schools. The Naming'omba Primary School students receive lunch, books, and transport for social activities. Estate workers receive lunch, as well as free housing, water, electricity, and sometimes firewood when it is available.

What the partnership intended. The project intended to improve the health of persons living on agricultural estates; it was important to establish a partnership in order to do so and to ensure that health services would continue when the project ended. However, what the partnership intended was not defined in the

project proposal, nor was there a partnership model that described each partner's role and responsibilities or otherwise formalized the partnership arrangement.

What happened. Estate management has a high appreciation of the importance of a healthy workforce, including the recognition that estates can be a high-risk environment for workers in relation to HIV/AIDS, above all for single men and women workers.[72] Estate clinics increased services, and clinic staff improved the quality of care provided. At present, 25 estate clinics offer family planning services, 26 estate clinics provide STI syndromic management services, 21 estate clinics practice infection prevention, 36 estate clinic and outreach staff are trained in infection prevention and quality assurance, and 18 clinic staff are trained in HIV prevention in women and mother-to-child HIV prevention education. On participating estates, 48 HSAs serve as the link between estate clinics and communities. They provide family planning and STI and HIV education and counseling, give health education talks, monitor community sanitation, and supervise CBDAs. Through Training for Transformation (TfT) and other capacity-building, HSAs have greatly improved the way they teach the communities on sensitive issues such as sexuality and they way they provide information to community members through counseling.[73]

The 114 CBDAs, who are community volunteers, promote information and education on family planning, STIs, and HIV/AIDS within communities to individuals, couples, and community groups, and distribute contraceptives. CBDAs, along with HSAs, are credited with the introduction of family planning on the estates. CBDAs have made a tremendous difference because women no longer have to walk great distances to estate clinics to obtain family planning methods; CBDAs make home visits. CBDAs were also trained to be as youth-friendly as possible, which has made condom use possible among estate youth who request condoms.

The concept of community volunteer groups—CBDAs, drama groups, peer educators and counselors—was new to the estates. Now trained adult drama groups on eight estates deliver health education messages through drama, which is perhaps the most effective means of reaching community members. Forty-two adult peer educators and counselors provide family planning, STI, and HIV information at the workplace; they also distribute condoms. TfT training for communities built the capacity of community members to talk to one another and discuss community issues.

With respect to youth, the project specifically targeted youth ages 11 to 14 (grades 5-7) for health education, especially HIV/AIDS information and prevention messages, because very little HIV infection is found in this age group, which is called the "window of hope" in combating the AIDS epidemic, and for whom prevention messages are a priority. An estimated 10 to 20 percent of students in 19 estate primary schools are members of Anti-AIDS clubs whose purpose is to motivate youth to change their behavior through peer education. The clubs teach youth how to

---

[72] An estimated 15 percent of adults in Malawi are currently infected with HIV, 75 percent of all AIDS cases occur among people in the most economically productive age group (20-45 years), life expectancy is estimated to have dropped from 52 to 42 years as a result of AIDS, and between 1990 and 2000, the estimated number of children under 15 who are living without one or both of their parents grew from 740,000 to 1.2 million, with most of the increase being the sharp rises in the rates of adult mortality. See National Statistical Office [Malawi] and ORC Macro, Malawi Demographic and Health Survey 2000, Zomba, Malawi and Calverton, Maryland, August 2001, p. 143.

[73] Training for Transformation (TfT) is a participatory approach to community development that encourages community empowerment and is based on the belief espoused by Paolo Freire (1970) that communities themselves are powerful resources for problem-solving.

prevent STIs and HIV/AIDS and to care for persons with AIDS, counsel young people on STI/HIV/AIDS prevention and deliver prevention messages at schools assemblies. Club members assist people suffering from HIV/AIDS with bathing, food, and blankets, and help orphans, in addition to other activities. Thirty-eight estate youth were trained in club management skills and as TfT youth leaders who teach youth how to prevent HIV/AIDS and how to plan for a good future, among others. Nineteen estate schools have youth peer educators and counselors who provide sexuality and reproductive health information to youth. Eight youth drama groups give drama performances with health education messages at schools, on playgrounds, and in the estate communities. Thirty-eight schoolteachers, who were trained in adolescent reproductive health education, serve as patrons to the youth groups at their respective schools, offering encouragement and support and supervising youth activities. Five estate companies are in the process of developing an HIV/AIDS in the workplace policy.

The impact of project activities on behavior change was significant. For example, youth groups reported a decrease in sexual activity and behavior; a decrease in teenage pregnancies, early marriages, and school dropouts; and increased knowledge about HIV/AIDS/STIs and how to prevent them, among others. Adult groups reported an increase in the knowledge and use of family planning, a greater understanding of HIV and how to prevent HIV/AIDS through condom use, and a reduction in sexual behavior due to HIV/STI messages.

The partnership experience. During the course of project implementation and building upon past experience, Project HOPE developed a partnership model, subject to trial and error, in which it was the lead partner.

The participation of estate management as a partner in project implementation was uneven. Some estates welcomed the project; others showed little interest in participating. Estates with someone on the management staff, who had health services in his/her portfolio, or where the clinic-in-charge was part of the management team, did better and had fewer problems than estates that did not. Very few senior managers consistently attended the project's quarterly management meetings, provided support beyond the minimum required, or monitored the project from a management of view. The involvement of management would have been better if management, notably senior management, had been kept better informed. It was assumed that managers had sufficient information to make decisions and support the project, but they did not in part because they were not included in project planning; neither were they involved in project design as a key stakeholder. It was also assumed that management had a certain level of knowledge and understanding with regard to reproductive health, STI/HIV/AIDS, and other crucial health issues. Over time, it became clear that managers were not fully cognizant of the issues that the project addressed, and the project should have provided more support in this area. The education of management on HIV/AIDS and other health issues was never part of the project's work plan, which was an oversight because managers complained that they were not included. Subsequently, the project held two rounds of HIV/AIDS education for estate management. Another missed opportunity was that the families of estate management were not provided with family planning or HIV/AIDS education, which was not contemplated in the training and education of clinic staff. As a result, there was not a good partnership between estate health staff and managers and their families.

Several estates monitored project activities. For example, Conforzi estate held fortnightly meetings with clinic staff and HSAs. Naming'omba estate tracked social indicators through

detailed analyses in human resources reports. Dwangwa estate required a report from persons who attended project training, and trained clinic staff were obligated to train satellite clinic staff.

The partnership between MOHP and the agricultural estates was established by virtue of the project. In 1996, there was no connection between agricultural estates and District Health Offices/Officers (DHOs). Under decentralization, the DHO mandate includes both the public and private sectors, whereas under the centralized health system, agricultural estates were not part of the district coverage area. Thus, it is important for estates to communicate with DHOs and to formulate health plans to be included in district-wide health plans. In the beginning, Project HOPE met separately with estates and DHOs; later, quarterly meetings were initiated, and gradually estate clinic staff went to the district and became part of the district. The district-level MOHP was involved in project capacity-building, and awareness was raised about estate health services and needs among district family planning coordinators, information, education, communication (IEC) coordinators, and DHOs. It remains to be seen whether coordination between the estates and MOHP will continue following the project closing because neither evidenced a strong sense of "ownership" in the project.

Project HOPE also worked with district commissioners who, as members of District Assemblies, have new planning responsibilities under decentralization, e.g. district health plans, but are not necessarily knowledgeable about health matters. The project informed the commissioners about estate health activities, but the commissioners need technical assistance in order to help the estates prepare their own health plans.

Community Volunteers Making a Difference:
The Case of Dwangwa Sugar Estate Ltd.

Dwangwa Sugar Estate Ltd., Nkhotakota District, consists of five estates with a total population of about 28,000. One of these is the Matiki estate, where the adult drama group works closely with the physician who is the medical director of the Matiki Health Care Clinic. The doctor gives the drama group specific health education messages, and the group develops a drama for each message. The drama group plays a major role in providing health education to compound communities. It performs four times per month on different estate compounds and has also performed at the workplace and estate schools. The topics of most interest to community audiences are STI/HIV/AIDS prevention, family planning, good sanitation, well baby care, and how to take care of orphans and terminally ill AIDS patients. The group was instrumental in the promotion of estate-sponsored community and household cleanliness competitions. Management is very supportive of the drama group and sometimes provides transport and small allowances.

Project HOPE established a relationship between the different volunteer groups—adult drama groups, youth groups, CBDAs—and district offices. For example, a linkage was forged between estate youth groups and district primary education advisers and district youth officers, which did not exist previously and resulted in the agreement that estate youth would be included when district youth events took place, e.g., the Nkhata Bay district's AIDS Day activities included youth from Dwangwa estate. Project HOPE created a linkage with the Youth Council of Malawi, helping to develop its adolescent reproductive health curriculum.

The partnership between the project and community volunteers was highly successful, and in all likelihood, the benefits of the numerous volunteer activities far outweigh the cost of training, supervision, and follow-up. Volunteers' needs and suggestions were

not given sufficient consideration; as a result, they could not do as good a job as they would have liked and were trained to do. Most volunteer groups needed IEC materials and supplies such as pens and notebooks, in addition to suggested incentives such as soap, t-shirts, and caps.

Costs and benefits. The cost of project implementation for estate management—as opposed to the cost of regular estate health services—included financing HSA salaries; on some estates, the maintenance costs of bicycles used by HSAs that were purchased by the project; the opportunity cost of releasing estate employees for training; on some estates, transport costs to training events; on some estates, transport costs for youth to attend different activities; and financing allowances and transport for a one-time only training of new HSA recruits. One estate reported that the cost of releasing personnel for training was a negative outcome of the project. Another estate said there were too many training events.

The benefits of estate participation in the project were several. Estate health care providers were trained in family planning, STI diagnosis and treatment, and HIV/AIDS education and prevention, and those services are provided. Estates must have health services and schools in order to attract workers; the project added value to those services by expanding the type of services and providing educational activities and training opportunities to youth. STAFH project management successfully lobbied the government for the inclusion of estate clinics in the MOHP program to supply STI drugs,[74] in addition to family planning commodities, which is of tremendous benefit to estates. Many estate clinic staff were trained in the new MOHP Reproductive Health Logistics Management Information System (RHLMIS),[75] which should ensure a regular flow of necessary commodities to estates. Project HOPE also donated pharmaceuticals, equipment, and supplies. The project's adherence to and support of national health policies helped to standardize local knowledge and practices on the estates. Estate management was assisted with the development of health plans and HIV/AIDS in the workplace policies.

According to estate management, one of the greatest benefits of the project was that Project HOPE provided technical expertise, planning and organization, training, and monitoring and supervision efficiently and without financial burden to the estates. Moreover, estate management concurred that Project HOPE undertook several initiatives such as seeking estate participation in the MOHP STI drug program, which would not have happened otherwise. Equally, Project HOPE's strategy for improving estate health services was responsible for government participation.

In relation to business benefits, two estate managers reported a drop in worker absenteeism. In one case, the decrease was attributed to the work of adult peer educators and counselors and HSA who provide health education at the workplace. In the second case, decreased absences on account of worker or family illnesses were said to result from project activities in general. Another benefit cited was a slight decrease in estate medical expenses due to the donation of pharmaceuticals by Project HOPE, the Malawi College of Medicine, and Lions Club Malawi. Family planning services were seen as a financial benefit because smaller family size translated into lower medical expenses. Improved family well-being signified a reduction in costs for the use of the estate ambulance to transport workers and family members to the hospital. Worker morale was assessed as good because the company is seen as providing health benefits.

---

[74] MOHP is procuring STI drugs under a six-year program (2001-2007) with the Department for International Development (DFID), British High Commission.

[75] The RHLMIS is a system of inventory management, recording and reporting for drugs, contraceptives, and other medical supplies that is integrated with the MOHP medical supply system.

One of the most important benefits noted was that Project HOPE came to the estates at the right time because of the need for HIV/AIDS prevention and education, which lifted the estates' burden in this regard.

The management of tea estates reported that project had a positive, unintended impact on them. The Tea Sourcing Partnership, United Kingdom (UK), aims to understand how tea is sourced and to validate conditions on estates and factories by credible, independent monitoring.[76] The partnership, which includes some of the UK's best-known tea brands, looks at five areas and assesses whether estates and factories comply with local laws and national union agreements for each area: employment, including minimum age and wage levels, education, maternity, health and safety, and housing. Tea estates and factories are given an in-depth questionnaire to complete on their policies and procedures in these areas. The estates' responses are then validated by an independent, on-site audit. If the estates/producers are identified as not complying with the relevant legal requirements, and if they do not achieve the improvement that the Tea Sourcing Partnership seeks, then after due process members of the Tea Sourcing Partnership will cease trading with them, which is very much a last resort.

Project activities contributed in an important way to the findings of the independent audit of estates and factories. For example, management on one estate reported that the auditors were impressed with the work of the HSAs. Management on another estate said that auditors found an increase in health care

The Role of Management in Health Care:
The Case of I. Conforzi Tea & Coffee Estate Ltd.

The Conforzi company operates eight tea and coffee estates in Thyolo District. It has one centrally located clinic and five health posts scattered among 36 compounds, with a population of about 5,000 permanent and 8,000 seasonal residents. Permanent workers are provided with free housing, water, subsidized electricity, and one or two meals a day, depending on the number of hours worked. Health care is extended to workers' families and neighboring communities.

Conforzi management is people-focused. Management's role in health care is based on two-way communication and the belief that a healthy community of workers is part and parcel of estate business. Management holds fortnightly meetings with clinic staff and HSAs to discuss problems and find a way forward. One example of the value of two-way communication is the 1997 survey of compound housing and sanitation conditions, which was conducted by HSAs. Survey findings were brought to the attention of senior management, which was unaware of poor conditions and undertook immediate, corrective measures and instituted regular maintenance. HSAs continue to monitor and report on housing and sanitation.

Like most estates, Conforzi's health budget is less than one percent of its total operating budget. It finances the salaries of clinic staff, six HSAs, maintenance for HSA bicycles, releases clinic staff and workers who are community volunteers for training and pays their transport costs, gives equipment to drama groups, pays for ambulance operation and upkeep, maintains medical staff housing, provides protective clothing for health care workers and furnishes health facilities with office and other supplies.

Despite the fact that the company has been in receivership for one year, and thus has an uncertain future, it is committed to maintaining health services at their current level.

[76] Source: http://www.teasourcingpartnership.org.uk/ Sixteen percent of tea imported into the UK comes from Malawi.

services such as family planning, which redounded favorably on the estate.

The cost of participation to MOHP was minimal because the project financed all activities with the exception of MOHP supervision costs, e.g., fuel. MOHP provided lead clinical trainers, training curricula, and training venues; conducted limited supervision of some project activities; participated in project-sponsored DHO coordination meetings; trained estate clinic health staff in the RHLMIS; supplied contraceptive methods and STI drugs; and provided all necessary policies and guidelines.

MOHP benefited from the project in several ways. Some estates provided health services to neighboring communities, thus, expanding coverage and new services such as family planning and STI diagnosis and treatment. Estates sent health statistics to the DHO, which assisted district-level data collection and analysis. The project ensured that MOHP was informed of interventions taking place at estate health facilities, and results were reported accordingly. District-level capacity was increased by the training and work of CBDAs.

Sustainability. The sustainability of project activities and benefits is uncertain because the project design did not plan for sustainability; no provision was made to develop and implement a transition plan that would hand-over the project to MOHP and participating estates at the conclusion of project financing. The sustainability of some activities and benefits is likely, and for others, unlikely or uncertain. The sustainability of family planning and STI services is likely because these are well-established interventions. The sustainability of health education activities is likely because the estates have hired HSAs. The sustainability of infection prevention in estate health clinics is uncertain because it is not known if estates will continue to purchase the necessary supplies when the project-provided supplies are exhausted.[77] The sustainability of community volunteer activities is uncertain because community volunteers are motivated in large part by refresher training, which the estates may not provide. One exception is Naming'omba estate, which already has a plan for HSA/HCW and CBDA refresher training, including funds budgeted for that purpose. The sustainability of STI drug supplies at the conclusion of the MOHP program is uncertain; it is not known whether the estates will purchase STI drugs in the future. The sustainability of estates' financial support for health services overall is uncertain because of the current doubts surrounding estates' profitability. Estates are able to invest in the social welfare of workers and their families when operations show a profit.

Estate managers hold mixed views on sustainability, although all would like to see the project continue. Most companies believe that the work of HSAs will continue because they are institutionalized within operational budgets. However, most estates cannot say if training activities, including refresher training, will continue because of not knowing who could do the training and how much it would cost or who could undertake the supervision and follow-up of activities and how much that would cost.

How could things be improved. The partnership could be improved through the greater involvement of senior estate management for the simple reason that senior management must be involved in order for anything to work. In most cases, estate management was involved after a

[77] In conjunction with training a core of estate health care providers with updated infection prevention knowledge, Project HOPE donated to each estate the minimum essential supplies for infection prevention, including JIK (Chlorine solution), buckets, hand-washing basins, heavy duty gloves, aprons, Sharp containers, black bags, soap, detergent, and hand towels (for each of the trainees).

project activity had taken place, when it would have been better to engage and inform management at the planning stage. Ideally, senior management would draw up a company health policy and guidelines that would be communicated to each and every employee, and mid-level management would have oversight and reporting responsibilities for policy implementation. Another means of securing senior management participation would be the creation of an estate health committee that would be responsible for disseminating information on health activities and concerns to management; the estate's general manager would chair the committee. As one senior manager stated, someone needs to be present and ask, "What about health?"

The partnership could also be improved by informing other agricultural estates about the benefits of the partnership model and thereby gain wider support of and participation in improved health care for agricultural workers and their families. For example, the Tea Association of Malawi Ltd. might be interested in the partnership model as a means to address social responsibility issues.

What should not be attempted again. Project HOPE should not enter again into an agreement to produce results that depend to a large extent on others whose roles are not adequately set forth and agreed to. The project design did not provide for building the partnerships on which the project would depend at its conclusion. Specifically, project preparation did not include the active participation of MOHP or estate management, define each partner's role and responsibilities, provide for strengthening the capacity of the partnership, identify the measures by which the partnership would be maintained, develop a communications strategy, assess the costs and benefits to each partner, ascertain the risks and opportunities for each partner, or make official the partnership arrangement through a Memorandum of Understanding or similar type of document. As a consequence, the partnership with both MOHP and estate management was weak, and the sustainability of project activities and benefits is in jeopardy. Project HOPE and USAID share the responsibility for poor project design.

Looking to the future. In spite of some weaknesses, the partnership model did work, and it holds considerable promise for the future. Both MOHP and the estates profited as a result of the project; the intended beneficiaries—estate workers and their families—benefited without question. Project HOPE has played a remarkable role to date in improving health services on the agricultural estates, and the potential exists for greater successes. Building upon lessons learned, the partnership model can, with a few adjustments, be replicated for scaling-up across the agricultural estate sector. In order to do this, it would be necessary to prepare a formal model of the partnership that describes the purpose, activities, and costs of health interventions and the partnership arrangement, including roles and responsibilities, and the costs and benefits of participation. The model could then be used to promote improved health services on non-participating estates and to promote the sustainability of project activities on participating estates. Furthermore, Project HOPE/Malawi could engage industry associations such as the Tea Association and the Tobacco Exporters of Malawi to adopt the model as an effective and efficient means of improving worker and family health in fulfillment of industry social responsibilities.

Lessons learned. The lessons learned from the STAFH Project experience that could be useful to similar Project HOPE undertakings in the future are:

- Private agricultural estates have an important role to play with respect to the health of their workers and their families, and this role becomes even more important the farther away the estate is from public health facilities.

- Projects in which private sector companies are partners are likely to work better when senior management is fully informed of and committed to project objectives and activities.

- The implementation of projects involving private and public sector partners can be greatly facilitated by a nongovernmental organization (NGO) acting as intermediary, as was the case with Project HOPE and the STAFH Project.

- The partnership approach to project implementation is effective; however, it can make the achievement of objectives more complicated—unlike other projects where project staff have control over inputs, processes, and outcomes.

- The partnership approach is particularly useful for projects in which persons are trained and are expected to carry on the work in which they were trained following the conclusion of external financing, assuming that provisions have been made to continue to support the work in question.

- Project objectives may be shared, but each partner has a distinct role, and frequently different interests, in project implementation; thus, it is critical to involve all partners (key stakeholders) in project preparation in order to achieve mutual understanding of and agreement on the commitments of each partner and to ensure the sustainability of project activities and benefits.

- Lack of planning for the sustainability of project activities and benefits, including the definition of an exit strategy, is an unjustifiable risk to take with the investment of human and financial resources in any project. During project preparation, the questions must be asked: What happens if the project succeeds, especially to the beneficiaries? What happens if the project fails, especially to the beneficiaries? The STAFH Project partners now face the dilemma of what to do, given that the project succeeded and external financing ended.

Table 1: Key Socioeconomic and Health Indicators in Malawi: Various Years

Indicators	**Latest Year Available**	
Total population	mid-1999	10.8 million
Avg. annual growth of pop.	1990-1998	2.8 percent
Percent urban population	1998	22.3 percent
Growth of urbanization	1990-1998	9.5 percent
Total fertility rate	1998	22.3 percent
Crude birth rate	2001	47 per 1,000 population
Crude death rate	2001	23 per 1,000 population
Life expectancy at birth	1998	42 years
Infant mortality rate	1998	134 per 1,000
Under-5 mortality rate	1998	229 per 1,000
Maternal mortality rate	1999	620 per 100,000
Adult HIV-1 seroprevalence per 100 adults	End-1999	16.1
Children 0-1 immunized against DPT	1998	96 percent
Children 0-1 immunized against measles	1998	90 percent
Oral rehydration therapy use among under-5 children	1992-93	50 percent
Percent of infants with low birth weights	1991-94	10 percent
Population per physician	1990-96	33,344
Population per hospital bed	1990-96	625
Percent of births attended by trained health personnel	1990-95	57 percent
GNI per capita (Atlas dollars) [1/]	1999	US$180
Public health expenditures as percent of GDP	1990-97	3.3 percent

Source: World Bank African Development Indicators 2001. This table was taken from Better Health Outcomes from Limited Resources, Focusing on Priority Services in Malawi, Africa Region Human Development Working Paper Series, 24132, World Bank, April 2002, p. 2.

[1/] Technical note: In calculating gross national income (GNI) (formerly referred to as GNP) and GNI per capita in U.S. dollars, the World Bank uses the Atlas conversion factor to reduce the impact of exchange rate fluctuations in the cross-country comparison of national incomes. The Atlas conversion factor for any year is the average of a country's exchange rate (or alternate conversion factor) for that year and its exchange rate for the two preceding years, adjusted for the difference between the rate of inflation in the country and that in the G-5 countries.

Table 2: Clinical Evaluation Activities

DISTRICT	ESTATE NAME	DHO	FP/STI Coord	IEC Coord.	DAC Coord.	PROVIDERS INTERVIEWED	CONSULTATION OBSERVATIONS	CLIENT EXIT INTERVIEWS
THYOLO		X	X	X	X			
-	**Conforzi**					X	X	X
	Naming'omba					X	0	X
	Makandi							
	Thunga						X	X
	Chisunga						0	0
NKHOTAKOTA		X	X					
	Dwangwa					X	X	X
	Matiki					X	X	X
	Nyamvuu					X	X	X
ZOMBA		X	X					
	Wallace estate					X	0	X

Table prepared by Graciela Salvador-Davila

Key of abbreviations

DHO = District Health Officer

FP/STI COORDINATOR Family Planning / Sexually Transmitted Infections

IEC = Information, Education, Communication

DACC = District Aids Coordinating Committee

Table 3: Number of Persons Interviewed by Estate, Category, and Gender: Community and Estate Management Component

Category Estate	Community	Adult Peer Educators & Counselors	Adult Drama Groups	CBDAs	HSAs	School Patrons	Youth Groups	Estate Mngmt.	Total
Conforzi	**32** 20 f 12 m	**2** 2 m	**0**	**8** 6 f 2 m	**6** 4 f 2 m	**3** 1 f 2 m	**34** (1) 17 f 17 m	**1** 1 m	**86** **48 f** **38 m**
Naming'omba	**43** 35 f 8 m	**4** 4 m	**0**	**6** 6 f	**4** 3 f 1 m	**4** 1 f 3 m	**50** (2) 25 f 25 m	**1** 1 m	**112** **70 f** **42 m**
Makandi	**100** 50 f 50 m	**2** 2 m	**10** 2 f 8 m	**6** 6 f	**5** 5 f	**1** 1m	**10** (3) 4 f 6 m	**1** 1 m	**135** **67 f** **68 m**
Dwangwa Primary School Secondary School	Community group interview was not possible due to size of group (100+) who watched drama performance.	**1** 1 m	**8** 3 f 5 m	**5** 5 f	**6** 2 f 4 m	**2** 1 f 1 m 1 1 f 1 1 m	**90** 45 f 45 m **50** (4) 25 f 25 m **40** (5) 20 f 20 m	**1** 1 m	**113** **56 f** **57 m**
Wallace estate Untrained youth group Trained youth group	**19** 15 f 4 m	**2** 2f	**6** 2 f 4 m	**11** 11 f	**2** 2 m	**1** 1 m	**59** (6) 22 f 37 m **20** 9 f 11 m **39** 13 f 26 m	**1** 1 m	**101** **52 f** **49 m**
Total	**194**	**11**	**24**	**36**	**23**	**11**	**243**	**5**	**547**
Percent female	**59%**	**1%**	**29%**	**94%**	**60%**	**36%**	**42%**	**-0-**	**53%**

Table prepared by Anna Kathryn Webb

(1) Includes 2 youth peer educators and counselors, 4 TfT youth leaders, 5 drama group members; all are AIDS TOTO club members

(2) Includes 2 youth peer educators, 4 TfT youth leaders, and 7 drama group members; all are AIDS TOTO club members

(3) Includes 2 peer educators (1 f, 1 m) and 1 TfT youth leader (1 m).

(4) Includes 3 TfT youth leaders (2 f, 1 m), 1 f peer educator and counselor

(5) Includes 2 youth peer educators and counselors (1 f, 1 m), 4 TfT youth leaders (2 f, 2 m), 8 drama group members (4 f, 4 m)

(6) Includes 2 youth peer educators and counselors (1f, 1 m), and 5 drama group members (3 f, 2 m)

Table 4: Second Follow-on STAFH Project Targeted Achieved Results (July 2002)

USAID Strategic Objective 3:
Adoption of measures that reduce fertility and the risk of STI and HIV transmission among persons living in the private agriculture estates in Malawi

KIR 3.2: Knowledge and use of good reproductive health practices and own HIV status improved	**PERFORMANCE INDICATORS**	**PERFORMANCE TARGETS**		**ACHIEVED RESULTS**	**% OF ACHIEVED RESULTS**	**REMARKS**
		Baseline by 2001	**Target by 2002**			
IR 3.2.1: Knowledge and use of Family Planning practices increased	a) FP methods expressed in CYP dispensed by CBDAs and clinic staff	10000	12000	7002	58%	Late submission of monthly returns CBDA, return rate 54% E. Produce Ave. return rate is 79%
	b) Number of estate FP clinics providing FP services	25	27	25	93%	
	c) Number of estate clinic staff providing FP services.	40	45	50	111%	Recruitment of FP providers
	d) Number of new FP clients seen by CBDA s and clinic staff.	3600	6000	5604	93%	
	e) Number of continuing FP clients seen by CBDAs and clinic staff	14800	20000	18611	93%	
	f) Number of individuals reached with FP messages through TFT, drama and counseling.	162000	203000	58474	29%	Target indicator for 2002 was over estimated to be achieved over 5 years, instead of 1 year only.
	g) % of persons reporting having knowledge of available FP methods on the estate clinic and CBDAs		80%	No data		Final survey not done

IR 3.2.2 Knowledge and use of HIV prevention, STI prevention and treatment increased.	a) Number of clinic staff providing STI counseling and treatment using syndromic approach	41	45	36	80%	
	b) CYP for condoms dispensed at the estates.	120	200	2243	1122	Improved logistics systems at DHO and estate level
	c) Number of estate clinics providing STI syndromic management services.	25	28	26	93%	
	d) Number of STI partners treated using syndromic approach.	2054	2465	816	33%	Most partners who were not members of the estate were not allowed to receive STI services from estate clinics.
	e) Number of HSAs providing risk reduction counseling for STI/HIV.	52	52	52	100%	
	f) Number of persons reached with STI/HIV messages through TFT, drama and counseling	117626	200,000	105354	52%	Target indicator for 2002 was over estimated to be achieved over 5 years, instead of 1 year only.
	g) % of population from selected estate companies that would know their HIV zero status.		20%	"		VCT services not provided
	h) Number of estate clinics offering HIV VCT services.		2	"		Health workers not trained in VCT
	i) Number of referrals for HIV testing made by CBDAs, HSAs/HCWs and/or clinic staff		7000	"		VCT services not provided

KIR 3.3: Community participation in reproductive health care improved	**PERFORMANCE INDICATORS**	**PERFORMANCE TARGETS**		**ACHIEVED RESULTS**	**VARIANCE**	**REMARKS**
		Baseline by 2001	**Target by 2002**			
IR 3.3.1 Estate community participation STI and HIV prevention activities increased.	a) Number of CBDAs providing FP services to estate community	50	100	115	115%	
	b) Number of estate adult drama groups conducting drama performances to the estate community. (each group = 10 members)	5	10	8	75%	
	c) Number of persons attending drama performance on HIV, STI and FP information	37072	45000	24611	55%	
	d) Number of adult peer counselors providing FP, STI and HIV information at the workplace		60	42	70%	
	e) % of estate providing FP, STI and HIV through drama performance.	27%	50%	47&	94%	
	f) % of estate compounds provided with FP, STI and HIV information by HSAs using TFT methodology	100%	100%	100%	100%	

IR 3.3.2 Estate youth participation in adolescent sexual and reproductive health care increased	a) Number of youth drama groups conducting drama performance (each group = 10 members).	5	10	8	75%	
	b) % of estate schools providing adolescent reproductive health education on class.		50%	36%	65%	
	c) Number of in-school and out of school peer youth counselors providing sexuality and reproductive health education	0	56%	19 (15 primary School 4 sec school	190%	
	d) Number of youth anti-AIDS clubs that would have developed adolescent RH program.		10 (7 primary schools and 3 secondary schools)	19 (15 primary schools and 4 secondary schools)	190%	
	e) Number of HIV/AIDS campaign organized and conducted by the schools and estates. Schools: 1 campaign/district/year (4 districts) = 4 campaigns Estates: 1 campaign/company/year (13 companies) =13 campaigns		4 School HIV/ AIDS campaigns 13 Estate HIV/AIDS campaigns			District campaigns planned for end July 2002
	f) % of estates schools provided with adolescent sexuality and reproductive health information by youth leaders using TFT methodology, drama and counseling.	60%	100%	100%	100%	

KIR 3.4: Range and quality of reproductive health services for women, men and youth expanded in the target agriculture estates	**PERFORMANCE INDICATORS**	**PERFORMANCE TARGETS**		**ACHIEVED RESULTS**	**VARIANCE**	**REMARKS**
		Baseline by 2000	**Target by 2002**			
IR 3.4.1 Management capacity, practices and systems improved	a) Number of estate clinics experiencing STI drugs contraceptive stock out.	50%	20%	8%	40%	STI drugs provided by MOHP through DHOs
	b) Number of estate companies with health plan HIV/AIDS workplace policy	Nil	13	Nil		5 companies in process of developing HIV/AIDS
	c) % of planned quarterly estate management meetings occurred Plan: 1 meeting/company/quarter = 1 meeting/ 13 companies/4 quarters = 52 meetings	75%	100% (n=6)	38% (n=15)	38%	Meeting to wind up the program to be completed end July, 2002
	d) % of planned district health co-ordination meetings occurred Plan: 1 meeting/district/quarter = 1 meeting/ 4 districts/4 quarters = 16 meetings	60%	100% (n=16)	75%	75%	
	e) % of planned district CBDA quarterly meetings occurred. Plan: 1 meeting/district/quarter = 1 meeting/ 4 districts/4 quarters = 16 meetings	75%	100% (n=16)	95% (n=15)	95%	
	f) % of planned district youth quarterly meetings occurred. Plan: 1 meeting/district/quarter = 1 meeting/ 4 districts/4 quarters = 16 meetings		100% (n=16)	25% (N=4)	25%	Meetings conducted in fourth quarter only
	g) Number of district AIDS co-coordinating committee with district		2	4	200%	

	HIV/AIDS program Plan:1 DACC/ district = 1 DACC x 2 districts					
	h) Number of estate companies that would have established youth centers (6 companies)	6	Nil			Clinic staff trained I youth friendly ARH services in June 2002
IR 3.4.2 Range and quality of reproductive health services for women, men and youth expanded in the target agriculture estates	a) % of estate health clinics reporting stockouts on infection prevention supplies. (25 health clinics)		75%	12% (n=3)	48%	
	b) % of estate health clinics practicing infection prevention.		50%	85% (n=21)	170%	
	c) % of clients expressing satisfaction with FP and STI services provided at the estate clinics.		60%			No data
	d) Number of types of available FP methods (including LAM) not used by estate FP users (n=8)		Nil	3	38	Long-term FP methods not available on estate clinics (sterilization, Norplant, IUCD.).

Source: STAFH Project

Table 5: Second Follow-on STAFH Project Training Summary (July 2002)

Program Activities	Baseline 2001	Targets by 2002	Total Achieved
KIR: 3.2: Knowledge and use of good reproductive health practices and own HIV status improved.			
KIR 3.2.1: Knowledge and use of Family Planning practices increased			
a) Orientation clinic staff in adolescent reproductive health services		25	20
KIR 3.2.2: Knowledge and use of HIV prevention, STI prevention and treatment increased.			
a) Refresher training of estate clinic staff in STI syndromic management	41	45	48
b) Training of estate clinic staff on HIV prevention in women and mother-to-child HIV prevention education.		20	18
c) Training of estate health workers in VCT		20	0
KIR 3.3: Community participation in reproductive health care improved			
KIR3.3.1: Estate community participation STI and HIV prevention activities increased.			
Refresher training of practicing CBD agents and their primary supervisors in family planning	50	80	75
Training of estate adult volunteers in peer education and counseling for FP promotion STI and HIV prevention.	50	30	40
Training of adult youth drama group members in theatre for development.	50	20	40
Training of new CBDAs and their supervisors in community FP services.		100	96
KIR 3.3.2: Estate youth participation in adolescent sexual and reproductive health care increased			
Training of estate youth co-coordinators and teachers as trainers of adolescent sexual and reproductive health program.		25	36
Training of in and out of school youth in peer education and counseling skills for sexual and reproductive health.		50	38
Training of estate youth drama group members in theatre for development.		20	60
Training of youth leaders in TFT and anti-AIDS management skills.	50	40	38
KIR 3.4: Range and quality of reproductive health services for women, men			

Program Activities	Baseline 2001	Targets by 2002	Total Achieved
and youth expanded in the target agriculture estates			
KIR 3.4.1: Management capacity, practices and systems improved			
Train new estate outreach staff as HSAs		20	12
Train members for district AIDS co-coordinating committee (DACC) in the management and co-ordination of district HIV/AIDS activities.		30	46
KIR 3.4.2: Range and quality of reproductive health services for women, men and youth expanded in the target agriculture estates			
Train estate clinic and outreach staff in infection prevention and quality assurance.		20	36

Source: STAFH Project

Table 6: Training Events By Date, Content, Participant Estate And Number of Days

Training Events By Date, Content, Participant Estate And Number of Days

Date	Content	Estates Invited	Participants				No. of of days
			RN	CO	MA	ENM	
23 Apr - 05 May 2000	* Family Planning policy and contraceptive guideline * Infection prevention * Menstrual cycle * Inter Personal Communication and Counseling * STIs HIV/AIDS - Dual protection + harmful practices * Emergency contraception * Adolescent fertility * Health Assessment * Combined oral pills * Progestin only pills * Hormonal injectables * LAM * Norplant * IUCD * Male and female condoms * Male and female sterilization * men and reproductive health * Briefing of sale motherhood * FP education * Management * Quality care * Post abortion care * Reproductive Health logistics management Information System	Makandi Naming'omba Satemwa Mianga Nchima Kawalazi Thandizani Moyo Wallace estate Dwangwa	0 0 0 0 0 0 1 0 0	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	3 1 1 1 2 1 0 1 3	10 days

Training Events By Date, Content, Participant Estate And Number of Days

Date	Content	Estates Invited	Participants				No. of of days
			RN	CO	MA	ENM	
15-28 Jul-01	* Family Planning policy and contraceptive guideline * Infection prevention * Menstrual cycle * IPCC * STIs HIV/AIDS - Dual protection + harmful practices * Emergency contraception * Adolescent fertility * Health Assessment * Combined oral pills * Progestin only pills * Hormonal injectables * LAM * Norplant * IUCD * Male and female condoms * Male and female sterilization * men and reproductive health * Briefing of sale motherhood * FP education * Management * Post abortion care * Reproductive Health logistics management Information System	Naming'omba Kawalazi Dwangwa Makandi Mafisi Conforzi Kasembereka Nchima Vizara	0 0 0 0 0 0 0 0 1	1 1 0 0 0 0 0 0 0	0 0 0 0 0 0 1 0 0	1 0 4 2 1 1 0 1 0	10 days

Training Events By Date, Content, Participant Estate And Number of Days

Date	Content	Estates Invited	Participants				No. of of days
			RN	CO	MA	ENM	
Feb-02	* Infection prevention concepts	Dwangwa		0	0		3
	* Disease transmission cycle of transmission of hepatitis B and HIV	Kawalazi		1	0		days
	* Precaution in infection prevention practices	Vizala		1	0		
	* Infection prevention used in providing FP and STI services	Nchima		0	0		
	* Knowledge and skill of applying asepsis procedure	Conforzi		0	0		
	* Understanding of infection prevention management at Health Centre	Mafisi		0	0		
	* Infection prevention work plan for estate health workers	Naming'omba		0	0		
		Satemwa		0	0		
		Kasembereka		0	0		
		Mianga		0	0		
		Makandi		0	1		
		Wallace estate		0	0		
		Dwangwa Sugar Corp					
May-02	* Infection prevention concepts		1	0	0	3	3
	* Disease transmission cycle of transmission of hepatitis B and HIV	Kawalazi	0	0	0	2	days
	* Precaution in infection prevention practices	Vizara	0	0	0	0	
	* Infection prevention used in providing FP an STI services	Nchima	0	0	0	3	
	* Knowledge and skills of applying asepsis procedure	Naming'omba	0	0	1	1	
	* Understanding of infection prevention management at Health Centre	Satemwa	0	0	0	1	
	* Infection prevention work plan for estate health workers	Makwasa	0	0	0	1	
		Mianga	0	0	0	1	
		Makandi	0	0	0	2	

Training Events By Date, Content, Participant Estate And Number of Days

Date	Content	Estates Invited	Participants				No. of of days
			RN	CO	MA	ENM	
15-25 May-02	* Health education analysis of mothers and children in Malawi	Mianga	0	0	0	1	12 days
	* Basic facts and prevention of HIV/AIDS	Satemwa	0	0	0	2	
	* Determinants of HIV/AIDS	Nchima	0	0	0	2	
	* STI	Kawalazi	1	0	0	1	
	* Mother to child transmission of HIV	Dwangwa	1	0	1	1	
	* HIV Therapies and vaccines	Conforzi	0	0	0	1	
	* HIV testing and related issues	Naming'omba	0	0	0	1	
	* Opportunistic infections	Mafisi	0	0	0	1	
	* Impact of HIV/AIDS	Makandi	0	1	0	2	
	* Maternal nutrition and HIV/AIDS	Project HOPE	1	0	0	0	
	* Anatomy of the breast	Wallace estate	0	0	0	1	
	* Physiology of lactation						
	* Breast examination						
	* Composition of breast milk						
	* Role of breast feeding and child survival						
	* Exclusive breast feeding during pregnancy						
	* Management of labor delivery and postnatal						
	* Care of newborn						
	* Postnatal care and HIV/AIDS						
	* Assessment and observing a breastfeeding						
	* Kangaroo care						
	* Maternal illness and breastfeeding						
	* Introduction to counseling						

Training Events By Date, Content, Participant Estate And Number of Days

Date	Content	Estates Invited	Participants				No. of of days
			RN	CO	MA	ENM	
Youth Friendly Services (YFS)							
17 - 21 June 02	* Definition of terms used in youth friendly Health services	Dwangwa	0	0	2	2	5 days
	* Physical and psychological changes	Makandi	0	0	0	3	
	* Needs of youth	Satemwa	0	0	0	2	
	* Problems that affect the youth	Naming'omba	0	0	0	1	
	* SRH components	Conforzi	0	0	0	1	
	* SRH outlets	Kasembereka	0	0	1	0	
	* SRH services	Nasonia	0	0	0	1	
	* Sexual Reproductive Health Rights	Mianga	0	0	0	1	
	* SRH Health problems that affect the youth	Makwasa	0	0	1	0	
	* Characteristics of youth friendly services	Mafisi	0	0	0	1	
	* Types of youth friendly health services	Nchimba	0	0	0	3	
	* Strategies in implementing youth friendly services	Thandizani Moyo	1	0	0	0	
	* Initiating youth friendly health services						
	* Barriers to utilization of services to youth						
	* Setting up action plans						
	* Presentation of action plans						

KEY FOR ABBREVIATIONS

RN = Register nurse

CO = Clinical officer

MA = Medical Assistant

ENM = Enrolled nurse midwife

Table 7: Characteristics of Health Infrastructure of Estate Visited For STAFH Clinical Evaluation

District	Name of Estate Visited	Infrastructure	Service hours	Services offered and frequency	Staffing
Thyolo	Conforzi, Tea and Coffee Estate LTD	One clinic centrally located and five health posts located around the compound The main clinic is composed of four large rooms with a large waiting area. One of the rooms is dedicated to ENM for consultation. It has two wooden examination tables, which are cover with blankets instead of linens or Macintosh. More than five posters on the walls, two of them related to condoms. The other two rooms are used for drug dispensing and for first aid. The rooms are having zinc's for hand washing and equipment cleaning. One room is used as storage for essential drugs as well as essential supplies. Health posts have one-single consultation room with waiting area for clients/patients	Monday through Friday: 7::00am to 12:00am 1:30pm to 4:30pm Saturday 7:00am to noon	FP –OD First visits are conducted on Tuesdays Methods: LAM, hormonal (oral and three-month injectables – Depo-Provera) Barrier (spermicides and male condoms), STI management and treatment - OD Under-five clinic (Tuesday) including vaccinations YFS - Saturday. Youth corner to be launch in August 2002 OPD – OD	1 ENM – RH provider 2 HSAs 2 Dresser 2 Cleaners 1 Receptionist Health post division 5 HSAs 5 Dressers 8 Cleaners 12 CBDAs Each of the health post is staffed with 1 HSA and 1 cleaner Estate has an ambulance staffed with 2 drivers

Thyolo	Makandi Tea and Coffee Estate LTD	Five clinics and two health posts Tsunga o main clinic has five rooms, one is dedicated to RH consultation. It is a large room equipped with a wooden examination bed and cover with a blanket. No linen and/or Macintosh. It does not have a hand washing zinc. Another room of similar size is attended by clinical officer where there is a zinc and is equipped with a microscope. There is one larger room apparently used for meetings and the other two are use for drug dispensing and equipment washing. Most of the clients wait in front of the clinic. Though there are some two benches in the clinic porch. Less than five posters were visualized in the entire clinic. One condom related	Monday through Friday: 7:00am to 12:00am 1:00pm to 4:00pm Saturday: 7:00am to noon	FP –OD Methods: LAM, hormonal (oral and three-month injectables – Depo-Provera) Barrier (spermicides and male condoms), STI management and treatment – OD ANC – weekly on Mondays Under-five clinic – once a month including vaccinations OPD – OD Lab: capabilities: malaria confirmation, hemoglobin and basic urine tests (?) Staffing 1 CO (responsible for most of OPD cases and conducting basic lab microscopic tests) 1 ENM-RH provider 1 HSA 2 Cleaners Chisunga is the prototype of the four clinics in the compound. Is a very large waiting room and surrounded by at least four additional rooms, of which one large room is dedicated to RH services. It has examination table and hand-washing zinc. The rest of the rooms are as large as the one for RH, they are dedicated for first-aid, drugs dispensation and storage.	1 ENM-RH provider 1 HSA 1 Dresser 1 Cleaner Services offered FP –OD First visits are conducted on Tuesdays Methods: LAM, hormonal (oral and three-month injectables – Depo-Provera) Barrier (spermicides and male condoms), STI management and treatment – OD ANC – Once a week Under-five clinic – once a month including vaccinations OPD – OD Health posts, same characteristic as previously described and are staffed with 1 dresser only who does first-aid and malaria treatment

Thyolo	Naming'omba Tea and Coffee Estate LTD	Health services of some kind had been offering since 1939. At the present health services are being offered through two clinics and one health post. For the present	6:30am 12:00 1:00pm to 4:00pm 6:30am to noon - Saturday	FP – OD LAM, Hormonal (Oral and Injectables), barrier methods (male condom), Spermicides STIs – OD	1 ENM 1 MA * 3 HSAs (all in the two clinics) 1 dresser

		evaluation, the clinic visited was Naming'omba. The facility has three rooms and a waiting area. RH services are provided in a medium size room equipped with a wooden examining table covered with a blanket. No hand-washing zinc was observed. There is a larger room for essential drug storage and where the medical assistant sees patients. The third room is being used partly as additional storage and for cleaning		ANC – Monday Under five clinic (Wednesday). Vaccination three times a month. OPD – OD Naming'omba clinic has been selected as a TB treatment center for the area.	No ambulance * The second clinic does not have a medical assistant. Health post division has 6 dressers responsible for first aid and malaria treatment. 13 CBDAs
Zomba	Wallace estate Coffee and Tobacco Estate LTD	Smallest Estate visited. The infrastructure of the health facility is rudimentary and rather small. It has three rooms with no running water. RH services are offered in a very small room where there is a bed constructed in cement. There is a small waiting area with two benches and a third room for the first aid and storage (including drugs and supplies)	6:00am to 12:00 1:30pm to 4:00pm 6:00 –12:00 - Saturday	FP – OD LAM, Hormonal (Oral and Injectables), barrier methods (male condom) Spermicides STIs - OD Under five clinic (once a month) Vaccination is not offer due to lack of refrigeration	1 ENM 1 dresser 1 HSAs 13 CBDAs Vehicle for critical patients transportation is available when needed
Nkhotakota	Dwangwa Sugar Estate LTD	The most complex health system visited is located at the Dwangwa Sugar Estate. Its infrastructure has been build over the last twenty-years. It is composed of four clinics. Matiki health Health Care Clinic as an in-patient facility has a total of 37 beds of which 7 are in the female ward in addition to a labor and delivery room that has two beds. Post-partum room has a total of 4 beds. Community women	7:00 to 12:00 noon 2:00pm to 5:00pm 7:00 to 12:00noon – Saturday	FP – OD LAM, Hormonal (Oral and Injectables), barrier methods (male condom), Spermicides and IUD (Copper IUD 380A) Infertility clinic (once a month or OD) STI clinic - OD ANC – Monday through Friday Post-natal (Monday from 2:00pm to 5:00pm) Under five clinic (Monday through Friday). Vaccination daily OPD – OD	1 ENM 1 HSA 1 Dresser who is also a cleaner

		who delivered at the Matiki clinic remain at the clinic for only 8 hours due to an increasing demand of post-partum beds. According to the hospital director, there is an average of 100 deliveries per month. Though, Matiki clinic offers a wide range of out-patient and in-patient services for their community of workers and their families there is not an isolation room and low-cost window screens are absent. Service providers' interviews also indicate that there is very limited equipment (e.g specula) limiting its ability to offer services. According to interviewees this is one of the three facilities among the agricultural estates that has a physician as a medical director a matron and a RN in a supervisory role. Matiki's RH services are offered in a large room equipped with two-examination tables' cover with linens and Mackintosh. It has hand-washing zinc A large open space is a waiting area.		Maternity ward 24 hours a day In-patient admission (male, female and pediatric)	

Nkhotakota		Nyamvuu clinic and the rest of the smaller clinics have an infrastructure composed of three rooms. A very small room with a wooden bed covered with linen and with hand-washing zinc. The RH services are offer according to schedule included attached, however due to shortage of equipment like specula FP initial visit is offer once a week only in order to borrow	7:00 to 12:00 noon 2:00pm to 5:00pm 7:00 to 12:00noon – Saturday	FP – OD LAM, Hormonal (Oral and Injectables), barrier methods (male condom), Spermicides and IUD (Copper IUD 380A) STI clinic – OD ANC Under five clinic (Monday through Friday). Vaccination not included	1 ENM 1 HAS 1 Dresser who is also a cleaner

		the necessary equipment for first-time clients. During the visit the clinic did not have blood pressure equipment. The second room even smaller is given to the MA for OP and there is a third room for storage. Clients wait in a large open waiting area.		due to lack of refrigeration. OPD – OD	

Table prepared by Graciela Salvador-Davila

Abbreviation key:
OD = On demand LAM = Lactation amenorrhea method STI = Sexually transmitted infections YFHS = Youth friendly health services
ENM = Enrolled nurse-midwife HSA = Health surveillance assistant CBD = Community base distributors
OPD = Out-patient department

Table 8: Estate-provided Basic Health Care Services by District, Estate Company, and Estate (July 2002)

District/ Estate Company/ Estate	Pop. Estate + Nearby Communities	No. of Compounds	Health Services								
			Out-patient	Women's health (FP)	Child health	Perinatal CARE (PNC)	Antenatal Care (ANC)	Environ-mental Health	HIV	STI	Total
Thyolo District											
Estate Company: **Press Agriculture** 1. Nantipwili estate	2,583	1	x	x				x	x	x	**5**
Estate Company: **Makandi** 1. Thunga estate 2. Delule estate 3. Chisunga estate 4. Mindali estate 5. Mpeni estate 6. Mphezo estate 7. Nkhami estate	34,000	24	x	x	x		x	x	x	x	**7**
Estate Company: **Naming'omba** 1. Lujenda estate 2. Mafisi estate 3. Naming'omba	35,227	43	x	x	x		x	x	x	x	**7**
Estate Company: **Satemwa** 1. Mwalawanthunzi 2. Sambankhanga 3. Satemwa 4. Chawani.	15,899	27	x	x	x	x	x	x	x	x	**8**
Estate Company: **Tea Research Foundation** 1. TRF estate	583	1						x	x	x	**3**

District/ Estate Company/ Estate	Pop. Estate + Nearby Communities	No. of Compounds	Health Services								
			Out-patient	Women's health (FP)	Child health	Perinatal CARE (PNC)	Antenatal Care (ANC)	Environ-mental Health	HIV	STI	Total
Estate Company: **Conforzi** 1. Conforzi General 2. Glengary estate 3. Lipumula estate 4. Mikundi estate 5. Mwalawanthunzi estate 6. Pumula estate 7. Tea factory 8. Upper Mboma	20,493	36	x	x	x	x	x	x	x	x	**8**
Estate Company: **Eastern Produce Malawi** **A. Eastern Produce North** 1. Makwasa estate 2. Kasembereka estate	26,000	34	x	x	x	x	x	x	x	x	**8**
B. Eastern Produce South 1. Gotha estate 2. Mianga estate			x	x	x	x	x	x	x	x	**8**
C. Eastern Produce Others 1. Kumadzi estate 2. Nasonia estate			x	x	x		x	x	x	x	**7**
Estate Company: **Nchima** 1. Nchima estate 2. Bandanga estate	9,434	25	x	x	x	x	x	x	x	x	**8**
Zomba District											

District/ Estate Company/ Estate	Pop. Estate + Nearby Communities	No. of Compounds	Health Services								
			Out-patient	Women's health (FP)	Child health	Perinatal CARE (PNC)	Antenatal Care (ANC)	Environ-mental Health	HIV	STI	Total
Estate Company: **Wallace estate** 1. Wallace estate	4,500	5	x	x	x		x	x	x	x	**7**
Nkhota-kota District											
Estate Company: **Dwangwa** 1. Matiki estate 2. Nyamvuu estate 3. Central estate 4. Kasasa estate 5. Ukasi estate	28,560	13	x	x	x	x	x	x	x	x	**8**
Nkhata-Bay District											
Estate Company: **Kawalazi** 1. Kawazi estate 2. Kavuzi estate 3. Menga estate	35,000	9	x	x	x	x	x	x	x	x	**8**
Estate Company: **Mandala** 1. Vizara estate 2. Chombe estate	8,300	8	x	x	x		x	x	x	x	**7**
Total	**220,579**	**226**	**13**	**13**	**12**	**7**	**12**	**14**	**14**	**14**	**99**

Source: STAFH Project

Table 9: Estate Health Care Workers by Category, District, Estate Company, and Estate (July 2002)

District/ Estate Company/ Estate	Population Estate + Nearby Communities	Health Care Workers								
		Medical Officer	Medical Assistant	RNM	ENM	HSA	HCW	CBDA	Other	Total
Thyolo District										
Estate Company: **Press Agriculture** 1. Nantipwili estate	2,583					1		2		**3**
Estate Company: **Makandi** 1. Thunga state 2. Delule estate 3. Chisunga estate 4. Mindali estate 5. Mpeni estate 6. Mphezo estate 7. Nkhami estate	34,000		1		5	6		13		**25**
Estate Company: **Naming'omba** 1. Lujenda estate 2. Mafisi estate 3. Naming'omba	35,227		1		3	5		13		**22**
Estate Company: **Satemwa** 1. Mwalawanthunzi 2. Sambankhanga 3. Satemwa 4. Chawani	15,899		1		2	3		8	1 M/wife	**15**
Estate Company: **Tea Research Foundation** 1. TRF estate	583					1		1		**2**
Estate Company: **Conforzi** 1. Conforzi General 2. Glengary estate 3. Lipumula estate 4. Mikundi estate	20,493				2	6		12		**20**

District/ Estate Company/ Estate	Population Estate + Nearby Communities	Health Care Workers								
		Medical Officer	**Medical Assistant**	**RNM**	**ENM**	**HSA**	**HCW**	**CBDA**	**Other**	**Total**
5. Mwalawanthunzi estate 6. Pumula estate 7. Tea factory 8. Upper Mboma										
Estate Company: **Eastern Produce Malawi** **A. Eastern Produce North** 1. Makwasa estate 2. Kasembereka estate **B. Eastern Produce South** 1. Gotha estate 2. Mianga estate **C. Eastern Produce Others** 1. Kumadzi estate 2. Nasonia estate	26,000		3		3	6		18	1 M/wife	**31**
Estate Company: **Nchima** 1. Nchima estate 2. Bandanga estate	9,434		1		5	4		5		**15**
Zomba District										
Estate Company: **Wallace estate** 1. Wallace estate	4,500				1	3		13		**17**
Nkhota-kota District										
Estate Company: **Dwangwa** Matiki estate Nyamvuu estate Central estate Kasasa estate Ukasi estate	28,560	1	5	2	11	5	1	11	1 M/wife 1 CHN 1 Matron 1 environ. Health assistant 12 Lab	**51**

District/ Estate Company/ Estate	Population Estate + Nearby Communities	Health Care Workers								
		Medical Officer	Medical Assistant	RNM	ENM	HSA	HCW	CBDA	Other	Total
									assistant	
Nkhata-Bay District										
Estate Company: **Kawalazi** Kawazi estate Kavuzi estate Menga estate	35,000		1	1	3	5	1	13	1 Lab assistant	**25**
Estate Company: **Mandala** Vizara estate Chombe estate	8,300		1	1		3		10		**15**
Total	**220,579**	**1**	**14**	**4**	**35**	**48**	**2**	**119**	**18**	**241**

Source: STAFH Project

RNM - Registered Nurse Midwife ENM – Enrolled Nurse Midwife M/wife – Midwife CHN - Community Health Nurse

Table 10: HIV/AIDS Prevention Summary of Client-exit Interviews, Thyolo and Nkhotakota Districts (N – 11)

	THYOLO	NK.K
1 Reason for Visit		
Family Planning	3	5
A.N.C.	0	0
S.T.I	2	1
Other	0	0
TOTALS	5	6
2 Received information on HIV/AIDS		
Yes	3	0
No	2	6
TOTALS	5	6
3 Condom use (present)		
Yes	1	0
No	4	6
TOTALS	5	6
4 Condom use (ever)		
Yes	1	1
No	4	5
TOTALS	5	6
5 Double Dual Protection Information Given		
Yes	2	0
No	3	6
TOTALS	5	6
6 Condom use present (in last intercourse)		
Yes	1	0
No	4	6
TOTALS	5	6
7 Knowledge on where to get condoms		
Yes	1	0
No	4	6
TOTALS	5	6

Table prepared by Graciela Salvador-Davila

Table 11: Observed Behavior Change by Group and Response

Group/ Response	Number of Responses	Percent of Total
Youth N = 243		
decrease in sexual activity and behavior, including sexual abstinence and reduction in rape	20	44
decrease in teenage pregnancies, early marriages, school dropouts, STIs, and reduction in multiple marriages	9	20
increased knowledge about HIV/AIDS/STIs and how to prevent them	4	9
home care of people with HIV/AIDS	3	7
reduction in alcohol consumption and marijuana smoking	3	7
women require use of condoms	2	4
solidarity with orphans (friendship, play, join AIDS TOTO club, money)	2	4
big behavior changes inside AIDS TOTO club but not outside	1	2
reduction in boys proposing but some say there hasn't been a reduction	1	2
Total	**45**	**100**
School Patrons N = 11		
good behavior change, including change in moral behavior, changed behavior of youth trained under the project and youth not trained under the project	10	31
decrease in teenage pregnancy and school dropouts due to early pregnancy	9	28
decrease in sexual activity and behavior, including decrease in rape	5	16
increased participation in Anti-AIDS club	3	9
Children have learned how to teach friends especially about HIV/AIDS, and now children can protect themselves against it.	3	9
sexual education incorporated into curriculum	1	3
decrease in school dropouts	1	3
Total	**32**	**100**
Health Surveillance Assistants (HSAs) N = 23		
increase in the knowledge and use of family planning, including condom distribution and use	15	35
behavior change as a result of HIV/AIDS education, including decrease in number of STIs and possibly few HIV positive persons, and some people are testing for HIV	15	35
decrease in sexual behavior, e.g., men complain that women are refusing sex, and before some men changed wives and now they don't	4	9
good health education and attendance at health education meetings, resulting in no cholera, good family planning, and good condom distribution	3	7
people are changing behavior on account of drama performances	2	5
no behavior change for both men who go to dormitories to have sex with female residents and women who do not have money and have sex in order to get money	2	5
Before 1989, people used traditional healers and now they go to the hospital.	1	2
improved hygiene conditions between first and second HSA household visit	1	2
Total	**43**	**100**
Community-based Distribution Agents (CBDAs)		

Group/ Response	Number of Responses	Percent of Total
N = 36		
understanding, acceptance and use of family planning, including more clients seen daily, people having fewer children and are able to live freely, and husbands and wives are very happy	11	52
a lot of condoms are distributed to youth (condom supply doesn't last a month), more youth are going to CBDAs for family planning services, boys and girls like condoms best and go to CBDAs' home to get them	7	33
women ask about side effects of FP	1	5
limited behavior change seen	1	5
Previously headmen were problems but later they changed their minds about family planning.	1	5
Total	**21**	**100**
Adult Peer Educators and Counselors N = 11		
now people understand more about HIV and know how to prevent HIV/AIDS through condom use	3	33
youth want to learn about STIs and a decrease in STIs among youth	2	22
increase in condom use (previously not many people came to them for condoms and now many come)	2	22
provision of family planning services and awareness and use of family planning	1	11
very difficult to know if behavior change is taking place but through meetings realize that people are coming to understand things, e.g., HIV/AIDS	1	11
Total	**9**	**100**
Adult Drama Groups N = 24		
progress in family planning, including a better understanding of family planning, increased acceptance of family planning, and a reduction in childbirths due to family planning	4	44
positive behavior change in general, including a reduction in sexual behavior due to HIV/STI messages and the marriage of some unmarried men		33
better sanitation due to drama messages	1	11
better understanding of what drama groups do to the extent that they are now invited to perform	1	11
Total	**9**	**100**

Table prepared by Anna Kathryn Webb
Numbers may not add up due to rounding.

Table 12: Challenges/Problems facing Youth as Reported by Youth Groups

Youth Groups N = 243 Challenges/Problems Facing Youth	Number of Responses	Percent of Total
poverty	10	15
forced marriage/early marriage	8	12
drug and alcohol abuse	8	12
orphans	7	11
teenage pregnancy	6	9
STIs and HIV/AIDS	6	9
child abuse and child labor	6	9
rape	5	8
sexual activity and behavior	5	8
illness	3	5
parents think youth are indulging in sexual behavior when they return home late from an AIDS TOTO club meeting	1	1
jealousy because some people have a lot of things	1	1
Total	**66**	**100**

Table prepared by Anna Kathryn Webb

Table 13: STAFH Project Staff Turnover 1996-July 2002

Year	Total Staff	Number of staff who left the project	"Turnover Rate"
1996	19	1	5.2%
1997	18	1	5.5%
1998	13	6	46.1%
1999	13	3	23.0%
2000	14	1	7.1%
2001	14	1	7.1%
2002	15	0	0%

Source: STAFH Project

Table 14: Demographics of STAFH Project Staff Turnover 1996-July 2002

Position Category	Number	Migrated	Jobs/Studies	Other	Terminated	Resigned no reason given	Position made redundant
Managerial	Nil						
Technical	3				1	2	
Administrative	2				1	1	
Support	8			1 died		1	6
Total	**13**			**1**	**2**	**4**	**6**

Source: STAFH Project

Table 15: STAFH Project Staffing, 1996-July 2002

Classification	1996	1997	1998	1999	2000	2001	2002
Professional							
Management							
Females	1	1	1	1	1	1	1
Males	1	1	1	1	1	1	1
Technical							
Females	1	1	1	1	1	1	2
Males	2	2	2	1	2	2	2
Subtotal	5	5	5	4	5	5	6
Support							
Females	2	2	2	2	2	2	2
Males	12	11	6	7	7	7	7
Subtotal	14	13	8	9	9	9	9
Total	**19**	**18**	**13**	**13**	**14**	**14**	**15**

Source: STAFH Project

Table 16: Summary of Assessments

RATING/ CATEGORY	Highly Satisfactory	Satisfactory	Unsatisfactory
1. Assessment of Project Outcome	x		
	Substantial	**Partial**	**Negligible**
2. Achievement of Key Intermediate Results (KIR)	x		
2.1 Knowledge and use of good reproductive health practices and own HIV status improved	x		
2.2. Community participation in reproductive health care improved	x		
2.3 Range and quality of reproductive health services for women, men, and youth expanded in the target agricultural estates	x		
	Likely	**Unlikely**	**Uncertain**
3. Project Sustainability			x
	Highly Satisfactory	**Satisfactory**	**Deficient**
4. Implementation Performance			
4.1 Project HOPE headquarters		x	
4.2 Project HOPE/Malawi		x	
4.3 STAFH Project	x		
4.4 MOHP – District level		x	
4.5 USAID		x	
4.6 Agricultural estates		x	
4.7 Community groups	x		
4.8 Thandizani Moyo (NGO)			x
	Highly Satisfactory	**Satisfactory**	**Deficient**
5. Project Monitoring and Evaluation		x	
5.1 Project HOPE headquarters		x	
5.2 Project HOPE/Malawi		x	
5.3 STAFH Project		x	

Table prepared by Anna Kathryn Webb

EVALUATION INSTRUMENTS

FINAL REPORT

FINAL EVALUATION

OF THE

SUPPORT TO AIDS AND FAMILY HEALTH (STAFH) PROJECT FOR PRIVATE AGRICULTURAL ESTATE EMPLOYEES IN THYOLO, ZOMBA, NKHOTAKOTA, AND NKHATA BAY DISTRICTS OF MALAWI SECOND STAFH FOLLOW-ON PROJECT – USAID GRANT NO. 690-G-00-99-00230-00 AUGUST 1, 2001 – JULY 31, 2002

PROJECT HOPE/MALAWI
BLANTYRE, MALAWI

PROJECT HOPE, THE PEOPLE-TO-PEOPLE FOUNDATION, INC.
MILLWOOD, VIRGINIA 22636

by

Graciela Salvador-Davila, M.D., MPH
Anna Kathryn Webb, Ph.D.

San Antonio, Texas
October 2, 2002

Contents

1. District Health Officials Interview Guide (English) 2
2. Client-Exit Interview Guide (English) 3
3. Client- Exit Interview Guide (Chichewa) 7
4. Estate Community Interview Guide (English) 11
5. Estate Community Interview Guide (Chichewa) 14
6. Community-based Distribution Agents (CBDAs) Interview Guide (English) 19
7. Community-based Distribution Agents (CBDAs) Interview Guide (Chichewa) 22
8. Health Surveillance Assistants (HSAs)/Home Craft Workers (HCWs) Interview Guide 28
9. Adult Peer Educators and Counselors and Drama Groups Interview Guide 32
10. Primary Education Adviser (PEA) and School Patron Interview Guide 34
11. Youth Educators and Counselors, Anti-AIDS Clubs, TfT Youth Leaders, and Youth Drama Group Interview Guide (English) 37
12. Youth Educators and Counselors, Anti-AIDS Clubs, TfT Youth Leaders, and Youth Drama Group Interview Guide (Chichewa) 39
13. Agricultural Estate Management Interview Guide 43
14. Project HOPE Interview Guide 47

1. District Health Officials Interview Guide (English)

Malawi, July 2002
Date:
District:
Interviewee:
Title:

1. What are your responsibilities (areas of concentration) concerning Reproductive Health service in the private sector and more specifically within the agricultural estates?

2. What is your specific role vis a vis the Project HOPE STAFH program initiative with the agricultural estate?

3. What is your understanding of the objectives of the STAFH program with the agricultural estates?

4. To the best of your knowledge, to what extent have these objectives have already been met? Please give some examples.

5. What do you think the impact of the STAFH program has been? Could you describe some successes. And the challenges?

6. What has been the District (he and/or other staff) involvement with the STAFH program? Have it been an advantages/disadvantages to having your staff involvement in this program? Explain (explore role in training, supervision and evaluation).

7. If the STAH program were to be expanded to the other agricultural estates in Malawi, what changes/revisions would you suggest?

8. Has your District reported contraceptive including condom stock-outs during the last twelve-months?

   If yes, what was the cause? For how long was it? How did you solve it?

9. Has your District reported STI drug stock-outs during the last twelve-months?

   If yes, what was the cause? For how long was it? How did you solve it?

10. What has been done in order to make STAFH a sustainable program?

11. What would you say about MOHP at the District level and Project HOPE STAFH partnership?

2. Client-Exit Interview Guide (English)

Malawi, July 2002
Date:
Interviewer:
Study site:
TBD (to be determined with field team)
Setting:
Clinic
Health Centre
Other, specify the type _____

I. Background Questions (In this section, I will ask you about personal information)*

1. What is your age now? (Write age in years) _____

2. Have you attended school?

    1. Yes
    2. No

3. What is the highest level of education you have completed?

    1. Standard one to five
    2. Standard six
    3. Standard seven
    4. Standard eight
    5. Form one
    6. Junior Certificate of Education
    7. Form three
    8. Malawi School of Certificate of Education

4. Have you attended a university college?
    1. Yes
    2. No

5. If yes, how many years of college did you complete? _____

6. What did you study in college? _____

7. If you did not attend a university programme, what other formal training have you had?
    1. Teaching
    2. Nursing
    3. Secretarial
    4. Business management
    5. Other, specify the type _____

8. Are you currently working?

1. Yes
3. No

9. If yes, what is your occupation? _____

10. What is your marital status
    1. Married
    2. Single
    3. Divorced
    4. Widowed
    5. Cohabiting
    6. On separation

11. If not married or cohabiting, do you have a regular sexual partner?
    1. Yes
    2. No

    If single please go to question # 16

12. How long have you been married to your current spouse (or involved with your current partner)? (duration in years)

    _____

13. Is the current husband/partner your
    1. First
    2. Second
    3. Third
    4. Other

14. Does your husband/partner have other wives or sexual partners now?
    1. Yes
    2. No
    3. Don't know

15. Did your husband/partner have other wives or sexual partners before?
    1. Yes
    2. No
    3. Don't know

16. Do you belong to any religion or church?
    1. Yes
    2. No

17. If yes, what is the name of your religion? _____

18. What is the name of your tribe? _____

II. Consultation Questions (if possible invite the participant to go to a private area to discuss the following questions).

19. Why did you come to the consultation today?/What services were you seeking? (explore all the reasons for the woman to visit the health facility)

_____

_____

20. Did the nurse discuss issues regarding reproductive health with you? Specifically explore what was discussed in regard to FP, STI and condom use
    1. Yes
    2. No

    If yes, what was discussed?

    _____

    _____

21 Were you told about dual protection?
Yes
No

Can you tell me what does it mean?

21. Have you ever use condoms? Yes, No and why not?

22. Did you use condoms at your last sexual intercourse?, Yes, No and why not? Do you know where to obtain condoms? Do you think your husband/partner knows where to get condoms?

23. Can you mention three ways of contacting HIV/AIDS?

24. Can you name three ways of preventing sexually transmitted infections?

III. Quality of services section (encourage the participant to respond to the questions as freely as possible. Reassure her that her information will assist health personnel to improve services)

25 How would you rate the care you received during your visit to the health facility?
1. Excellent
2. Very good
3. Good
4. Bad
5. No response

26 Would you recommend a sister/friend to come to this health facility?
1. Yes
2. No

Why?
_____
_____
_____

27 Are you satisfied with services received today at the health facility?
1. Yes
2. No

Why?
_____
_____
_____

Would you like to make a suggestion to offer better services to women like yourself?
_____
_____
_____
_____
_____

Thank the participant for her time and her interest in responding the questionnaire. Assure her that the information provided will not be disclosed to any other person.

* The present questionnaire adapted the background questionnaire from PH/Malawi CCSET client-exit interview.

3. Client- Exit Interview Guide (Chichewa)

Malawi, July 2002
Date:
Interviewer:
Study site:
TBD (to be determined with field team)
Setting

Clinic
Health Center
Other, specify the type ----------

A.Background Questions (Ndikufunsani mafunso okhudza inuyo)

1. Muli ndi zaka zingati?(write age in years).

2. Munapitako ku sukulu?
   a. Inde
   b. Ayi

3.Munalekeza kalasi yanji?
   a. Sitandade 1 mpakana 5
   b. Sitandade 6
   c. Sitandade 7
   d. Sitandade 8
   e. Fomu 1
   f. Fomu 2
   g. Fomu 3
   h. Fomu 4

4.Munaphunzirapo ku univesite.
   a. Inde
   b. Ayi

5. Ku kolegi munaphunzirako zaka zingati?
6. Mumatenga maphunziro ati ku kolegiko?
7. Ngati simunaphunzire ku univesite, ndi maphunziro ati anchito amene mwachita
   a. Uphunzitsi
   b. Unamwino
   c. Usekelitale
   d. Bizinesi
   e. Maphunziro anchito zina _____

8. Mukugwira nchito?
   a. Inde
   b. Ayi

9. Mumagwira nchito yanji?

---

10. Kodi muli pa banja?
    a. Okwatiwa
    b. Osakwatiwa
    c. Banja linatha
    d. Wamasiye
    e. Kukhalira limodzi
    f. Sakukhalira limodzi

11. Ngati simuli pabanja kapena simukukhalira limodzi, muli ndi mzanu amene mumakhala naye malo amodzi kawiri kawiri.
    a. Inde
    b. Ayi

If single please go to question # 16

12. Mwakhala muli pabanja nthawi yaitali bwanji? (duration in months/ years)____

13. Amuna anuwa ndi
    a. Oyamba
    b. Achiwiri
    c. Achitatu
    d. Kapena oposera apa
    e.

14. Amuna anu ali ndi akazi ena panopa
    a. Inde
    b. Ayi
    c. Sindikudziwa

15. Nanga amuna anu anali ndi akazi ena m'mbuyomu?
    a. Inde
    b. Ayi
    c. Sindikudziwa

16. Muli mu mpingo uli onse?

17. Nanga mumaphemphera mpingo wanji?_____

18. Ndinu mtundu wanji? _____

II. Consultation Questions (if possible invite the participant to go to a private areas to discuss the following questions).

19. Mwabwereranji ku chipatala lero? Mumafuna chithandizo chiti? (Explore all the reasons for the woman to visit the health facility).

20. Kodi anamwino anakambirana nanu za maphunziro azaubereki? Funsani ngati anakambirana za kulera, matenda opatsirana pogonana ndi kagwiritsidwe nchito ka kondomu.

a. Inde
b. Ayi
Ngati inde, anakambirana chiani?

_____

_____

21. Kodi munakambirana za njira yoteteza zinthu ziwiri?
    a. Inde
    b. Ayi
    Mundiuze tanthauzo lake.

22. Munagwiritsapo nchito makondomu?

23. Pomwe munakumana ndi abambo komaliza, munagwiritsa nchito makandomu?
_____

_____

Chifukwa chiani?

24. Makondomu mungawapeze kuti?
_____

_____

25. Nanga amuna anu/ abwenzi anu amadziwa malo amene angapeze makondomu?

26. Mundiuze njira zitatu zimene munthu anga tenge HIV/AIDS

27. Tchulani njira zitatu zimene tingapewere matenda opatsirana pogonana.

III Quality of Services Section (encourage the participant to respond to the questions as freely as possible. Reassure her information will assist health personnel to improve services)

28. Kodi chithandizo chimene mwalandira ku chipatala chinali chotani?
  a. Abwino koposa
  b.Chabwino kwambiri
  c. Chabwino
  d. Choipa
  e. Palibe yankho

29. Mungauze a chemwali anu kapena a nzanu kudzalandira chithandizo ku chipatala.
  a. Inde

b. Ayi

Chifukwa chiani?

_____

_____

Achipatala achite chiani kuti apereke chithandizo chokwanira?

_____

_____

Thank the participant for her interest in responding the questionnaire. Assure her the information provided will not be disclosed to any other person.

4. Estate Community Interview Guide (English)

(a) What are the most important challenges facing your community today?
-- What are the most important challenges for men?
-- What are the most important challenges for women?
-- What are the most important challenges for youth?
(b) What are your aspirations for your community?
(c) What is the most important health problem in your community?

1. Health Services on the Estate (general)

1.1 What types of health services are offered on the estate? (list)
1.1.1 Do you use the health services offered on the estate? (list)
Why or why not?
1.2 What is the quality of the health services by type of service? (above average, average, below average)
1.3 Satisfaction with the health services by type of service (highly satisfactory, satisfactory, unsatisfactory)
1.4 Are there health services that you need, which are not provided? If yes, what are they? Are there any barriers?
1.5 Recommendations to improve health services

2. Health Education

2.1 Meetings that discuss health topics
2.1.1 Have meetings been held in the community that discussed health topics?
2.1.2 If yes, what health topics were discussed?
2.1.3 Were the meetings useful and informative? Why or why not?
2.1.4 Is there a health topic that you would like to be discussed at a meeting? If yes, what is it?
2.2 Community members who bring health education to the community
2.2.1 Are there community members who bring health education to the community?
2.2.2 If yes, do you think it is a good idea for community members to help educate other community members on health topics? Why or why not?
2.2.3 What kinds of health topics do they talk about?
2.2.4 Is the information provided helpful? Why or why not?
2.2.5 Is there a health topic that has not been talked about, which you would like to know about? If yes, what is it? (list)
2.2.6 Do you find their work highly satisfactory, satisfactory, or unsatisfactory?
2.3 Health organizations in the community
2.3.1 Does the community have a Compound Health Committee? If yes, what does it to?
2.3.2 Does the community have AIDS TOTO clubs for youth? If yes, what do they do?
2.3.3 Other (list)
2.4 Health education materials
2.4.1 Have you seen any health education materials (e.g., posters, pamphlets, etc.)? If yes, where?
2.4.2 Are these materials helpful to you? Why or why not?

2.5 Health education for youth
- 2.5.1 Are there any activities in your community that specifically provide health education for youth? If yes, what are they? (list)
- 2.5.2 Do you think these activities are helpful? Why or why not?
- 2.5.3 Do your children participate in these activities? Why or why not?
- 2.5.4 What are the health topics that you think should be taught to the youth? (list)
- 2.5.5 Who should educate youth about their health?
- 2.5.6 Do the schools provide health education to youth? If yes, do you find it highly satisfactory, satisfactory or unsatisfactory?

3. Drama Groups for Youth
- 3.1 Have the youth in the community put on a drama production?
- 3.2 If yes, did you participate in the production?
- 3.3 If yes, did you enjoy your participation? Would you participate in another production?
- 3.4 If you attended the youth drama production, did you like it? Why or why not?
- 3.5 Did the drama production have anything to do with health and health problems?
- 3.6 If the drama production had messages about health, what were they?
- 3.7 Do you think a drama production is a good way to talk about health? Why or why not?
- 3.8 Would you like to attend more drama productions that talked about health? Why or why not?

4. Drama Groups for Adults
- 4.1 Have the adults in the community put on a drama production?
- 4.2 If yes, did you participate in the production?
- 4.3 If yes, did you enjoy your participation? Would you participate in another production?
- 4.4 If you attended the drama production, did you like it? Why or why not?
- 4.5 Did the drama production have anything to do with health and health problems?
- 4.6 If the drama production had messages about health, what were they?
- 4.7 Do you think a drama production is a good way to talk about health? Why or why not?
- 4.8 Would you like to attend more drama productions that talked about health? Why or why not?

5. Other Types of Entertainment (e.g., puppet shows, music festivals)
- 5.1 Have you seen other types of entertainment that talk about health?
- 5.2 If yes, what were they?
- 5.3 Did you like them? Why or why not?
- 5.4 Would you like to see more of this type of entertainment? Why or why not?

6. Community Problem-solving
- 6.1 How does your community solve its problems?
- 6.2 What are examples of problems that the community has solved?
- 6.3 What are examples of problems that the community has not solved?
- 6.4 Has the community worked on finding solutions to the problem of AIDS?
- 6.5 If yes, what has been done?
- 6.6 Has the community worked on finding solutions to other health problems?
- 6.7 If yes, what has been done?

6.8 Does the community receive help in solving its problems? If yes, what kind of help?
6.9 Has the help received been highly satisfactory, satisfactory or unsatisfactory?
6.10 Does the community need help in solving its problems? If yes, what kind of help?
6.11 Who does the community want to provide help?

7. Recommendations on solving community health problems

5. Estate Community Interview Guide (Chichewa)

a. Kodi ndizopinga zanji zimene anthu kudela lanu kuno amakumana nazo – pamoyo wao wa tsiku ndi tsiku.

- Nanga nzopinga zanji zimene azibambo amakomana nazo paumoyo wao watsiku ndi tsiku?
- Nanga nzopinga zanji zimene amayi amakumana nazo paumoyo wao watsiku ndi tsiku?
- Nanga nzopinga zanji zimene achinyamata kwanu kuno amakumana nazo pamoyo wao wa tsiku ndi tsiku?

b. Mmalakalaka chiyani pa zatsogolo la anthu anu kuno?

c. Vuto lalikulu kwambiri kumbali yaumoyo kwanu kuno ndilotani?

1.0 NTCHITO ZAUMOYO PA ESTETI

1.1 Ndi chithandizo chanji chazaumoyo chimene chimapelekedwa pa esiteti pano?

1.1.1 Kodi chithandizo chaumoyo chimene chimaperekedwa mumachigwiritsa ntchito.

1.2 Kodi chithandizo chazaumoyo nchabwino bwanji ku:

1.2.1 Umoyo wamayi
1.2.1.1 Chabwino kwambiri
1.2.1.2 Nchabwinoko
1.2.1.3 Chabwino

1.2.2 Umoyo wa ana
1.2.2.1 Chabwino kwambiri
1.2.2.2 Nchabwinoko
1.2.2.3 Chabwino

1.2.3 Awuti peshenti
1.2.3.1 Chabwino kwambiri
1.2.3.2 Nchabwinoko
1.2.3.3 Chabwino

1.2.4 Amayi oyembekezera
1.2.4.1 Chabwino kwambiri
1.2.4.2 Nchabwinoko
1.2.4.3 Chabwino

1.2.5 Milungu inayi mutachila
1.2.5.1 Chabwino kwambiri
1.2.5.2 Nchabwinoko
1.2.5.3 Chabwino

1.2.6 Ulangizi wazaumoyo

1.2.6.1 Chabwino kwambiri
1.2.6.2 Nchabwinoko
1.2.6.3 Chabwino

1.3 Mukukhutila bwanji ndichisamaliro cha zaumoyo

1.3.1 Umoyo wa amayi

1.3.1.1 Tikukhutila mwambiri
1.3.1.2 Tikukhutila
1.3.1.3 Sitikukhutila

1.3.2 Umoyo wa mwana

1.3.2.1 Tikukhutila mwambiri
1.3.2.2 Tikukhutila
1.3.2.3 Sitikukhutila

1.3.3 Auti peshenti

1.3.3.1 Tikukhutila mwambiri
1.3.3.2 Tikukhutila
1.3.3.3 Sitikukhutila

1.3.4 Amayi oyembekezera

1.3.4.1 Tikukhutila mwambiri
1.3.4.2 Tikukhutila
1.3.4.3 Sitikukhutila

1.3.5 Milungu inayi mutachila

1.3.5.1 Tikukhutila mwambiri
1.3.5.2 Tikukhutila
1.3.5.3 Sitikukhutila

1.3.6 Ulangizi wazaumoyo

1.3.6.1 Tikukhutila mwambiri
1.3.6.2 Tikukhutila
1.3.6.3 Sitikukhutila

1.4 Kodi pali chithandizo china chaumoyo chimene inu mumachifuna koma sichikuperekedwa?

2.0 MAPHUNZIRO A ZAUMOYO

2.1 Misonkhano yokambirana mitu yazaumoyo

2.1.1 Kodi misonkhano yokambirana zaumoyo imachitika mdera lanuli
2.1.2 Ngati choncho, ndi mitu iti yazaumoyo imene mudakambirana
2.1.3 Kodi misonkhano inali yaphindu ndi yofunikila bwanji? Chifukwa chiani?
2.1.4 Kodi pali mutu wina wazaumoyo umene mukufuna kuti uzikambidwa mmisonkhano? Nanga ndi uti?

2.2 ANTHU A MDELA LANU AMENE AMABWERETSA MAPHUNZIRO A ZAUMOYO KU DELAKO

2.2.1 Kodi muli ndi anthu a mdera lanu amene amabweretsa uthenga wazaumoyo ku derako.

2.2.2 Ngati ndi choncho, mukuganiza ndibwino kuti anthu akudera lanulo adziphunzitsa anzawo aku delalo maphunziro a zaumoyo.

2.2.3 Ndi mitundu yanji yamaphunziro a zaumoyo imene amakambirana.

2.2.4 Kodi uthenga umene akuperekawo ndiwothandiza? chifukwa chiani?

2.2.5 Kodi pali mutu wina wazaumoyo umene siunakambidwepo umene mungafune kuudziwa. Nanga ndi uti?

2.2.6 Kodi mukuona ntchito yaoyi yopindulitsa

2.2.6.1 Kwambiri

2.2.6.2 Yopindula

2.2.6.3 Yosapindulitsa

2.3 MABUNGWE A ZAUMOYO

2.3.1 Kodi mderali muli komiti ya zaumoyo ya kampaundi? Ngati choncho, imapanga chiani?

2.3.2 Kodi mderali muli bungwe la EDZI Toto Club ya achinyamata? Ngati ndichoncho, limachita chiyani?

2.3.3 Nanga mabvungwe ena ndi ati?

2.4 ZIDA ZOPHUNZITSIRA ZAUMOYO

2.4.1 Mudayamba mwaonapo zida zophunzitsira zauoy mong posters (chikwangwani), timapepala/mabuku tating'onoting'ono (nanga zina)? Ngati ndi choncho, mudaziona kuno?

2.4.2 Kodi zidazi kukuziona zofunikila kwa inu? Bwanji

2.5 MAPHUNZIRO A ZAUMOYO KWA ACHINYAMATA

2.5.1 Kodi pali zochitika zina mdera lanulo zimene zimangothandiza kuphunzitsa achinyamata zaumoyo mdera lanulo. Ngati ndi choncho, ndiziti?

2.5.2 Mukuona ngati zochitika zimenezi nzothandiza? Bwanji?

2.5.3 Kodi ana anu amatenga mbali muzochitika-chitikazi? Chifukwa chiani?

2.5.4 Kodi ndimaphunziro ati azaumoyo amene mukuganiza kuti angamaphunzitsidwe kwa achinyamatawa?

2.5.5 Ndi anthu ati omwe ali oyenera kuphunzitsa a chinyamatawa?

2.5.6 Kodi mmasukulumu achinyamatawa amaphunzilanso zaumoyo? Ngati ndi choncho, mukuziona?

2.5.6.1 Zofunikira kwambiri

2.5.6.2 Zofunikilako

2.5.6.3 Zosafunikira

3.0 MAGULU A ZITSUDZO A CHINYAMATA

3.1 Kodi achinyamata amderalo ali ndi gulu la dzitsuzo

3.2 Ngati ndi choncho, mudatengako mbali popanga gululi?

3.3 Ngati ndi choncho, mudasangalala ndikutenga mbaliko? Kodi mudzatenganso mbali popanga gulu lina?

3.4 Ngati mudakhala nawo pa gulu lopanga gulu lazitsudzozi, mudalikonda? Bwanji?

3.5 Kodi zitsudzozo zinali zokhudza zaumoyo, ndiponso mavuto a zaumoyo?

3.6 Ngati zitsudzozo zinali ndi uthenga wazaumoyo, uthengawo ndi uti?

3.7 Mukuganiza kuti zitsuzo ndi njira yabwino yokambirana zokhudza umoyo? Bwanji?

3.8 Mungakonde kudzakhala nawo mmagulu ambiri opanga zitsuzo amene amakambirana zaumoyo? Chifukwa chiani?

4.0 MAGULU AZITSUDZO A ACHIKULILE (AKULUAKULU)

4.1 Kodi akulu akulu a mdera lanulo apanga gulu la zitsudzo?

4.2 Ngati ndichoncho, mudatenga mbali pokhazikitsa gululi?

4.3 Ngati ndichoncho, mudasangalala ndikutenga mbaliku? Kodi mudzatenganso mbali popanga gulu lina?

4.4 Ngati mudakhala nawo pa gulu lopanga gulu la zitsudzoli, mudalikonda? Bwanji?

4.5 Kodi zitsudzo zinali zokhudza zaumoyo, ndiponso mavuto a zaumoyo?

4.6 Ngati zitsuzo zinali ndi uthenga wazaumoyo, uthengawo unali otani?

4.7 Mukuganiza kuti zitsuzo ndi njira yabwino yokambirana zokhudza umoyo? Chifukwa chiani?

4.8 Mungakonde kudzakhala nawo mmagulu ambiri opanga zitsudzo amene amakambirana zaumoyo? Chifukwa chiani?

5.0 MITUNDU INA YA ZISANGALALO (MASEWERO A ZIDOLE, MPIKISANO WA NYIMBO)

5.1 Kodi mudaonapo mitundu ina ya masewelo yokamba zaumoyo?

5.2 Ngati ndi choncho ndi ati?

5.3 Mudawakonda? Chifukwa chiani

5.4 Mungakonde mutamaona mitundu yambili ya masewerowa? Chifukwa chiani

6.0 KUTHETSA MAVUTO A MDELA LANU

6.1 Kodi anthu amdera lanulo amathetsa bwanji mavuto awo.
6.2 Ndi zitsanzo ziti zamavuto amene dela lanulo linathetsa.
6.3 Ndizitsanzo ziti zamavuto amene dela lanulo lidalephera kuthetsa.
6.4 Anthu a mmudzimo apeza njira yothetsera vuto la matenda a EDZI?
6.5 Ngati ndichoncho, achitapo chiani?
6.6 Anthu a mmudzimu adapeza njira yothetsera mavuto ena azaumoyo?
6.7 Ngati ndichoncho, achitapo chiani?
6.8 Kodi anthu akumudziwa akulandira nthandizo lina lililonse mukuthetsa mavuto awowa? Ngati ndichoncho, chithandizo chake ndi chotani?
6.9 Kodi chithandizo chomwe alandiracho,
  6.9.1 Chakhutitsidwa kwambiri
  6.9.2 Akhutitsidwa
  6.9.3 Sanakhutitsidwe nacho.

6.10 Kodi anthu amderali akufuna chithandizo chothetsera mavuto awowa? Ngati ndi choncho, ndichithandizo chanji angachifune?
6.11 Ndi anthu angati amene anthu mmamudziwa angafune kuwathandiza?

7.0 Zofunikira pakuthetsa mavuto a zaumoyo mderali?

6. Community-based Distribution Agents (CBDAs) Interview Guide (English)

(a) Describe the typical day of a community-based distribution agent.
(b) Since you began work as a CBDA, what have been the most significant changes that you have observed? What has not changed?
(c) What are the most important challenges facing your community today?
(d) Population in your coverage area: Percent adults: Percent youth: Percent female: Percent female:
(e) Number of clients: Percent adults: Percent youth: Percent female: Percent female:

1. Training

1.1 Family planning
- 1.1.1 quality of training (above average, average, below average)
- 1.1.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
- 1.1.3 results of training
- 1.1.4 need for additional training
- 1.1.5 lessons learned and recommendations for the future

2. Outreach Activities

2.1 Family planning services for adults
- 2.1.1 percent of time per month spent on family planning services
- 2.1.2 How are adults targeted? What kind of targeting works best? What doesn't work?
- 2.1.3. Who are the majority of clients?
- 2.1.4 What contraceptive methods are most in demand? What are least in demand?
- 2.1.5 What approach to family planning promotion seems to work best? What approach has not worked?
- 2.1.6 How effective are family planning services for adults? Has knowledge of family planning increased? Has the practice of family planning increased?
- 2.1.7 lessons learned and recommendations for the future

2.2 Youth reproductive health prevention services (Youth friendly services piloted in 12 clinics owned by 13 estate companies, including early pregnancy prevention, HIV prevention, and management of STIs)
- 2.2.1 percent of time per month spent on youth reproductive health prevention services
- 2.2.2 Targeting. How are youth targeted? What kind of targeting works best? What doesn't work?
- 2.2.3 Who are the majority of youth clients? (age? gender? in-school youth? out-of-school youth?)
- 2.2.4 What services are most in demand by youth? What services are least in demand?
- 2.2.5 What approach to youth reproductive health prevention services seems to work best? What approach has not worked?
- 2.2.6 How effective are youth reproductive health prevention services? Has knowledge of reproductive health increased? What percentage of youth in your community is using these services?
- 2.2.7 lessons learned and recommendations for the future

2.3 TfT methodology counseling and drama

2.4 Quarterly district CBD family planning services meetings
- 2.4.1 satisfaction with meetings (highly satisfactory, satisfactory, unsatisfactory)
- 2.4.2 Who participates in quarterly district meetings?
- 2.4.3 What is the purpose of quarterly district meetings?
- 2.4.4 What is most useful about these meetings? What is least useful?
- 2.4.5 Do these meetings address all of your concerns?
- 2.4.6 lessons learned and recommendations for the future

3. Supervision by Health Surveillance Assistants (HSAs)
- 3.1 quality of supervision (above average, average, below average)
- 3.2 results of supervision
- 3.3 need for additional supervision
- 3.4 lessons learned and recommendations for the future

4. Supervision by Project HOPE and DHMT on a quarterly basis
- 4.1 quality of supervision (above average, average, below average)
- 4.2 results of supervision
- 4.3 need for additional supervision
- 4.4 lessons learned and recommendations for the future

5. On-the-job support
- 5.1 Who provides on-the-job support?
- 5.2 quality of on-the-job support (above average, average, below average)
- 5.3 results of on-the-job-support
- 5.4 need for additional on-the-job support
- 5.5 lessons learned and recommendations for the future

6. Reporting requirements
- 6.1 percent of time per month spent on reporting requirements
  - 6.1.1 Time in hours on each required report (list)
- 6.2 lessons learned and recommendations for the future

7. Materials and supplies
- 7.1 percent of time per month spent on obtaining materials and supplies (list)
- 7.2 Are IEC materials developed for target audiences (e.g., youth and religious community members) culturally appropriate?
- 7.3 results of using IEC materials
- 7.4 need for additional IEC materials
- 7.5 Are needed contraceptive supplies adequate to meet demand? Why or why not?
- **7.6** lessons learned and recommendations for the future

8. Logistics and Transportation
- 8.1 average amount of time (number of hours) per day spent on logistics (e.g. arranging home visits, workplace visits, and so forth)
- 8.2 average amount of time (number of hours) per day spent on transportation
- 8.3 transportation issues
- 8.4 need for transportation
- 8.5 lessons learned and recommendations for the future

9. Communications and Information (where applicable)
- 9.1 Project HOPE
- 9.2 Estate management
- 9.3 Estate clinic in charge

9.4 Health Surveillance Assistants (HSAs)
9.5 Clients
9.6 Other CBDAs
9.7 District Health Management Team (DHMT)
9.8 Communities close to the estate

10. Other

7. Community-based Distribution Agents (CBDAs) Interview Guide (Chichewa)

a. Fotokozani mmene tsiku la CBDA limakhalira (ntchito zomwe mumagwira)?

b. Chiyambileni ntchito ya u CBDA, ndikusintha kotani komwe mwakuona? Nanga ndi ziti zomwe sizinasinthe?

c. Kodi ndi zopinga zanji zimene anthu akudera lanu amakumana nazo?

d. Nambala ya kuchuluka kwa anthu mu dela lanu:

Nambala ya akulu	____	Nambala ya achinyamata	____
Nabala ya akazi	____	Nambala ya atsikana	____

e. Nambala ya makalayanti:

Nambala ya akulu	**____**	**Nambala ya achinyamata**	**____**
Nambala ya akazi	**____**	**Nambala ya atsikana**	

1.0 MAPHUNZIRO

1.1 Kulera

1.1.1 Kodi maphunzirowa anali abwino bwanji?
- 1.1.1.1 abwino kwambiri
- 1.1.1.2 abwino pang'ono
- 1.1.1.3 sanali abwino

1.1.2 Kodi maphunzirowa munakhutitsidwa nawo bwanji?
- 1.1.2.1 Ndinakhutitsidwa kwambiri
- 1.1.2.2 Ndinakhutitsidwa
- 1.1.2.3 Ndinakhutitsidwa pang'ono

1.1.3 Zotsatira za maphunziro.

1.1.4 Kufunika kwa maphunziro oonjezera

1.1.5 Zomwe munaphunzira ndi maganizo anu amtsogolo

1.2 Maphunziro a zakusintha

1.2.1 Kodi maphunziro a zakusintha anali abwino bwanji?
- 1.2.1.1 Anali abwino kwambiri
- 1.2.1.2 Anali abwino
- 1.2.1.3 Sanali abwino

1.2.2 Kodi maphunzirowo munakhutitsidwa nawo bwanji?
- 1.2.2.1 Ndinakhutitsidwa kwambiri
- 1.2.2.2 Ndinakhutitsidwa
- 1.2.2.3 Sindinakhutitsidwe nawo.

1.2.3 Zotsatira zampahunziro.

1.2.4 Kodi maphunzirowo munakhutitsidwa nawo bwanji?

1.2.5 Kodi mwaphunzirapo chiyani? nanga maganizo anu a mtsogolo ndi otani?

2.0 OUTREACH ACTIVITIES

2.1 Ntchito zakalera wa akulu

2.1.1 Kodi pamwezi mumatha nthawi yaitali bwanji kupereka kalera kwa makalayanti?

2.1.2 Kodi akulu-akulu mumawafikira bwanji? Kodi ndikafikiridwe kati kwabwino komwe mumagwiritsa ntchito? Kodi ndi kafikiridwe kati komwe sikayenda bwino?

2.1.3 Kodi ambiri mwa makalayanti anu ndi ndani?

2.1.4 Kodi ndi njira ziti za kalera zomwe zimafunidwa kwambiri? Nanga ndi njira ziti za kalera zomwe sizifunidwa kwambiri ndi makalayanti?

2.1.5 Kodi ndi njira ziti zakaperekedwe ka uthenga wa kalera zomwe mumagwiritsa ntchito. Nanga ndi njira ziti zomwe siziyenda bwino?

2.1.6 Kodi kalera akupindulitsa bwanji akulu? Kodi chidziwitso chakalera chikupita patsogolo? Kodi kugwiritsa ntchito kalera kukuwonjezeka?

2.1.7 Pantchito za ku outreach, kodi mwaphunzirapo chiyani? Nanga maganizo anu amtsogolo ndi otani?

2.2 Kupewa ubeleki kwa a chinyamata (kalandiridwe ka achinyamata komwe kanayambika muma clinic khumi ndi awiri. Oyang'aniridwa ndi ma estate khumi ndi atatu, komwe kakuphatikizapo kapewedwe ka mimba za msanga kwa achinyamata, kupewa HIV ndiponso kasamalidwe ka matenda opatsirana mwakugonana.

2.2.1 Kodi mumatha nthawi yaitali bwanji pa mwezi kuthandiza achinyamata kupewa ubeleki?

2.2.2 Kafikidwe

- Kodi ndikafikidwe kati komwe kali kabwino?
- Nanga ndi kafikidwe kati komwe sikabwino?

2.2.3 Kodi ambiri mwa makalayati achinyamata omwe mumawathandiza ndi ati?
(Zaka zawo, amuna kapena akazi? Akupita kusukulu kapena anasiya?

2.2.4 Kodi achinyamata amafuna chithandizo chiti kwambiri? Nanga ndi chithandizo chiti chomwe safuna mwambiri?

2.2.5 Kodi ndi kafikiridwe kati ka kapewedwe ka ubeleki kwa a chinyamata komwe kali kabwino. Nanga ndi kafikiridwe kati komwe sikayenda bwino.

2.2.6 Njira zakapewedwe kaubeleki ndi zothandiza bwanji kwa achinyamata? Ndi chiwerengero chanji cha achinyamata mdera lanu omwe mukuwathandiza pa ubeleki wabwino?

2.2.7 Zomwe mwaphunzira ndiponso maganizo anu amtsogolo

2.3 Misonkhano yakanayi pachaka ya ntchito zakaleredwe za ma CBD

2.3.1 Kukhutiritsa kwa misonkhano
- Yokhutiritsa kwambiri?
- Yokhutiritsa
- Yosakhutiritsa

2.3.2 Pamisonkhano yakanayi pachaka pamapezeka ndani?

2.4 Misonkhano yakanayi pa chaka ndi yofunika bwanji?

2.4.1 Pamisonkhanoyi kodi chofunika kwambiri ndi chiti? Nanga zosafunika ndi ziti?

2.4.2 Kodi misonkhanoyi imakwaniritsa zosowa zake?

2.4.3 Zomwe mwaphunzira ndipo maganizo anu amtsogolo.

3.0 KUYENDERA NTCHITO KWA MA HEALTH SURVEILLANCE ASSISTANTS (HSAs)

3.1 Ubwino wa kuyendra ntchito
- Wopambana kwambiri
- Wopambana
- Wosafunika kwenikweni

3.2 Zotsatira za kayendedwe

3.3 Kufunika kwa kuyendera koonjezereka

3.4 Zomwe mwaphunzira ndinso maganizo anu amtsogolo.

4.0 KUYENDERA NTCHITO KWA PROJECT HOPE NDI DHMT KWA KANAYI PACHAKA

4.1 Ubwino wa kuyendera
- Wabwino kwambiri
- Wabwino
- Wosafunika kwenikweni

4.2 Zotsatira zakayendedwe

4.3 Kufunika kwa kuyendera koonjezereka

4.4 Kodi mwaphunzirapo chiyani nanga maganizo anu amtsogolo ndi otani?

5.0 THANDIZO LOPEREKEDWA PA NTCHITO

5.1 Amapereka thandizo pa ntchito ndani?

5.2 Ubwino wakupereka thandizo pa ntchito

- Wabwino kwambiri
- Wabwino
- Wosafunika kwenikweni

5.3 Zotsatira zakupereka thandizo pa ntchito.

5.4 Kufunika kwa kupereka thandizo pa tchito koonjezereka.

5.5 Kodi mwaphunzirapo chiyani nanga maganizo anu amtsogolo ndi ati?

6.0 ZOFUNIKA POTUMIZA MA REPORT

6.1 Mumatha nthawi yaitali bwanji potumiza ma report?

6.1.1 Mumatha maola angati kulemba ma report (tchulani)

6.1.2 Kodi mwaphunzirapo chiyani? Nanga maganizo anu amtsogolo ndi otani?

7.0 ZIDA ZOGWIRITSA NTCHITO

7.1 Ndi nthawi yochuluka bwanji pamwezi yomwe mumatha polandira zida zogwiritsa ntchito (tchulani zonse).

7.2 Kodi zida zophunzitsira a chinyamata ndiponso magulu amathalichi ndi zovomerezeka pa chikhalidwe chawo?

7.3 Zotsatira za zida zophunzitsira nzotani?

7.4 Kodi pakufunika zida zina zowonjezera pa kuphunzitsa?

7.5 Kodi njira zolera ndizokwanira ndi momwe zikufunikira? Chifukwa, Kapenanso chifukwa chiyani siziri choncho?

7.6 Nanga mwaphunzirapo chiyani kapena maganizo anu amatsogolo ndi otani?

8.0

8.1 Kodi ndi maola ochuluka bwanji omwe munathera polinganiza ulendo wammakomo, ndiponso ulendo wakuntchito zosiyana-siyana ndi zina zotero?

8.2 Kodi ndi nthawi yochuluka bwanji patsiku yomwe mumatenga pokonzekera maulendo?

8.3 Kufunika kwa maulendo ena.

8.4 Zomwe mwaphunzira ndiponso maganizao anu amtsogolo ndi otani

9.0 COMMUNICATIONS AND INFORMATION

9.1 Project HOPE

9.1.1 Kodi makambitsirano ndi kutumiza mauthenga anu ndi a Project HOPE ndi okwanira ndiponso a panthawi yake?

9.1.2 Kodi pakufunika katumizidwe ndinso makambitsirano owonjezera?

9.1.3 Kodi mwaphunzirapo chiyani? nanga maganizo anu amtsogolo ndi otani?

9.2 Chisamaliro cha pa estate

9.2.1 Kodi katumizidwe ka mauthenga ndi makambitsirano ndi mabwana pa estate ndi okwanira ndiponso a panthawi yake?

9.2.2 Kodi mwaphunzirapo chiyani? Nanga maganizo anu amtsogolo ndi otani?

9.3 Abwana a pa chipatala cha pa estate

9.3.1 Kodi mgwirizano pa mauthenga ndiponso makambitsirano ndi abwana a clinic ndi wokwanira ndipo a panthawi yake?

9.3.2 Kodi pakufunika mgwirizano pa mauthenga ndi makambitsirano owonjezera.

9.3.3 Kodi mwaphunzirapo chiyani pa mauthenga ndi makambitsirano? Nanga maganizo anu amtsogolo ndi otani?

9.4 Health Surveillance Assistants (HSAs)

9.4.1 Kodi mgwirizano pa makambitsirano ndi mauthenga ndi ma HSA ndiwokwanira ndiponso wapanthawi yake?

9.4.2 Kodi pakufunika zina zowonjezera pa makambitsirano ndi mgwirizano.

9.4.3 Pa mgwirizano ndi makambitsirano, kodi pali kufunika kuwonjezera?

9.5 Kwa ofuna chithandizo

9.5.1 Kodi kukambirana ndiponso mgwirizano ndi ofuna chithandizo chokwanira ndiponso kwa panthawi yake?

9.5.2 Kodi pakufunika zowonjezera pa makambitsirano ndiponso mgwirizano ndi ofuna chithandizo?

9.5.3 Kodi mwaphunzirapo chiyani pa mgwirizano ndi makambitsirano anu, nanga maganizo anu mtsogolo ndi otani?

9.6 Enanso otengera kulera khomo ndi khomo

9.6.1 Kodi mgwirizano ndi kukambitsirano kwanu ndi ma CBDA ena ndi okwanira? Ndiponso wa panthawi yake?

9.6.2 Kodi pakufunika zoonjezera pa mgwirizano ndi makambitsirano?

9.6.3 Kodi mwaphunzirapo chiyani pa mgwirizano ndi makambitsirano, nanga maganizo anu a mtsogolo ndi otani?

9.7 District Health Management Team (DHMT)

9.7.1 Kodi mgwirizano ndimakambitsirano ndi a DHMT ndi wokanira? Kodi ndi wapanthawi yake?

9.7.2 Kodi pakufunika zowonjezereka pa mgwirizano ndi makambitsirano omwe alipo kale?

9.7.3 Kodi mwaphunzirapo chiyani pa mgwirizano umenewu? Nanga maganizo anu amtsogolo ndi otani?

9.8 Madera a pafupi ndi estate

9.8.1 Kodi ndi mgwirizano ndi kukambirana ndi madera a pafupi ndi estate ndi wokwanira, komanso wapanthawi yake?

9.8.2 Kodi pafunika zowonjezera pa magwirizano ndi makambitsirano omwe alipo kale?

9.8.3 Kodi mwaphunzirapo chiyani pa mgwirizano umenewu? Nanga maganizo anu amtsogolo ndi otani?

10.0 Zina zowonjezera.

8. Health Surveillance Assistants (HSAs)/Home Craft Workers (HCWs) Interview Guide

(a) Describe the typical day of an HSA/HCW

(b) Since you began work as an HSA/HCW, what have been the most significant changes that you have observed? What has not changed?

(c) What are the most important challenges facing your community today

(d) Population in your coverage area: Percent adults: Percent youth:
Percent female: Percent female:

(e) Number of clients: Percent adults: Percent youth:
Percent female: Percent female:

(f) Number of CBDAs under supervision:

1. **Training**
   - 1.1 STI/HIV risk reduction counseling
     - 1.1.1 quality of training (above average, average, below average)
     - 1.1.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
     - 1.1.3 results of training
     - 1.1.4 need for additional training
     - 1.1.5 lessons learned and recommendations for the future
   - 1.2 Training for Transformation (TfT)
     - 1.2.1 quality of training (above average, average, below average)
     - 1.2.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
     - 1.2.3 results of training
     - 1.2.4 need for additional training
     - 1.2.5 lessons learned and recommendations for the future
   - 1.3 Family planning promotion education
     - 1.3.1 quality of training (above average, average, below average)
     - 1.3.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
     - 1.3.3 results of training
     - 1.3.4 need for additional training
     - 1.3.5 lessons learned and recommendations for the future
   - 1.4 Training for supervision of community-based distribution agents (CBDAs)
     - 1.4.1 quality of training (above average, average, below average)
     - 1.4.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
     - 1.4.3 results of training
     - 1.4.4 need for additional training
     - 1.4.5 lessons learned and recommendations for the future

2. **Outreach Activities**
   - 2.1 STI/HIV risk reduction counseling of estate community members in their own homes
     - 2.1.1 percent of time spent per month providing home counseling
     - 2.1.2 How are potential clients targeted? Are new targeted, e.g., are newly arrived workers targeted? Are different social groups targeted separately (married women, single women workers, adolescent children of workers living on the estates, young men and women separately, married men, single men)?
     - 2.1.3 What kind of targeting works best? What doesn't?
     - 2.1.4 Who are the majority of clients?

2.1.5 What counseling works best? What doesn't?
2.1.6 effectiveness of counseling
Has the knowledge of STI/HIV and the perception of personal risk increased? Has the behavior of community members changed?
2.1.7 lessons learned and recommendations for the future

2.2 STI/HIV risk reduction counseling of estate community members in the workplace
2.2.1 How are potential clients/beneficiaries targeted?
2.2.2 How are potential clients/beneficiaries targeted?
2.2.3 Who are the majority of clients?
2.2.4 What counseling works best? What doesn't?
2.2.5 effectiveness of counseling
Has knowledge of STI/HIV and the perception of personal risk increased? Has the behavior of community members changed?
2.2.6 lessons learned and recommendations for the future

2.3 Other

3. **Supervision by HSAs and HCWs**

3.1 Supervision of adult peer educators and counselors and adult drama groups
3.1.1 percent of time per month spent on supervising peer educators and counselors and adult drama groups
3.1.2 use of supervision checklist and counseling services report form
3.1.3 results of supervision
3.1.4 need for additional supervision
3.1.5 performance of peer educators and counselors (highly satisfactory, satisfactory, unsatisfactory)
3.1.6 performance of adult drama groups (highly satisfactory, satisfactory, unsatisfactory)
3.1.7 lessons learned and recommendations for the future

3.2 Supervision of CBDAs
3.2.1 percent of time per month spent on supervising CBDAs
3.2.2 results of supervision
3.2.3 need for additional supervision
3.2.4 performance of CBDAs (highly satisfactory, satisfactory, unsatisfactory)
3.2.5 lessons learned and recommendations for the future

3.3 Supervision of other HSAs/HCWs
3.3.1 percent of time per month spent on supervising other HSAs/HCWs
3.3.2 results of supervision
3.3.3 need for additional supervision
3.3.4 lessons learned and recommendations for the future

4. **Supervision of HSAs and HCWs by Project HOPE** (quarterly supervision and monitoring of HSAs and HCWs in the provision of STI/HIV prevention education using TfT and HIV/STI risk reduction counseling by Project HOPE)

4.1 quality of supervision (above average, average, below average)
4.2 results of supervision
4.3 need for additional supervision
4.4 lessons learned and recommendations for the future

5. Supervision of HSAs and HCWs by Clinic in Charge

5.1 quality of supervision (above average, average, below average)
5.2 results of supervision
5.3 need for additional supervision
5.4 lessons learned and recommendations for the future

6. Supervision of HSAs and HCWs by MOHP

6.1 quality of supervision (above average, average, below average)
6.2 results of supervision
6.3 need for additional supervision
6.4 lessons learned and recommendations for the future

7. On-the-job support

7.1 quality of on-the-job support (above average, average, below average)
7.2 results of on-the-job-support
7.3 need for additional on-the-job support
7.4 lessons learned and recommendations for the future

8. Reporting requirements

8.1 percent of time per month spent on reporting requirements
6.1.1 Time in hours on each required report (list)
8.2 lessons learned and recommendations for the future

9. Materials and supplies

9.1 percent of time per month spent on obtaining materials and supplies (list)
9.2 Are IEC materials developed for target audiences (e.g., youth and religious community members) culturally appropriate?
9.3 results of using materials
9.4 need for additional materials
9.5 Are STI supplies adequate to meet demand? Why or why not?
9.6 Are family planning supplies adequate to meet demand? Why or why not?
9.7 lessons learned and recommendations for the future

10. Logistics and transportation

10.1 average amount of time (number of hours) per day spent on logistics (e.g., arranging home visits, workplace visits, and so forth)
10.2 average amount of time (number of hours) per day spent on transportation
10.3 purchase of bicycle through revolving fund (cost and time savings)
10.4 need for transportation/transportation issues
10.5 lessons learned and recommendations for the future

11. Communications and Information Exchange

11.1 Project HOPE
11.2 Estate management
11.3 Estate clinic in charge
11.4 CBDAs
11.5 Adult drama groups
11.6 Adult peer educators and counselors

11.7 Clients
11.8 Other HSAs and HCWs
11.9 District Health Management Team (DHMT)
11.10 Communities close to the estate

12. Other

9. Adult Peer Educators and Counselors and Drama Groups Interview Guide

(a) Why did you decide to become a volunteer?
(b) What do you like best about volunteering?
(c) What do you like least about volunteering?
(d) What are the most important challenges facing adults today?
(e) What is the most important health problem facing adults?
(f) What are your aspirations for the future?

1. Training

1.1 Peer educators and counselors
- 1.1.1 quality of training (above average, average, below average)
- 1.1.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
- 1.1.3 results of training
- 1.1.4 need for additional training
- 1.1.5 lessons learned and recommendations for the future

1.2 Drama Clubs
- 1.2.1 quality of training (above average, average, below average)
- 1.2.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
- 1.2.3 results of training
- 1.2.4 need for additional training
- 1.2.5 lessons learned and recommendations for the future

2. **Other Training (specify)**

3. **Activities**

3.1 Provide education/educational messages
- 3.1.1 percent of time per month (or number of hours) spent on this activity
- 3.1.2 How do you reach adults? What approach works best? What doesn't work?
- 3.1.3. Who are the adults (age and gender)? How many have you reached?
- 3.1.4 What topics are of most interest to adults? (e.g., basic information on HIV/AIDS and STI)
- 3.1.5 What approach works best in providing education on these topics? What approach has not worked?
- 3.1.6 Do you think the work you are doing with adults is adequate and timely?
- 3.1.7 Have the education/educational messages you have provided been effective? Why or why not? For example, have you observed a decrease in high-risk behavior?
- 3.1.8 How many youth clients have you referred for further management?
- 3.1.9 lessons learned and recommendations for the future

3.2 Other Activities (specify)

4. **Supervision by Health Surveillance Assistants (HSAs)**
- 4.1 quality of supervision (above average, average, below average)
- 4.2 results of supervision
- 4.3 need for additional supervision

4.4 lessons learned and recommendations for the future

5. Reporting requirements

5.1 percent of time per month spent on reporting requirements

5.1.1 Time in hours on each required report (list)

5.2 lessons learned and recommendations for the future

6. Materials and supplies

6.1 What kinds of materials and supplies do you use in your activities?

6.2 Are the materials appropriate? Do the youth like them and use them?

6.3 need for additional materials and/or supplies

6.4 lessons learned and recommendations for the future

7. Communications and Information Exchange

7.1 Estate clinic in charge

7.2 Project HOPE

8. Other

10. Primary Education Adviser (PEA) and School Patron Interview Guide

STAFH Project Objective: Increased adoption of measures that reduce fertility and risk of sexually transmitted infections (STI) and human immunodeficiency virus (HIV) transmission amongst people working in the private agricultural estates through (a) improved knowledge and use of good reproductive health practices and own HIV Status, (b) increased community participation in family planning (FP) promotion, STI and HIV prevention activities, and (c) expanded range and quality of reproductive health services

1. Evaluation

1.1 How would you evaluate the STAFH Project overall? (a) highly satisfactory, (b) satisfactory, or (c) unsatisfactory? What do you think the project really tried to do? What did it contribute to the community?

(a) Highly satisfactory. Project achieved or exceeded its major objectives, without major shortcomings.

(b) Satisfactory. Project achieved most of its major objectives, with only a few shortcomings.

(c) Unsatisfactory. Project failed to achieve most of its major objectives.

1.2 How would you evaluate the specific project objective to increase youth participation in adolescent sexual and reproductive health care? (a) highly satisfactory, (b) satisfactory, or (c) unsatisfactory?

1.3 What has been the experience with estates as partners? With the estate schools? With the local MOHP? With Project HOPE?

1.4 Project sustainability. (a) likely, (b) unlikely, or (c) uncertain?

Assessment of the project's sustainability, defined as the probability of its maintaining the achievements generated in relation to its major objectives. In evaluating sustainability as likely, unlikely, or uncertain, major factors such as the following should be taken into account: business environment, management effectiveness, the project's technical and financial viability, social impact, estate commitment, MOE commitment, MOHP commitment, and incentives for local participation. Sustainability may also be affected by a follow-on project that continues or expands project activities.

2. Training

2.1 Youth peer educators and counselors (HIV/STI prevention and teenage pregnancy prevention)

2.1.1 quality of training (above average, average, below average)

2.1.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)

2.1.3 results of training

2.1.4 need for additional training

2.1.5 lessons learned and recommendations for the future

2.2 AIDS TOTO Clubs

2.2.1 quality of training (above average, average, below average)

2.2.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)

2.2.3 results of training

2.2.4 need for additional training

2.2.5 lessons learned and recommendations for the future

2.3 TfT Youth Leaders
- 2.3.1 quality of training (above average, average, below average)
- 2.3.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
- 2.3.3 results of training
- 2.3.4 need for additional training
- 2.3.5 lessons learned and recommendations for the future

2.4 Youth Drama Groups
- 2.4.1 quality of training (above average, average, below average)
- 2.4.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
- 2.4.3 results of training
- 2.4.4 need for additional training
- 2.4.5 lessons learned and recommendations for the future

3. **Activities**

3.1 Outreach
- 3.1.1 Through the youth groups, are youth being reached with education/educational messages? Why or why not?
- 3.1.2 Who are the youth reached? (age, gender, in school, out-of-school) How many have been reached? How many are in school? Out of school?
- 3.1.3 What topics are of most interest to youth?
- 3.1.4 What approach appears to work best in providing education/educational messages to youth on these topics? What approach has not worked?
- 3.1.5 Do you think the work that the youth groups are doing is adequate and timely?
- 3.1.6 Have the education/educational messages been effective? Why or why not? For example, have you observed a decrease in high-risk behavior?
- 3.1.7 lessons learned and recommendations for the future

4. **Supervision by Primary Education Adviser (PEA) and/or School Patron**
- 4.1 quality of supervision (above average, average, below average)
- 4.2 results of supervision
- 4.3 need for additional supervision
- 4.4 lessons learned and recommendations for the future

5. Support provided by School Patron
- 5.1 What kind of guidance and support does the School Patron provide?
- 5.2 need for guidance and support
- 5.3 lessons learned and recommendations for the future

6. Reporting requirements
- 6.1 percent of time per month spent on reporting requirements
  - 6.1.1 Time in hours on each required report (list)
- 6.2 lessons learned and recommendations for the future

7. Materials and supplies
- 7.1 What kinds of materials and supplies do the youth groups use?
- 7.2 Are the materials appropriate?
- 7.3 Is there a need for additional materials and/or supplies?
- 7.4 lessons learned and recommendations for the future

8. Communications and Information Exchange
- 8.1 Agricultural Estate

8.2 Primary Education Adviser (PEA) and/or School Patron
8.3 Project HOPE

9. Other

11. Youth Educators and Counselors, Anti-AIDS Clubs, TfT Youth Leaders, and Youth Drama Group Interview Guide (English)

(a) Why did you decide to become a volunteer?
(b) What do you like best about volunteering?
(c) What do you like least about volunteering?
(d) What are the most important challenges facing youth today?
(e) What is the most important health problem facing youth?
(f) What are your aspirations for the future?

1. Training

1.1 Peer educators and counselors (HIV/STI prevention and teenage pregnancy prevention)
- 1.1.1 quality of training (above average, average, below average)
- 1.1.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
- 1.1.3 results of training
- 1.1.4 need for additional training
- 1.1.5 lessons learned and recommendations for the future

1.2 AIDS TOTO Clubs
- 1.2.1 quality of training (above average, average, below average)
- 1.2.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
- 1.2.3 results of training
- 1.2.4 need for additional training
- 1.2.5 lessons learned and recommendations for the future

1.3 TfT Youth Leaders
- 1.3.1 quality of training (above average, average, below average)
- 1.3.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
- 1.3.3 results of training
- 1.3.4 need for additional training
- 1.3.5 lessons learned and recommendations for the future

1.4 Youth Drama Groups
- 1.4.1 quality of training (above average, average, below average)
- 1.4.2 satisfaction with training (highly satisfactory, satisfactory, unsatisfactory)
- 1.4.3 results of training
- 1.4.4 need for additional training
- 1.4.5 lessons learned and recommendations for the future

2. **Other Training (specify)**

3. **Activities**

3.1 Provide education/educational messages
- 3.1.1 percent of time per month (or number of hours) spent on this activity
- 3.1.2 How do you reach the youth? What approach works best? What doesn't work?
- 3.1.3. Who are the youth reached? (age, gender, in school, out-of-school) How many have you reached? How many are in school? Out of school?
- 3.1.4 Which of the following topics are of most interest to youth?

-- basic information on HIV/AIDS and STI
-- preventing teen age pregnancy
--other

3.1.5 What approach works best in providing education/educational messages to youth on these topics? What approach has not worked?
3.1.6 Do you think the work you are doing with youth is adequate and timely?
3.1.7 Have the education/educational messages you have provided been effective? Why or why not? For example, have you observed a decrease in high-risk behavior?
3.1.8 How many youth clients have you referred for further management?
3.1.9 lessons learned and recommendations for the future

3.2 Other Activities (specify)
3.2.1 AIDS TOTO Club
3.2.2 youth drama
3.2.3 TfT youth leaders
3.2.4 peer educators and counselors

4. Supervision by School Patron
4.1 quality of supervision (above average, average, below average)
4.2 results of supervision
4.3 need for additional supervision
4.4 lessons learned and recommendations for the future

5. Support provided by School Patron
5.1 What kind of guidance and support does the School Patron provide?
5.2 need for guidance and support
5.3 lessons learned and recommendations for the future

6. Reporting requirements
6.1 percent of time per month spent on reporting requirements
6.1.1 Time in hours on each required report (list)
6.2 lessons learned and recommendations for the future

7. Materials and supplies
7.1 What kinds of materials and supplies do you use in your activities?
7.2 Are the materials appropriate? Do the youth like them and use them?
7.3 need for additional materials and/or supplies
7.4 lessons learned and recommendations for the future

8. Communications and Information Exchange
8.1 Primary Education Adviser (PEA), Ministry of Education
8.2 Project HOPE

9. Other

12. Youth Educators and Counselors, Anti-AIDS Clubs, TfT Youth Leaders, and Youth Drama Group Interview Guide (Chichewa)

APHUNZITSI NDI A LANGIZI A ZACHINYAMATA, MAKALABU A ZA 'EDZI TOTO' TFT YOUTH LEADERS NDIPONSO MABUNGWE A ZAMASEWERO (DRAMA)

a. Ndichifukwa chiyani munasankha kukhala volunteer?
b. Mumakonda kwenikweni chiyani pa za uvolunteer?
c. Nanga chomwe simukonda kwambiri ndi chiyani pa za uvolunteer?
d. Kodi zopinga zomwe achinyamata amakomana nazo ndi ziti?
e. Nanga vuto la umoyo lomwe achinyamata amakomana nalo ndi liti?
f. Kodi mumalakalaka mutakhala ndani mtsogolo muno.

1.0 MAPHUNZIRO A ZACHINYAMATA (PEER EDUCATION) NDI ULANGIZI WA ZA KAPEWEDWE KA HIV/STI NDI KUPITISA MTSOGOLO NJIRA ZA KULERA.

1.1 Kupewa matenda opatsirana HIV ndiponso kupewa kutenga mimba munthu uli wang'ono

1.1.1 Ubwino wa maphunziro:
1.1.1.1 abwino kwambiri
1.1.1.2 abwino
1.1.1.3 oyipa

1.1.2 Kukhutitsidwa kwa maphunziro?
1.1.3 Zotsatira za maphunziro?
1.1.4 Pakufunika maphunziro ena?
1.1.5 Munaphunzira zotani? nanga maganizo anu amtsogolo ndi otani?

1.2 AIDS Toto Clubs

1.2.1 Ubwino wa maphunziro
1.2.1.1 abwino kwambiri
1.2.1.2 abwino
1.2.1.3 oyipa

1.2.2 Kukhutitsidwa kwa maphunziro
1.2.2.1 Tinakhutitsidwa kwambiri
1.2.2.2 Tinakhutitsidwa
1.2.2.3 Sitinakhutitsidwe

1.2.3 Zotsatira zamaphunziro

1.2.4 Pakufinika maphunziro owonjezera ena

1.2.5 Munaphunzira zotani? Nanga maganizo anu a mtsogolo ndi otani?

1.3 TFT (Adindo a TFT)

1.3.1 Ubwino wa maphunziro:
1.3.1.1 Abwino kwambiri
1.3.1.2 Abwino

1.3.1.3 Oyipa

1.3.2 Kukhutitsidwa kwa maphunziro
1.3.2.1 Tinakhutitsidwa kwambiri
1.3.2.2 Tinakhutitsidwa
1.3.2.3 Sitinakhutitsidwe

1.3.3 Zotsatira za maphunziro

1.3.4 Pakufunika maphunziro owonjezera?

1.3.5 Munaphunzira zotani? Nanga maganizo anu amtsogolo ndi otani?

1.4 Zitsudzo Za Achinyamata

1.4.1 Ubwino wa maphunziro
1.4.1.1 abwino kwambiri
1.4.1.2 abwino
1.4.1.3 oyipa

1.4.2 Munakhutitsidwa ndi maphunziro?
1.4.2.1 tinakhutitsidwa kwambiri
1.4.2.2 tinakhutitsidwa
1.4.2.3 sitinakutitsidwe

1.4.3 Zotsatira za maphunziro

1.4.4 Pakufunika maphunziro owonjezera?

1.4.5 Munaphunzira zotani? Maganizo anu amtsogolo ndi otani?

2.0 Maphunziro Ena (Specify) Fotokozani

_____

_____

3.0 Zochitika

3.1 (**Kupereka maphunziro)**

3.1.1 (Percent ya nthawi pa mwezi, kapena maola angati) omwe munatha pa maphunzirowo.

3.1.2 Mumawafikira bwanji achinyamata

- Nanga ndi njira yiti yophunzitsira yomwe ndi yabwino.
- Nanga ndi njira yiti yophunzitsira yomwe siyabwino.

3.1.3 Kodi achinyamata ake ndi ati omwe anafikilidwa, nanga ndi angati (zaka za pakatikati nanga ndi akazi/amuana? Nanga ndi angati omwe ali pa school

3.1.4 Kodi ndimaphunziro ati mwa maphunziro awa omwe anali abwino kwainu

3.1.4.1 Maphunziro a za AIDS ndi zamatenda opatsirana
3.1.4.2 Kupewa mimba pamene adakali wang'ono
3.1.4.3 Njira zina

3.1.5 Ndinjira iti yomwe imathandiza pophunzitsa ndi uphungu kwa achinyamata pa maphunziro ali mmwambawa?
3.1.5.1 Nanga ndinjira iti sinathandize

3.1.6 Kodi mukuganiza kuti ntchito yomwe mukugwira kwa a chinyamata ndiyokwanira ndipo ili kugwiridwa pa nthawi yake?
3.1.6.1 Nanga kodi maphunziro omwe mwapereka athandiza? Chifukwa chiyani?
3.1.6.2 Chifukwa chiyani sanathandize
3.1.6.3 Kodi mwaonapo kubwerera mbuyo pamakhalise a achinyamata?

3.1.7 Mwatumiza achinyamata angati kutalandira chithandizo kwina?

3.1.8 Mwaphunzira chiyani? Nanga maganizo anu ndiotani a mtsogolo?

3.2 Zochita Zina

3.2.1 Mabungwe a Toto

3.2.2 Zitsudzo za achinyamata

3.2.3 TFT Youth leaders

3.2.4 Aphunzitsi azachinyamata (abwalo) mzake ndi mzake ndi za uphungu.

4.0 KUYENDERA/KWA MA HSA

4.1 Ubwino Wa Kuyendera:

4.1.1 Kwabwino kwambiri
4.1.2 Kwabwino
4.1.3 Koyipa

4.2 Zotsatira za kuyendera

4.3 Mkofunika kuonjezera kuyendera kwina?

5.0 CHITHANDIZO CHOCHOKERA KWA AYANG'ANILI AMASUKULU (SCHOOL PATRONS)

5.1 Kodi ayang'anili a msukulu amapereka chithandizo ndi Utsogoleri wotani?

5.2 Mkofunikanso kutsogolereredwa ndi ayang'anili?

5.3 Mwaphunzirapo chiyani? Nanga maganizo anu ndi otani a mtsogolo?

6.0 ZOFUNIKA ZA MALIPOTI?

6.1 nthawi yomwe mwaononga pa mwezi (%) pa malipoti.
6.1.1 Nthawi (pamaola) yomwe inaikidwa (list)

6.2 Mwaphunzirapo chiyani?
Nanga maganizo anu ndi otani amtsogolo?

7.0 ZINTHU NDI ZIWIYA ZOPATSIDWA

7.1 Kodi mumagwiritsa ntchito katundu ndi ziwiya za mtundu wanji pa zochita zanu.

7.2 Kodi katunduyo ndi woyenera? Kodi achinyamata amamukonda ndipo amamgwiritsa ntchito?

7.3 Kodi palinso kufunika kupeza katundu ndi ziwiya zina?

7.4 Mwaphunzirapo chiyani? Nanga muli ndi zolinga/maganizo otani amtsogolo?

8.0 DONGOSOLO NDI KUGAWANA KWA MFUNDO (COMMUNICATION & INFORMATION EXCHANGE)

8.1 Alangizi amaphunziro aku primary PEA Ministry of Education (unduna wa za maphunziro)

8.1.1 Kodi dongosolo ndi kugawana kwa mfundo kuli ndi ma PEA?

8.1.2 Kodi pakufunikanso ndondomeko zina ndi mfundo zina zoyenera kusinthana?

8.1.3 Mwaphunzirapo chiyani? Nanga muli ndi malingaliro/ maganizo otani amtsogolo.

8.2 Project HOPE

8.2.1 Kodi ndonodomeko za maphunziro ndi mfundo zoyenera kugawana ziri ndi a Project HOPE?

8.2.2 Kodi ndikofunikanso kupeza ndondomeko ndi mfundo zina zoti musithane?

8.2.3 Mwaphunzirapo chiyani? Nanga maganizo anu amtsogolo ndi otani

9.0 ZINA_____

13. Agricultural Estate Management Interview Guide

1. STAFH Project

Project Objective: Increased adoption of measures that reduce fertility and risk of sexually transmitted infections (STI) and human immunodeficiency virus (HIV) transmission amongst people working in the private agricultural estates through (a) improved knowledge and use of good reproductive health practices and own HIV Status, (b) increased community participation in family planning (FP) promotion, STI and HIV prevention activities, and (c) expanded range and quality of reproductive health services for women, men, and youth in the target agricultural estates.

1.1 Evaluation

1.1.1 How would you evaluate the project? (a) highly satisfactory, (b) satisfactory, or (c) unsatisfactory? What do you think the project really tried to do? What did it contribute to the community?

(a) Highly satisfactory. Project achieved or exceeded its major objectives, without major shortcomings.

(b) Satisfactory. Project achieved most of its major objectives, with only a few shortcomings.

(c) Unsatisfactory. Project failed to achieve most of its major objectives.

1.1.2 Assessment of major factors that affected achievement of project objectives and degree to which they did so (substantially, partially, or negligibly). Factors divided into

(a) Factors not generally subject to government control, such as changes in world markets and prices, natural disasters, and war and civil disturbance.

(b) Factors generally subject to government control, such as macroeconomic policies and conditions, sector policies, and administrative procedures.

(c) Factors generally subject to Project HOPE Center control.

(d) Factors generally subject to Project HOPE/Malawi control, such as management effectiveness, staffing, cost changes, implementation delays, use of technical assistance, adequacy of monitoring (supervision) and evaluation, and beneficiary participation.

(e) Factors generally subject to estate control.

1.1.3 Project sustainability. (a) likely, (b) unlikely, or (c) uncertain?

Assessment of the project's sustainability, defined as the probability of its maintaining the achievements generated in relation to its major objectives. In evaluating sustainability as likely, unlikely, or uncertain, major factors such as the following should be taken into account: business environment, management effectiveness, the project's technical and financial viability, social impact, estate commitment, MOHP commitment, and incentives for local participation. Sustainability may also be affected by a follow-on project that continues or expands project activities.

--Does the estate plan to sustain the health interventions at the conclusion of the STAFH Project?

--What resources (human and financial) are necessary to sustain the health interventions?

1.2 Implementation, management, and planning

1.2.1 To what extent has estate management been involved in the implementation and management of project interventions?

1.2.2 Has estate management developed a policy and plan to address HIV/AIDS?

1.2.3 Has estate management been involved in developing the national HIV/AIDS workplace policy?

2. **Partnership between Agricultural Estates, Project HOPE/Malawi, and the Ministry of Health and Population (MOHP)**

2.1 What was intended by the partnership (the stated objectives and unstated motivations)?

2.2 What happened? (outcomes: services provided, people trained, community capacities developed; and impacts: health benefits, increased protection, etc.)

2.2.1 What have been the actual development impacts and business benefits delivered through the partnership? What are the development impacts according to MOHP?

2.2.2 Were there any unintended/unexpected/spin-off development impacts or business benefits?

2.2.3 Have there been any negative outcomes of the partnership for estate communities, surrounding communities, business, and/or government (MOHP)?

2.2.4 Has there been, or is it anticipated that there will be, "added value" to the outcomes that would not have been the case without the partnership?

2.2.5 Have the positive gains on the estates under the earlier project been sustainable?

2.2.6 What are the costs to business? To the District level MOHP?

Costs.

--What are the project costs (by category and amount) that are financed by the estate?

--pharmaceuticals/commodities

--annual refresher training for health care workers

--training of replacement volunteer workers and mangers as they move among the estates

--salaries

--logistical support and transportation

--Have project costs changed over time?

--What is the percent of estate-financed project costs relative to the annual, total estate-financed budget for health care? Does the estate have a health care budget? If yes, what are the budget line items?

--What is the percent of estate-financed budget for health care relative to the annual, total estate budget?

2.2.7 What are the benefits to business? To the District level MOHP?

Benefits. Higher worker productivity? Decreased absences due to worker or family sickness? Save on funeral costs? Save on illness treatment

costs? Generate goodwill among workers and their families? Generate goodwill with the government? Improved well-being of workers and their families? Improved business image? Good corporate citizenship?

2.3 How did the partnership come about?
- 2.3.1 What was the process to explore/plan the partnership, e.g., how the risks and costs for each party were weighed against the opportunities and benefits?
- 2.3.2 Who were the key actors who were instrumental in bringing the partners together?
- 2.3.3 What measures, if any, were taken to strengthen capacity (institutional and human) to make the partnership work?
- 2.3.4 What was the contribution of resources and the distribution of roles and responsibilities between the partners? Is there a Memorandum of Understanding?
- 2.3.5 How did/does the partnership work? Is there a lead partner who takes the initiative most of the time? (What measures were put in place from the outset intended to manage/maintain the partnership over time?) Is it really a partnership?
- 2.3.6 What have been the biggest challenges in working with MOHP, MOE, and Project HOPE?

2.4 How is the partnership maintained/managed? (What is the process?)
- 2.4.1 What has been the experience with Project HOPE as a partner? With the local MOHP? With MOE?
- 2.4.2 How do partners actually communicate, make decisions, and resolve grievances within the partnership (and with their respective constituents and other parties)
- 2.4.3 What is the extent of satisfaction with the way the partnership works? Is managed?
- 2.4.4 How does the partnership responds to changes in the external environment (e.g., financial business environment, economic, political, environmental, security, etc.) or internal environment (e.g., changes in key personnel, management, profit structure, etc.)?
- 2.4.5 How have roles and responsibilities changed over time?
- 2.4.6 Is there evidence of institutional change brought about by the partnership, e.g., institutionalization of the partnership for the longer-term, for example, within operational budgets? Changes in micro policy? Changes in incentive structures such as staff performance criteria and reporting requirements? Changes in overall attitude and behavior of the for-profit sector toward the non-profit sector and government and vice versa?
- 2.4.7 Given that the project had an estate approach, what did the partnership leverage for the estate community? What did business and the District/local government (MOHP/MOE) gain from the project?

2.5 How could things be improved?

2.6 What should not be attempted again?

2.7 Which aspects of the partnership (context, structure, process or outcomes) have replicability for scaling-up across the agricultural estate sector as a whole and to business in general?

3. Lessons Learned

4. Other

4.1 What rationale was used to allocate health personnel? Population-based? Complexity?

4.2 Who assisted in making the decision of what health services to offer?

14. Project HOPE Interview Guide

STAFH Project Objective: Increased adoption of measures that reduce fertility and risk of sexually transmitted infections (STI) and human immunodeficiency virus (HIV) transmission amongst people working in the private agricultural estates through (a) improved knowledge and use of good reproductive health practices and own HIV status, (b) increased community participation in family planning (FP) promotion, STI and HIV prevention activities, and (c) expanded range and quality of reproductive health services for women, men, and youth in the target agricultural estates.

1. Evaluation

1.1 How would you evaluate the project overall? (a) highly satisfactory, (b) satisfactory, or (c) unsatisfactory? What do you think the project really tried to do? What did it contribute to the community?

(a) Highly satisfactory. Project achieved or exceeded its major objectives, without major shortcomings.

(b) Satisfactory. Project achieved most of its major objectives, with only a few shortcomings.

(c) Unsatisfactory. Project failed to achieve most of its major objectives.

1.2 Assessment of Progress toward Key Intermediate Results (KIR) (substantially achieved, partially achieved, negligible)

1.2.1 KIR 3.2. Knowledge and Use of Good Reproductive Health Practices and Own HIV Status Improved
--KIR 3.2.1 Knowledge and use of Family Planning practices increased
--KIR 3.2.2 Knowledge and use of HIV prevention, STI prevention and treatment increased

1.2.2. KIR 3.3 Community Participation in Reproductive Health Care Improved
--KIR 3.3.1 Estate community participation in FP promotion, STI and HIV prevention activities increased
--KIR 3.3.2 Estate youth participation in adolescent sexual and reproductive health care increased

1.2.3 KIR 3.4 Range and quality of reproductive health services for women, men and youth expanded in the target agriculture estates
--KIR 3.4.1 Management capacity, practices and systems improved
--KIR 3.4.2 Range, quality and safety of reproductive health services for women, men and youth expanded in the target agriculture estates

1.3 Assessment of major factors that affected the achievement of project objectives and the degree to which they did so (substantially, partially, or negligibly). Factors divided into

(a) Factors not generally subject to government control, such as changes in world markets and prices, natural disasters, and war and civil disturbance.

(b) Factors generally subject to government control, such as macroeconomic policies and conditions, sector policies, and administrative procedures, including factors subject to MOHP

control.

(c) Factors generally subject to Project HOPE Center control

(d) Factors generally subject to Project HOPE/Malawi control, such as management effectiveness, staffing, cost changes, implementation delays, use of technical assistance, adequacy of monitoring and evaluation, and client/beneficiary participation.

(e) Factors generally subject to estate control.

1.4 Project sustainability. (a) likely, (b) unlikely, or (c) uncertain?

Assessment of the project's sustainability, defined as the probability of its maintaining the achievements generated in relation to its major objectives. In evaluating sustainability as likely, unlikely, or uncertain, major factors such as the following should be taken into account: business environment, management effectiveness, the project's technical and financial viability, social impact, estate commitment, MOHP commitment, and incentives for local participation. Sustainability may also be affected by a follow-on project that continues or expands project activities.

1.5 Assessment of Project Design

Indicate (a) whether the design of the project was appropriate for achieving objectives, and (b) how well the criteria for judging the achievement of objectives was quantified in the Technical Proposal.

1.6 Implementation delays

If there were implementation delays, discuss the major reasons for the delays, e.g. unrealistic implementation schedule; unexpected technical difficulties; changes in project scope; quality of management; delays in selecting staff; delays in receiving gifts in kind or other commodities; inefficient procurement or disbursement procedures; security problems; natural disasters.

1.7. Implementation Performance (highly satisfactory, satisfactory, deficient)

Elaborate on the reasons for the evaluation rating of highly satisfactory, satisfactory, or deficient, such as the quantity and quality of management and staff, the performance of partners (e.g., USAID, MOHP, estates), the level and timeliness of Project HOPE's contribution and USAID's contribution to the project, the adequacy of project monitoring and evaluation, and otherwise.

1.7.1 Project HOPE Center
1.7.2 Project HOPE/Malawi
1.7.3 MOHP/DHO/DHMT
1.7.4 USAID
1.7.5 Estates
1.7.6 HSAs/HCWs, CBDAs, and other community volunteers
1.7.7 Thandizani Moyo
1.7.8 Others (National AIDS Commisson? Reproductive Health Unit?)

1.8 Project Monitoring and Evaluation

1.8.1 Supervision (highy satisfactory, satisfactory, deficient)

Evaluation of project supervision performance should take into account such criteria as whether project progress was adequately reported; the adequacy and timing of supervision visits; whether problems were identified and remedied; and how successfully the Project HOPE Center, Project HOPE/Malawi, USAID, MOHP, and the estates worked together.

1.8.2 Health Information Management System (HIMS)
--MOHP Reproductive Health Logistic Management Information System (RHLMIS)
--estate database

2. **Partnership between Agricultural Estates, Project HOPE/Malawi, and the Ministry of Health and Population (MOHP)**

2.1 What was intended by the partnership (the stated objectives and unstated motivations)?

2.2 What happened? (outcomes: services provided, people trained, community capacities developed; and impacts: health benefits, increased protection, etc.)

2.2.1 What have been the actual development impacts and business benefits delivered through the partnership? What are the development impacts according to MOHP?

2.2.2 Were there any unintended/unexpected/spin-off development impacts or business benefits?

2.2.3 Have there been any negative outcomes of the partnership for estate communities, surrounding communities, business, and/or government (MOHP)?

2.2.4 Has there been, or is it anticipated that there will be, "added value" to the outcomes that would not have been the case without the partnership?

2.2.5 Have the positive gains on the estates under the earlier project been sustainable?

2.2.6 What are the costs to business? To the District level MOHP?
<u>Costs</u>.
--What are the project costs (by category and amount) that are financed by the estate?
--pharmaceuticals/commodities
--annual refresher training for health care workers
--training of replacement volunteer workers and mangers as they move among the estates
--salaries
--logistical support and transportation
--Have project costs changed over time?
--What is the percent of estate-financed project costs relative to the annual, total estate-financed budget for health care? Does the estate have a health care budget? If yes, what are the budget line items?
--What is the percent of estate-financed budget for health care relative to the annual, total estate budget?

2.2.7 What are the benefits to business? To the District level MOHP?

Benefits. Higher worker productivity? Decreased absences due to worker or family sickness? Save on funeral costs? Save on illness treatment costs? Generate goodwill among workers and their families? Generate goodwill with the government? Improved well-being of workers and their families? Improved business image? Good corporate citizenship?

2.3 How did the partnership come about?

- 2.3.1 What was the process to explore/plan the partnership, e.g., how the risks and costs for each party were weighed against the opportunities and benefits?
- 2.3.2 Who were the key actors who were instrumental in bringing the partners together?
- 2.3.3 What measures, if any, were taken to strengthen capacity (institutional and human) to make the partnership work?
- 2.3.4 What was the contribution of resources and the distribution of roles and responsibilities between the partners? Is there a Memorandum of Understanding?
- 2.3.5 How did/does the partnership work? Is there a lead partner who takes the initiative most of the time? (What measures were put in place from the outset intended to manage/maintain the partnership over time?) Is it really a partnership?
- 2.3.6 What have been the biggest challenges in working with MOHP, MOE, and the estates? And with Thandizani Moyo?

2.4 How is the partnership maintained/managed? (What is the process?)

- 2.4.1 What has been the experience with estates as partners? With the local MOHP? MOE? With Thandizani Moyo?
- 2.4.2 How do partners actually communicate, make decisions, and resolve grievances within the partnership (and with their respective constituents and other parties)
- 2.4.3 What is the extent of satisfaction with the way the partnership works? Is managed?
- 2.4.4 How does the partnership responds to changes in the external environment (e.g., financial business environment, economic, political, environmental, security, etc.) or internal environment (e.g., changes in key personnel, management, profit structure, etc.)?
- 2.4.5 How have roles and responsibilities changed over time?
- 2.4.6 Is there evidence of institutional change brought about by the partnership, e.g., institutionalization of the partnership for the longer-term, for example, within operational budgets? Changes in micro policy? Changes in incentive structures such as staff performance criteria and reporting requirements? Changes in overall attitude and behavior of the for-profit sector toward the non-profit sector and government and vice versa?
- 2.4.7 Given that the project had an estate approach, what did the partnership leverage for the estate community? What did business and the District/local government (MOHP) gain from the project?

2.5 How could things be improved?

2.6 What should not be attempted again?

2.7 Which aspects of the partnership (context, structure, process or outcomes) have replicability for scaling-up across the agricultural estate sector as a whole and to business in general?

3. Lessons Learned
   - 3.1 positive lessons learned
   - 3.2 negative lessons learned
   - 3.3 role of private employers in providing reproductive health programs
   - 3.4 quality of family planning counseling
   - 3.5 youth friendly services
   - 3.6 peer education of youth