



# Seeding Project Impact Assessment

September – December, 2007

Lilongwe, Malawi

January, 2008



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## **GLOSSARY**

AIDS	Acquired Immunodeficiency Syndrome
BC	British Council
DFID	Department for International Development (UK)
DTED	Department for Teacher Education and Training (Malawi)
EMAS	Education Methods Advisory Service (Malawi, Ministry of Education, Science and Technology)
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
MACRO	Malawi AIDS Counselling and Research Organisation
MoEST	Ministry of Education, Science and Technology
NAC	National AIDS Commission (Malawi)
HIV	Human Immunodeficiency Virus
SSI	Semi-structured Interview
TfaC	Theatre for a Change
TMO	Training and Monitoring Officer
UN	United Nations
VCT	Voluntary Counselling and Testing

## **FOREWORD**

Having worked in Africa school partnerships with the British Council since January 2006, I was appointed as Monitoring and Evaluation Coordinator to the Theatre for a Change (TfaC) Malawi programme in August 2007. TfaC state their commitment to objective and independent evaluation of their work and it had been agreed the British Council would provide support in this area, as part of its broader partnership with the organisation.

Though I had some knowledge of the successes of TfaC in Ghana, I had initial doubts about the effectiveness of drama and theatre as developmental tools, particularly in an HIV-prevention context. I specifically struggled to understand how meaningful changes in behaviour could be effected through performance and physical activity, while the fully participatory nature of the training and planning seemed subject to social or cultural biases.

My reservations have since been exposed as unfounded. On beginning my analysis of the TfaC methodology, it became clear that it encompasses a wide range of experiential and often innovative learning techniques that go beyond conventional drama and theatre. Rather than purely didactic education, the organisation empowers participants to reflect on their own behaviour, to identify components that can put them at risk of infection and to make important, though often difficult, changes. As this impact assessment will show, TfaC has demonstrated a unique ability to equip participants with skills, knowledge and attitudes that not only protect against personal HIV-infection, but could also contribute to a reduction in prevalence on a national scale.

With the Seeding Project completed, TfaC plans to significantly increase the size and scope of its Malawi operation, with training starting in Malawi's nine teacher training colleges in October 2008. From my evaluation of the work so far, I am confident of the organisation's ability to make a substantial, lasting impact on the rates of HIV infection among Malawian teachers and in the country as a whole.

A handwritten signature in black ink that reads "A. Stevenson". The signature is written in a cursive style with a horizontal line underneath the name.

**Andrew Stevenson, January 2008**  
**HIV and AIDS Programme Officer**  
**British Council Malawi**

## **INTRODUCTION**

The Theatre for a Change Malawi Seeding Project began in September 2007 after two preparatory visits and a viability pilot project in 2006, and after consultation with The Ministry of Education, Science and Technology (Department of Teacher Education and Development, Education Methods Advisory Service and the HIV and AIDS Desk Officer), DFID, the British Council and GTZ.

Malawi was selected for the TfaC Seeding Project due to the very high HIV infection rate and extreme poverty present in the country. Malawi ranks 164<sup>th</sup> out of 177 countries on the United Nations Human Development Index<sup>1</sup>, scoring particularly poorly on nutrition, food security, education, health provision, gender equality and GDP. Two thirds of the population live below the national poverty line<sup>2</sup> while 51% of the government budget comes from donor aid<sup>3</sup>. Malawi has one of lowest numbers of doctors per capita in the world (124 government doctors serving a population of 13 million<sup>4</sup>) with access to adequate healthcare impossible for the majority of its citizens. Approximately 14.1% of the population is infected with HIV<sup>5</sup>, with this proportion rising to above 30% in rural districts and to over 40% among certain social and vocational groups<sup>6</sup>. Teachers and children are at particular risk; studies have observed some districts losing 20% of their teaching population from AIDS-related illnesses over a five year period<sup>7</sup>, while there are 468,000 AIDS-orphans nationwide<sup>8</sup>. 14.5% of young women (15-24) are HIV positive compared to 6.5% of young men<sup>9</sup>, with many rural communities practising non-sterile female genital mutilation, child sexual initiation rites and widow inheritance. Rape, domestic violence and sexual assault are widespread.

Despite the significant challenges facing Malawi, there are indicators of progress. Since becoming democratic in 1994, Malawi's government has remained stable and committed to national development. In 2006, the economy grew by 13.9%<sup>10</sup> and primary school education has been publicly funded and free for all children since 1994. The government fertiliser subsidy increased production of maize by 700,000 tonnes in 2007, adding between \$100-160 million to the economy<sup>11</sup>. In the field of HIV, the National AIDS Commission was founded in 2001 and now provides millions of dollars of funding to prevention, home-based care, nutrition, capacity

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<sup>1</sup> *UN Human Development Index 2007/2008* (2005 statistics, <http://hdr.undp.org/en/reports/global/hdr2007-2008/>)

<sup>2</sup> *Ibid*

<sup>3</sup> *Ministry of Finance: Annual Economics Report (2007)*

<sup>4</sup> *Scottish Executive International Development: Report of Health Sector Visit to Malawi 18th-22nd April 2005* (<http://www.scotland.gov.uk/Publications/2005/06/15105055/50577>)

<sup>5</sup> *UNAIDS: AIDS Epidemic Update 2007*

(<http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2007/default.asp>)

<sup>6</sup> *National AIDS Commission: National Action Framework 2005-2009*

<sup>7</sup> *The Impact of the AIDS Epidemic on Primary and Secondary School Teachers and University Staff in Malawi* (Bennel and Kadzamira, 2003,

[http://hivaidsclearinghouse.unesco.org/ev.php?ID=3194\\_201&ID2=DO\\_TOPIC](http://hivaidsclearinghouse.unesco.org/ev.php?ID=3194_201&ID2=DO_TOPIC))

<sup>8</sup> *UNAIDS: Women Girls and HIV AND AIDS in Malawi* (2004)

<sup>9</sup> *Ibid*

<sup>10</sup> *Ministry of Finance: Annual Economics Report (2007)*

<sup>11</sup> *UN Human Development Report 2007/2008* (<http://hdr.undp.org/en/reports/global/hdr2007-2008/>)

building, medical and awareness raising projects every year. Donor aid to Malawi is growing both in quantity and effectiveness, with well funded presences of most major governmental and non-governmental international development agencies, including the United Nations, the UK Department for International Development, the International Red Cross, USAID, Medecins Sans Frontieres, Oxfam, Save the Children and Plan International. The current President of Malawi, Dr Bingu wa Mutharika, has expressed his dedication to defeating HIV in his country, working with local and international organisations to bring about sustainable and lasting change.

The TfaC Seeding Project selected 24 young Malawian graduates to receive training in HIV prevention, behaviour change, facilitation and child-centred learning techniques, with the long-term goal of employing them as teacher trainers. In addition to their own training, participants were required to create and regularly facilitate their own youth focus groups and to conduct extensive personal research on HIV, gender rights, advocacy and development work in Malawi. Following the Seeding Project, participant training will continue until October 2008 with the focus progressing from individual behaviour change and facilitation to advanced skills in multiple group facilitation, working with trainee teachers and education authorities, local and national gender rights promotion and research on new and innovative behaviour change strategies.

In October 2008 (start of Year Two), two trainees will be posted to each of Malawi's nine teacher training colleges to deliver learning modules that will be compulsory, covering child-centred learning techniques, personal and community HIV-prevention, education on child, gender and sexual rights, community development and personal life skills to help teachers work effectively in their postings. Over the course of a five year programme, and provided funding is available, TfaC will provide approximately 7,200 new teachers with this training resulting in an anticipated reduction in HIV infection rates and a minimum 100% increase in numbers attending voluntary counselling and testing (VCT). Over a four year period, trained teachers will go on to deliver similar training to 72,000 children. In terms of sustainability, delivery and management by international staff will be reduced from Year Three onwards with full programme delivery handed to local staff by Year Five. International donor support will be reduced from Year Three with local agencies expected to provide majority funding from Year Four onwards.

## **RESPONDENT GROUP**

Theatre for a Change Malawi advertised in the national press for applications for its volunteer training programme. The advertisements had the following stipulations:

- Minimum post-secondary/tertiary education (preferably first degree) or minimum of 2-years working experience with young people or people living with HIV and AIDS
- Commitment to working with disadvantaged youth in the community
- A real team player willing to support colleagues and work together
- Age should be between 18-28 years
- Fluent in English and Chichewa

Over 500 applications were received, with 80 candidates eventually shortlisted for the workshop and interview recruitment exercise. The shortlisting process was based on applicant levels of education (degree level qualifications in Education were preferred) and experience of working in a developmental, youth or community based context. Though a higher number of applicants were male, a 50-50 split was maintained in the shortlisting process. Candidates were required to complete the baseline survey in supervised conditions before taking part in the recruitment process

Final recruitment was based on performance in a group workshop and a formal interview with a panel of TfaC, GTZ/DTED, and British Council staff. Though the process was carried out with the eventual aim of creating new Training and Monitoring Officers (TMOs), this was not initially communicated to applicants in order to ensure they were not financially motivated. The workshop evaluated skills in communication, planning and facilitation, with emphasis also placed on motivation, gender sensitivity, HIV and AIDS awareness and dynamics within the group.

Following the workshops, half of the initial shortlisted group were invited back for interview process, with gender balance maintained. Interviews looked in more depth at understanding of the HIV pandemic in Malawi and a broader regional context, motivation for working and training with TfaC and understanding of gender and sexual rights issues, as well as assessing basic confidence and communication skill levels. Twelve young women and twelve young men were selected to take part in the TfaC training.

The majority of trainees came from the Central and Southern regions of Malawi, with over 50% coming from one of the two main cities – Lilongwe or Blantyre. All but one had been educated to degree level, with the majority either possessing a degree in Education or experience of working in an education context. All trainees possessed significantly higher levels of education and access to funds than the national average which, given the predominantly rural population of Malawi, is very low.

Following their selection, the 24 successful applicants were inducted into the Theatre for a Change training programme as trainee facilitators. Over the course of the seeding project they received ten weeks of training, covering:

- personal reflection on attitudes and behaviours;
- behaviour change;
- gender and sexual rights;
- advocacy;
- interactive and child-centred facilitation techniques;
- HIV history, treatment and physiology, and a variety of reduction and prevention methods;
- One day per week facilitating their own youth focus groups in local communities;

Over this ten week period, the number of participants in the training was reduced from 24 to 17, with seven of the trainees failing to demonstrate the necessary skills and abilities to progress further.

## **SURVEY TOOLS**

The TfaC Malawi Seeding Project Impact Assessment used a variety of evaluative tools to assess progress against set outcomes and indicators (see attached document).

### **Questionnaire**

Respondents were required to complete a questionnaire at the beginning of the Seeding Project in September 2007 and an identical questionnaire in December 2007 at the end. A control group that were not involved in training also took part in the baseline and endline questionnaires. The questionnaire comprised four key monitoring areas – **Knowledge, Attitudes, Behaviour and Gender and Sexual Rights** – with questions posed within the context of HIV in Malawi. Questions were decided by TfaC and British Council staff, in consultation with GTZ and an HIV Monitoring and Evaluation specialist from Voluntary Services Overseas.

### **Interviews**

Semi-structured interviews (SSIs), where the interviewer steered an informal conversation in the direction of the four key monitoring areas, were conducted during the baseline and endline surveys. They were used to assess trainees use and exposure to voluntary counselling and testing (VCT), understanding, practice and promotion of gender rights and advocacy skills. In addition to the SSI, trainees also received regular informal feedback meetings where their development was assessed.

### **Role play Observation**

Personal and life skills progress that was not assessable through interviews was evaluated through baseline and endline observation of specific role plays. The primary focus of these role plays was sexual encounters and relationships, particularly the ability to say no to sex and to negotiate for condom use in a variety of contexts. Ability to use voice, eye contact, body language, space and spoken language were assessed against set criteria.

### **Workshop Observation**

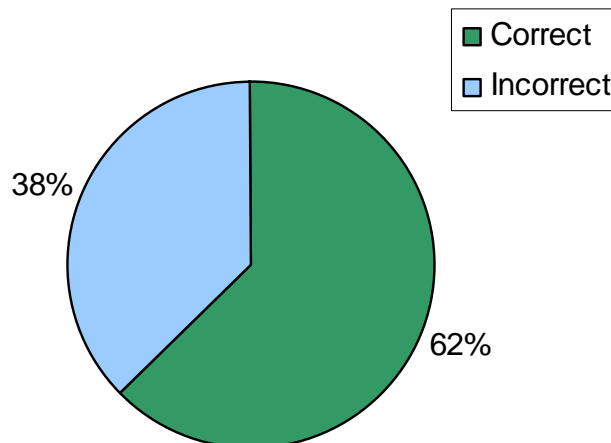
Workshop observation was used as an informal means of evaluating changing respondent attitudes and behaviour that was not apparent from the other formal survey methods. Observers and facilitators focused on personal attitudes to gender, sexuality, condom use and harmful cultural practices – subjects which can be considered taboo and are difficult to assess outside of a secure and supportive environment.

## **RESULTS – BASELINE AND ENDLINE SURVEYS**

### **PART A – KNOWLEDGE**

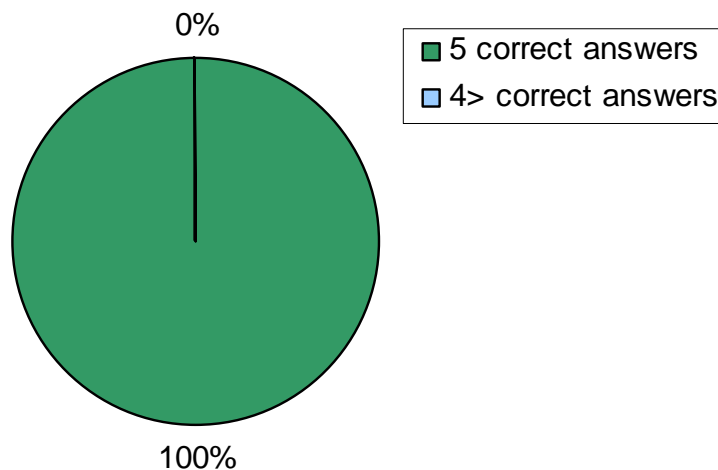
#### **1. “What do the letters HIV and AIDS stand for?”**

##### **BASELINE (September 2007)**



Despite the high levels of media and social exposure given to HIV and AIDS in Malawi, the initial baseline survey showed that less than two thirds of the trainees could identify and correctly spell Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome. Errors ranged from basic spelling mistakes to ambiguity.

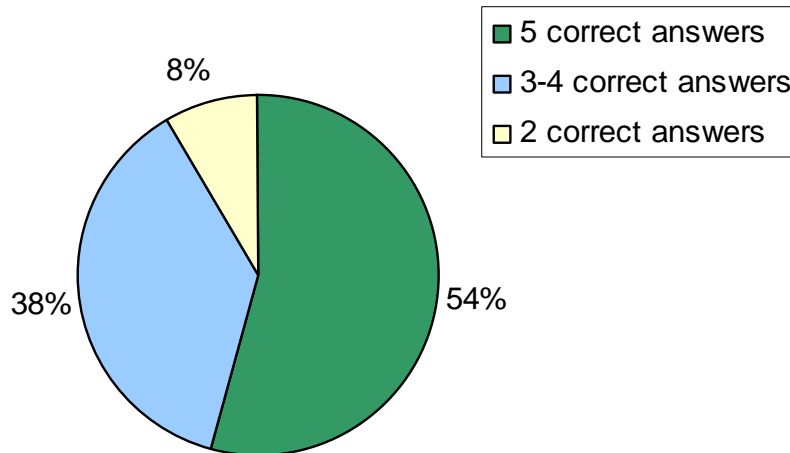
##### **ENDLINE (December 2007)**



The physiological research component of the Seeding Project allowed trainees to collectively investigate the medical nature of the virus, including the relationship between HIV and AIDS, anti-retroviral treatments, nutritional impact, multiple infections and the differences between HIV type I and type II. Trainees were required to present their research to the group on a regular basis and were subject to both peer and facilitator led assessment. The endline survey showed that 100% of trainees could identify and correctly spell the words of the HIV and AIDS acronyms.

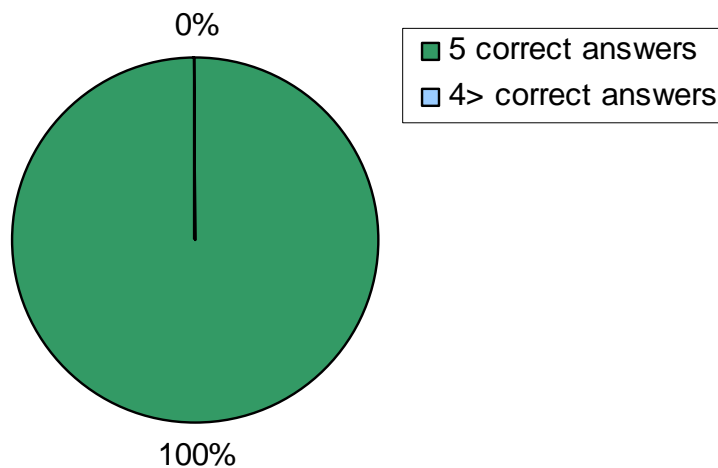
**2. "State five ways in which HIV infection can be transmitted."**

**BASELINE (September 2007)**



The baseline survey indicated that all respondents were able to identify sexual intercourse as a key factor in HIV infection, with the majority specifically mentioning unprotected sex with an infected person as the most common mode of transmission. Mother to child transmission was the next most common answer, with sharing of razors, toothbrushes and needles, non-sterile surgical or first aid procedures and blood transfusions also featuring regularly.

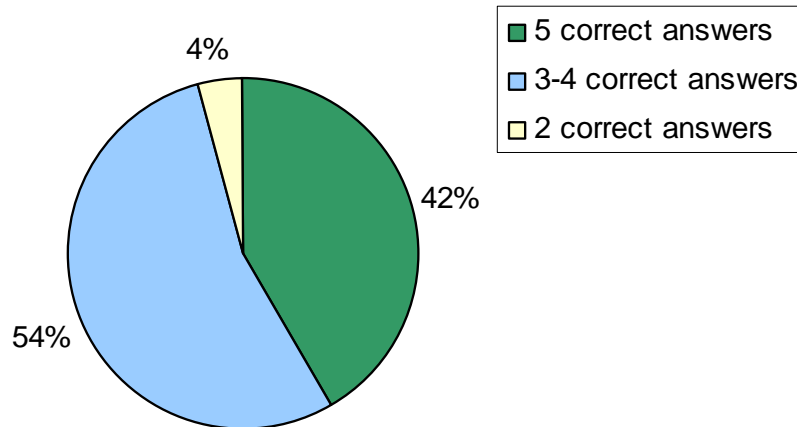
**ENDLINE (December 2007)**



Respondent answers to the endline survey showed a greatly increased awareness of HIV transmission, both in the number of modes listed and the detail attached to each of those modes. All trainees were able to focus on the primary causes of infection in Malawi, specifically unprotected sex and mother to child transmission, with less emphasis placed on negligible factors such as the sharing of toiletries and intravenous drug use.

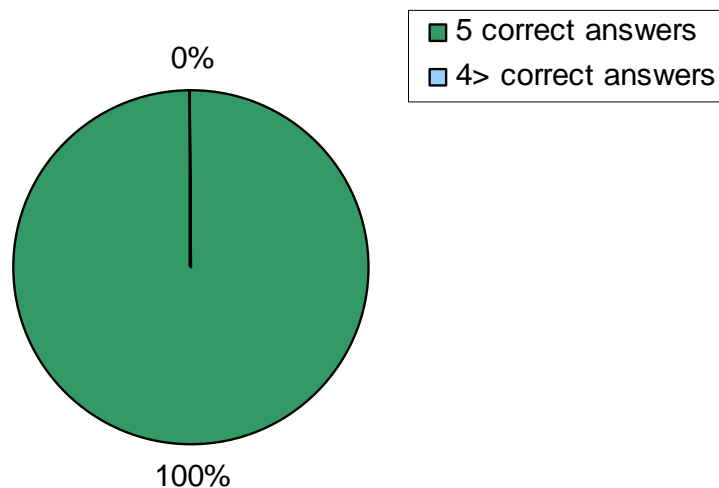
**3. “State five ways in which HIV infection can be prevented.”**

**BASELINE (September 2007)**



Awareness of the ABC prevention methods (Abstinence, Being Faithful, Condom Use) among respondents to the baseline was high, with 87% of respondent listing all three. Attitudes to condoms were particularly negative and none of the respondents listed knowing one's sero-status or VCT (Voluntary Counselling and Testing) as preventative measures. Non-sexual protections such as sterile medical equipment, rubber gloves and the nevirapine drug for newborns were also absent. The *NAC Behavioural Surveillance Survey (2004)* and trainee interviews indicate that adequate understanding of these methods is nationally very low.

**ENDLINE (December 2007)**

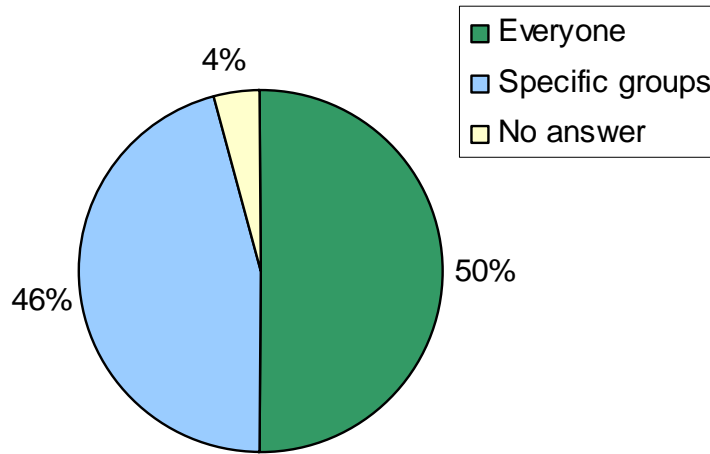


The endline survey indicated a significant improvement in trainee awareness of HIV-prevention, both individually and socially. The majority listed condom use as their first answer, with many also specifying “correct and consistent use”. Other answers highlighted complete, as opposed to partial, abstinence and faithfulness to one partner. All trainees were able to list at least two other prevention methods, with many specifically mentioning knowing one's own sero-status as a key factor.

**PART B – ATTITUDES**

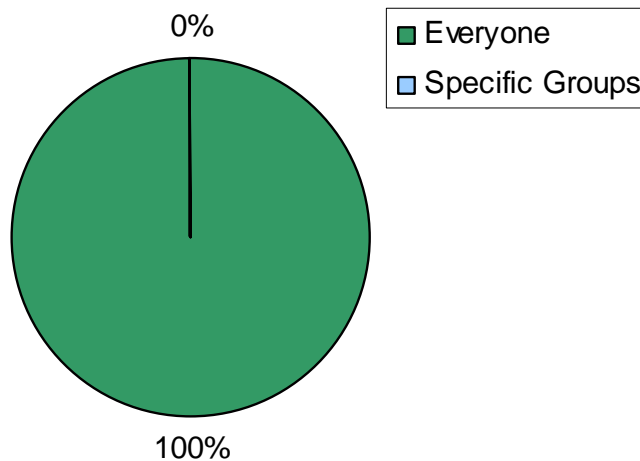
**4. “Who is at risk of HIV infection?”**

**BASELINE (September 2007)**



The baseline survey reflected high levels of stigma attached to HIV and AIDS. While half of the respondents stated that everyone was at some risk of contracting HIV, half focused on specific groups, listing variations on “immorality” and “sexual freeness” in their answers. A significant degree of gender bias was observed among respondents, with several specifically stating that women were more responsible for the spread of HIV.

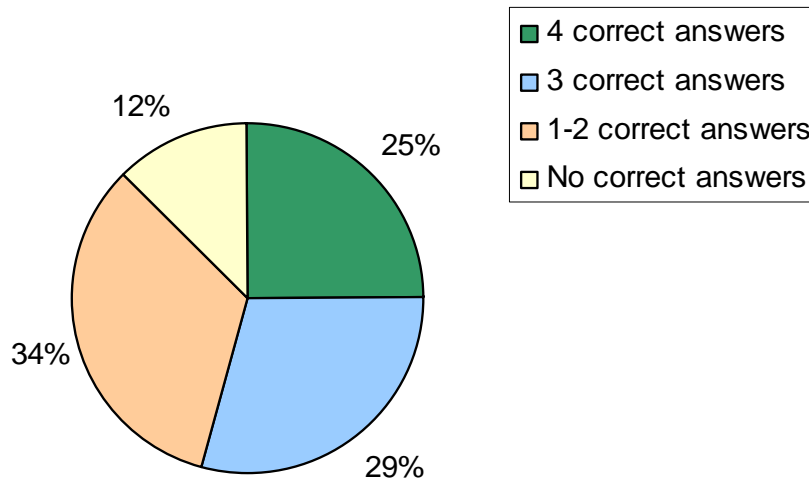
**ENDLINE (December 2007)**



The endline survey showed substantial improvement in the trainee’s understanding of HIV-risk. All trainees stated that everyone was at some risk from the virus in their questionnaire answers, while those interviewed demonstrated a high awareness of the specific gender and cultural practices that can contribute to the demographic spread of HIV.

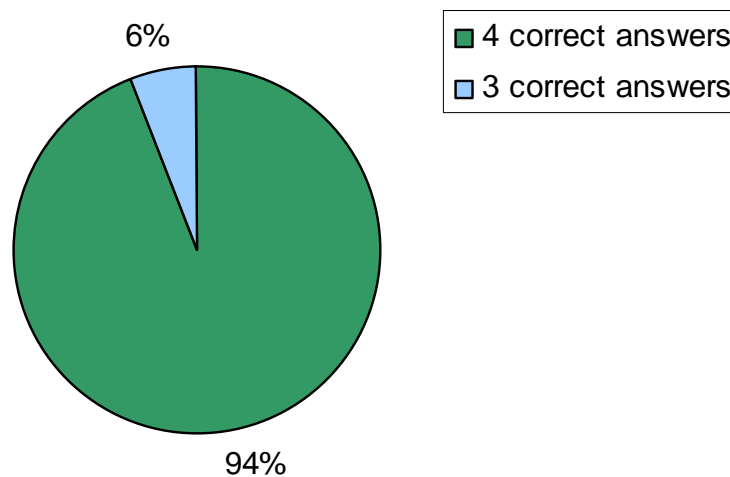
**5. “State four *attitudes* of young men that put themselves, young women or others at risk of HIV.”**

**BASELINE (September 2007)**



The baseline survey indicated that less than one third of the respondents could list four risky attitudes with many unable to make the distinction between attitudes that carried a specific HIV risk, such as a dislike of condoms, and those that did not, such as smoking cigarettes or disinterest in religious practice. The low understanding of attitudinal factors in HIV-risk reflected a broader inability among the trainees to engage with prevention on a personal level. Many were unwilling to consider the possibility that their own behaviour could put them at risk.

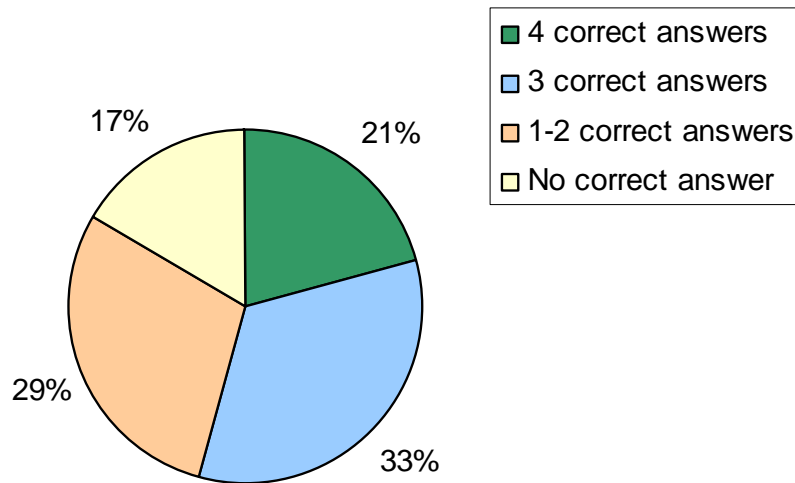
**ENDLINE (December 2007)**



The endline showed a marked improvement in understanding of how personal and social attitudes can increase risk of HIV-infection. Most positively, virtually all trainees included some element of gender in their stated answers, such as the objectification of women or the belief that husbands are naturally entitled to multiple partners. Interviews and workshop observation also indicated an advanced and very perceptive understanding of attitudes among males that can increase HIV-risk, as well as the potential causes of and responses to these attitudes.

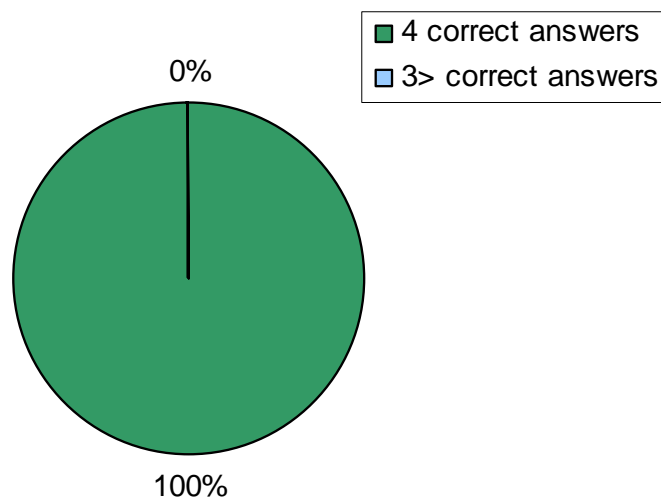
**6. “State four *attitudes* of young women that put themselves, young men or others at risk of HIV.”**

**BASELINE (September 2007)**



The baseline indicated a similar difficulty among the trainees to engage with female attitudes in the context of HIV-risk. Also of note was the degree of gender bias, which was not present in corresponding answers for men. Typical of these responses were “immoral attitudes to sex”, “too interested in fashion” and “refusing to marry”.

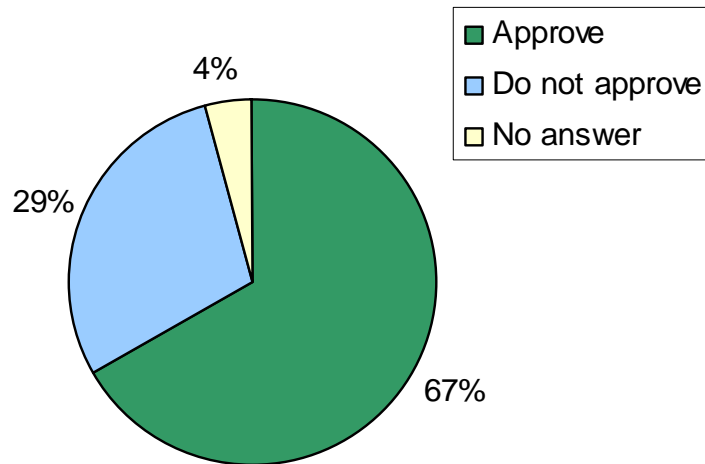
**ENDLINE (December 2007)**



The endline survey reflected a significantly improved understanding of the role attitudes can play in HIV-risk. Of note was the degree of gender sensitivity demonstrated in respondent answers. While the baseline survey reflected several gender biases among the respondent group, endline responses demonstrated a high degree of empathy in their focus on the difficulties encountered by women. Answers in the endline included “believing that women need any man to be happy and safe”, “believing that carrying condoms is immoral”, “thinking that a husband is allowed more than one woman” and “thinking that you can be popular by having sex with lots of boys”. Interviews and observation also demonstrated a significantly improved ability among trainees to self-reflect and to identify the personal attitudes that could contribute to their HIV-risk

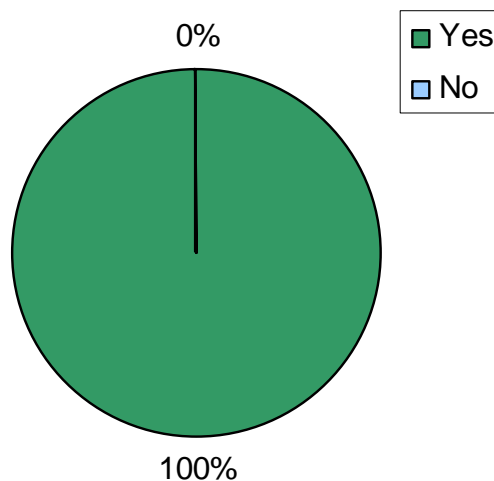
**7. “Do you approve of condom use in a sexual relationship?”**

**BASELINE (September 2007)**



29% of respondents to the baseline survey actively disapproved of condom use in any sexual relationship. While there is no comparable national data on condom approval, the *NAC Behavioural Surveillance Survey (2004)* indicates that only 57% of Malawian teachers, the closest social group to the trainees, believe that condom use can protect against HIV. This is in part a reflection of the popular belief that any association with condoms, in particular carrying them on your person, is an indicator of sexual immorality or promiscuity.

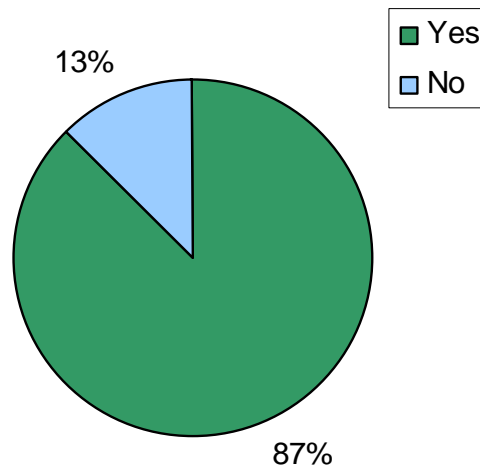
**ENDLINE (December 2007)**



The endline survey showed a marked change in attitudes towards condoms, both in a societal context and in personal relationships. 100% of trainees stated that they approved of condoms in a sexual relationship. Also of note was the complete absence of negative moral judgement present in trainee responses both in the questionnaire, and in workshops and interviews. While some trainees preferred either abstinence or faithfulness as a prevention method in their personal lives, those favouring condoms were able to talk openly and honestly about their own beliefs and experiences without fear of condemnation.

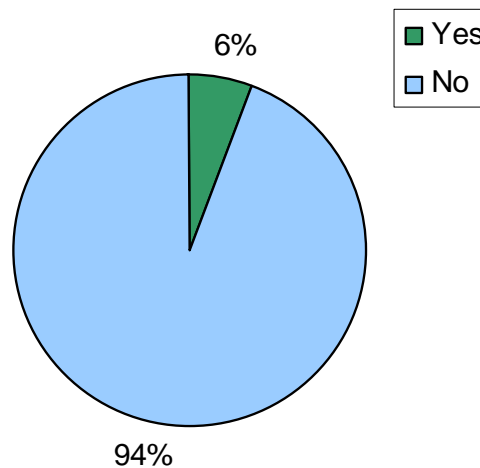
**8. "If you discovered a person was HIV positive, would you tell anyone else?"**

**BASELINE (September 2007)**



The baseline survey indicated an alarmingly high number of respondents willing to reveal another person's sero-status without their permission. While this posed serious confidentiality issues for their work with TfaC, interviews with respondents did indicate that those prepared to disclose someone's status would do so with the aim of providing assistance. Despite this, none indicated that they would gain permission before doing so.

**ENDLINE (December 2007)**

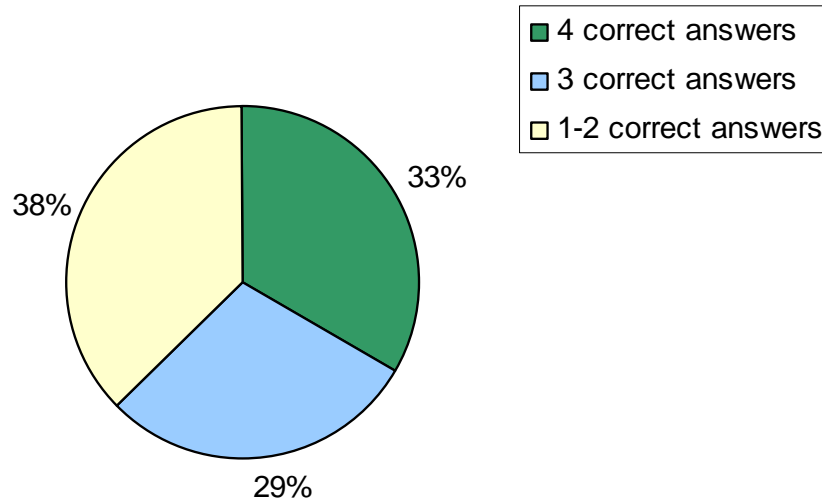


94% of trainees stated that they would not reveal another person's positive status and interviews indicated a thorough understanding of the sensitive confidentiality issues around personal status. In interviews, all trainees demonstrated a significantly improved awareness of the professional issues of working with HIV positive people. Encouragingly, all retained their personal commitment to providing assistance but preferred a participatory approach carried out with the express consent of the HIV positive person.

**PART C - BEHAVIOUR**

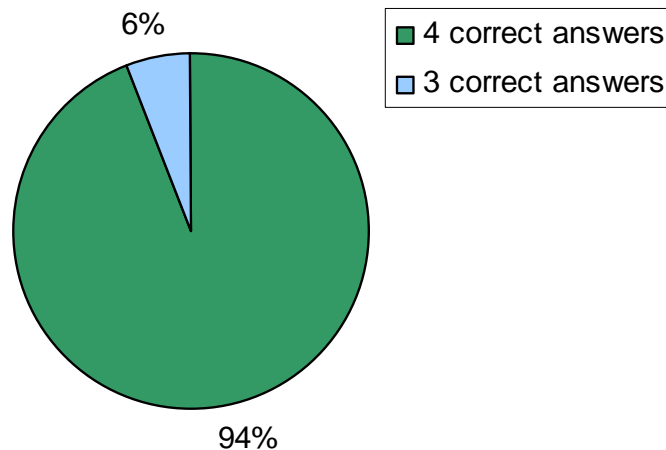
**9. "State four actions or behaviours of young men that put them, young women or others at risk of HIV infection."**

**BASELINE (September 2007)**



The baseline survey showed that the number of respondents able to identify risky actions or behaviours in young men was significantly higher than for attitudes, with all able to identify one or more. 62% were able to identify three or more, though the incidence of incorrect answers, particularly those stating undefined or general immorality, was high. As with the questions on attitudes, interviews indicated a strong difficulty or unwillingness to reflect on personal behaviours that could increase HIV risk.

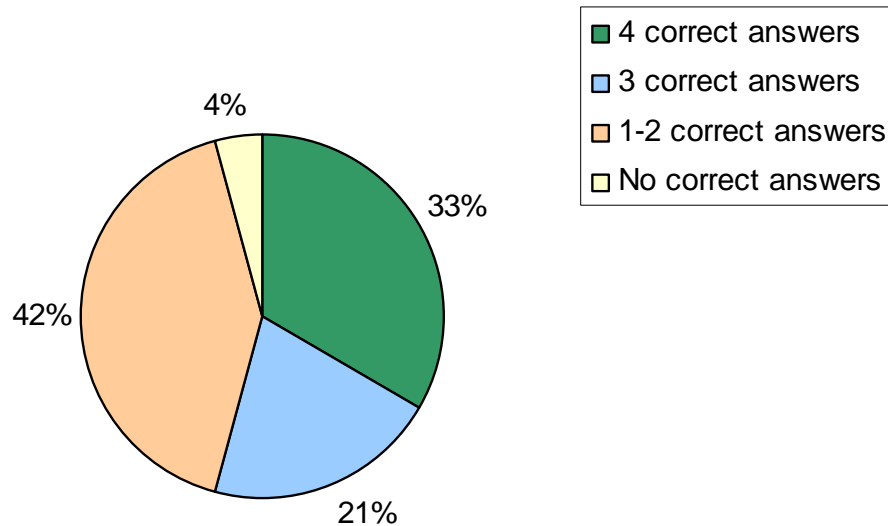
**ENDLINE (December 2007)**



The endline survey demonstrated a significantly increased degree of insight into behaviours that can contribute to HIV-risk among young men. Where respondent answers to the baseline focused on indirect risk-factors, such as drinking excessively, endline answers focused on specifically risky behaviours, such as unprotected sex with multiple partners or visiting sex workers. Also of note was a significantly increased capacity for self-reflection among trainees, with all willing and able to identify behaviours of their own that could increase their risk of contracting HIV.

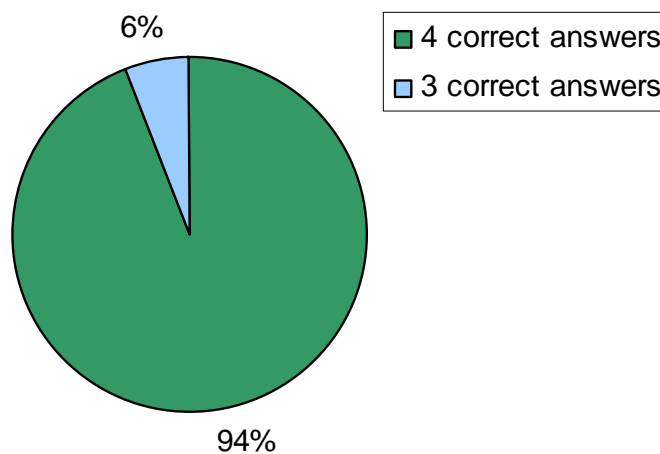
**10. “State four *actions or behaviours* of young women that put themselves, young men and others at risk of HIV infection.”**

**BASELINE (September 2007)**



The number of respondents able to list risky behaviours among young women was similar to those among young men, however, a significant degree of gender bias was again present. While the majority of respondents listed two or three correct answers, they also typically included one answer that did not have a direct relational impact on HIV risk, such as “having many male friends” and “thinking too much about fashion and clothing.”

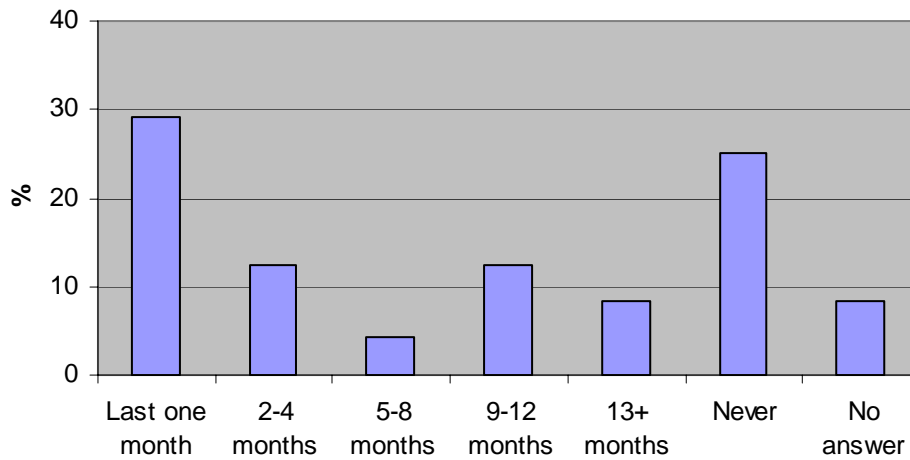
**ENDLINE (December 2007)**



The endline survey showed a substantial increase in the number of respondents able to identify risky behaviours among young women. Non-direct risk factors, such as going to bars, were not present, while in interviews trainees demonstrated a high degree of gender sensitivity and insight into the challenges around women’s sexual health in Malawi. A widespread revelation among young women in the group that they could change their own behaviour to protect against HIV-infection was also observed.

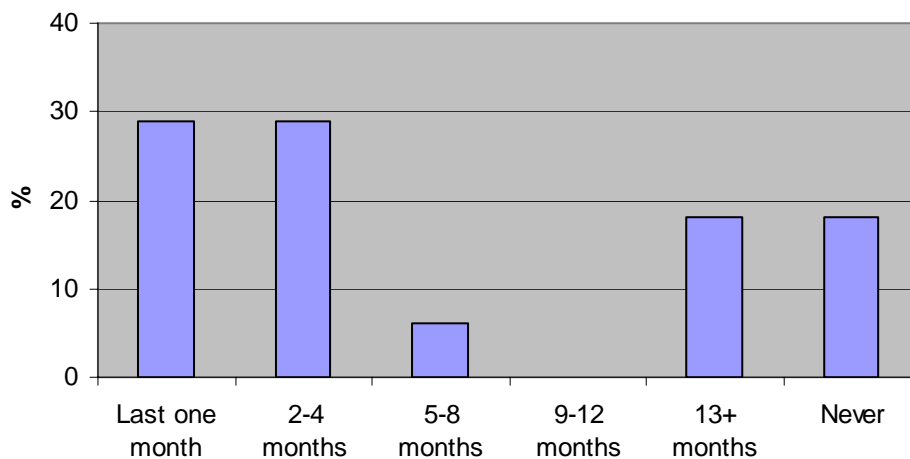
**11. "When was the last time you had sex?"**

**BASELINE (September 2007)**



Given the infrequency of frank discussions around sexual relationships in the initial workshops, it is expected that the baseline results for sexual activity had a significantly higher error margin than other areas. The baseline indicated that around half of the respondents had been sexually active in the previous six months with 25% stating that they had never had a sexual encounter or relationship.

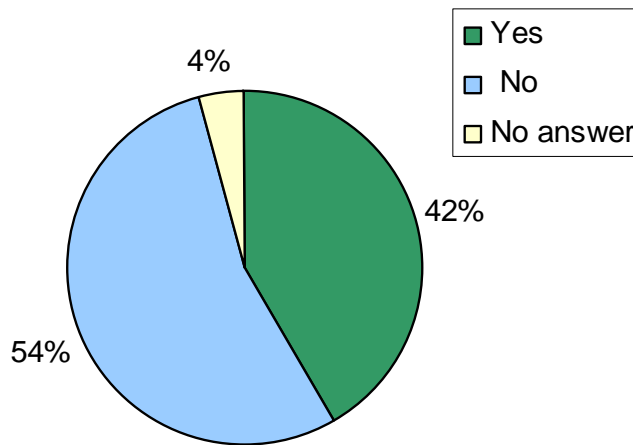
**ENDLINE (December 2007)**



Given the increasingly open and honest discussions around sexual relationships during the training workshop, it is expected that the error margins relating to sexual relationships in endline data are minimal. The survey indicates that over 60% of trainees have been sexually active in the past six months, with 18% stating they have never had a sexual encounter or relationship.

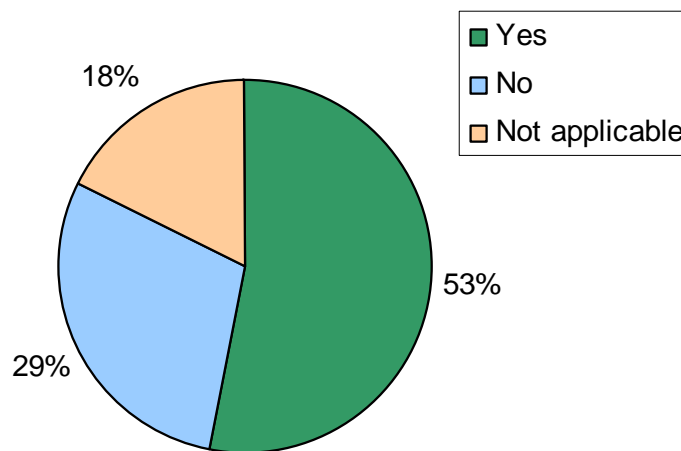
**12. "Do you have a sexual partner now?"**

**BASELINE (September 2007)**



42% of respondents indicated that they were in a sexual relationship in the baseline survey, however, it was again suspected that the error margin for this result is higher than the average. 4% declined to answer.

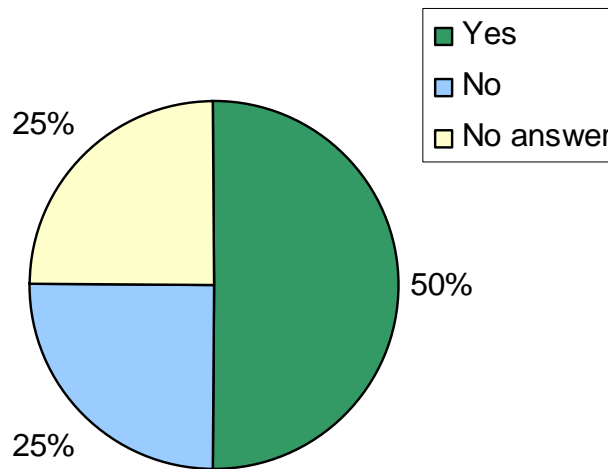
**ENDLINE (December 2007)**



53% of trainees stated they had a current sexual partner in the endline survey, which has been broadly confirmed in group discussions around the issue. Though this represents a statistical increase, it is highly likely that this is due to the newfound in discussions on sex, not a net increase in the number trainees in a sexual relationship. 18% had never had sex and marked the question "not applicable".

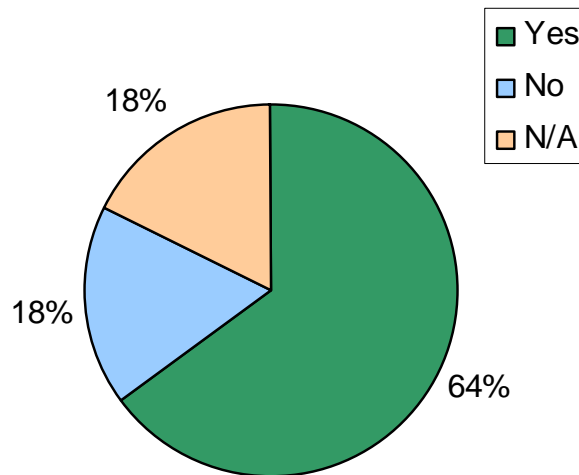
**13. "Did you use condoms that last time you had sex?"**

**BASELINE (September 2007)**



Though 50% of respondents to the baseline survey indicated that they regularly used condoms, subsequent interviews and group discussions indicated this proportion to be significantly lower. Several members of the respondent group were in monogamous, faithful relationships and several others preferred abstinence as a preventative measure for religious reasons. However, it was indicated that the majority of the unattached, sexually active section of the group were inconsistent in their condom use.

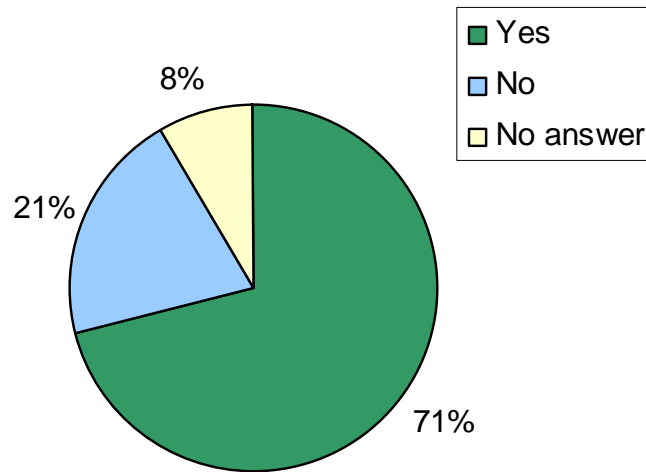
**ENDLINE (December 2007)**



The endline survey showed a 14% increase in the total number of trainees using condoms correctly and consistently in their sexual relationships, however, this proportion was substantially higher among single, sexually active trainees. Though it was not possible to collect statistical data among this specific group, informal interviews and group discussions indicated that all were committed to condom use in any case of unprotected sex with a new or untested partner.

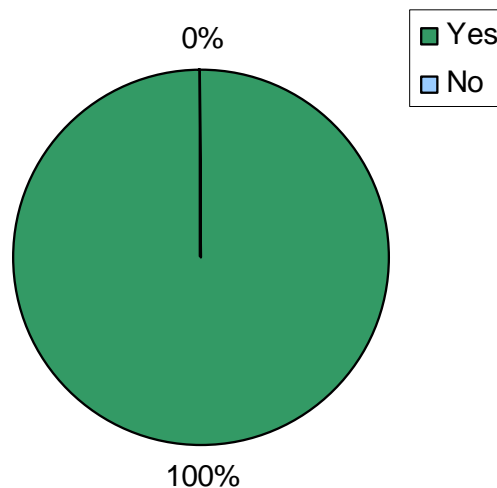
**14. "Have you ever visited a Voluntary Counselling and Testing (VCT) Centre?"**

**BASELINE (September 2007 - questionnaire)**



Almost three quarters of respondents to the baseline survey stated that they had visited a VCT clinic at some point in their lives. Given that the national average for VCT testing in Malawi is under 5% it is very likely that in reality this figure was far lower. Subsequent group discussions and one-on-one interviews confirmed this, with around 90% of trainees very uncomfortable with the prospect of visiting a centre and a continued high degree of resistance to VCT for the first six weeks of the programme.

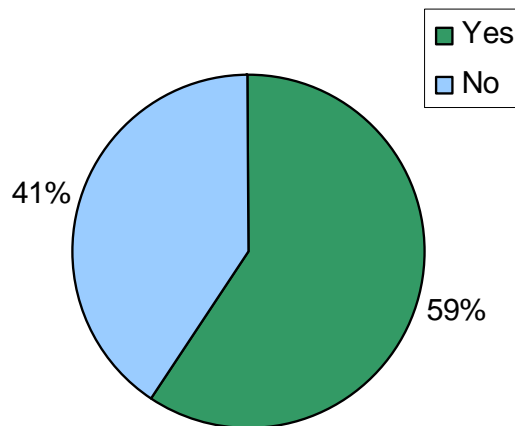
**ENDLINE (December 2007 – MACRO data)**



After receiving anonymous data from the Malawi AIDS Counselling and Research Organisation (MACRO), which is responsible for providing VCT services in Lilongwe, it was established that 100% of the trainees had gone for confidential counselling and testing. This represents a major success for the TfaC methodology, and is a strong indication of their potential future effectiveness. Several baseline responses had reflected the popular stigma around VCT – TfaC's ability to change these beliefs in such a short space of time is impressive.

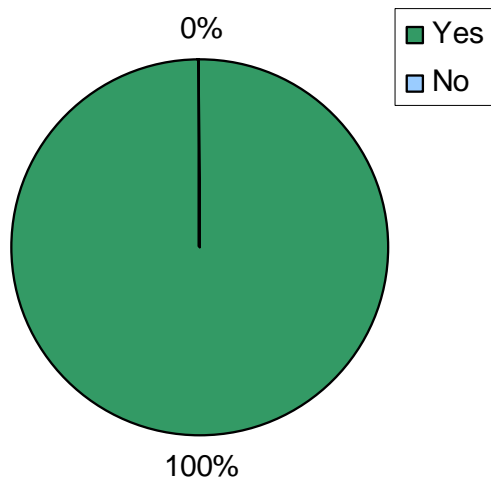
**15. “Do you know your own HIV status?”**

**BASELINE (September, 2007 – interview)**



Though fewer respondents to the baseline survey indicated that they knew their own status than had visited a VCT clinic, it is still expected that the proportion genuinely aware of their own status was significantly lower than 59%. Subsequent interviews and initial reactions to VCT among the trainees have confirmed this, with a strong reluctance to participate in discussions relating to risk and status, and a reluctance to consider going for individual, confidential, anonymous VCT.

**ENDLINE (December, 2007 – MACRO data)**

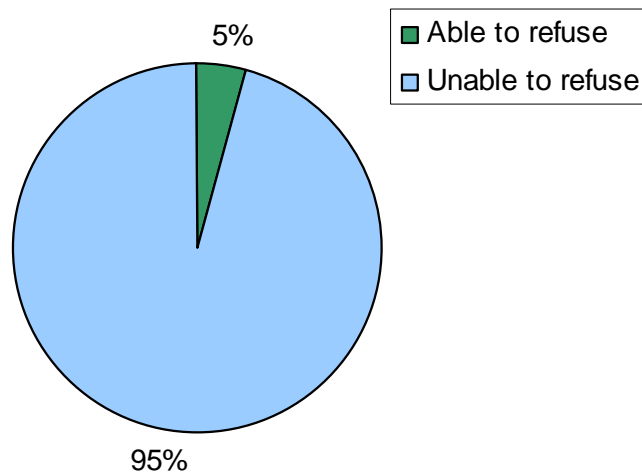


All respondents to the endline survey indicated an awareness of their status, which has been confirmed by MACRO data. While the majority of trainees were initially very vocal in their opposition to VCT, all have subsequently expressed their happiness and relief at knowing their status and reported a feeling of personal empowerment at being able to respond accordingly. A strong desire to advocate for VCT among their peers in their personal and professional lives was also observed.

## WORKSHOP AND ROLE PLAY OBSERVATION

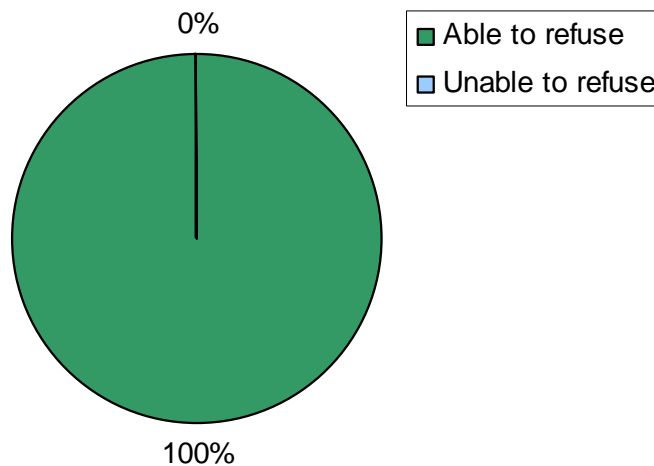
### 16. Ability to assertively say no to sex

#### BASELINE (September 2007)



The baseline respondent group were assessed on their ability to say no to sex through a series of interviews and role plays. 95% of the group were incapable of saying no effectively, resorting to retreat or timid negotiation in role play. In interviews, the majority of respondents acknowledged their difficulty with assertiveness in sexual encounters, while numerous female and several male respondents expressed surprise that women had a right to refuse sex to a long-term partner or spouse.

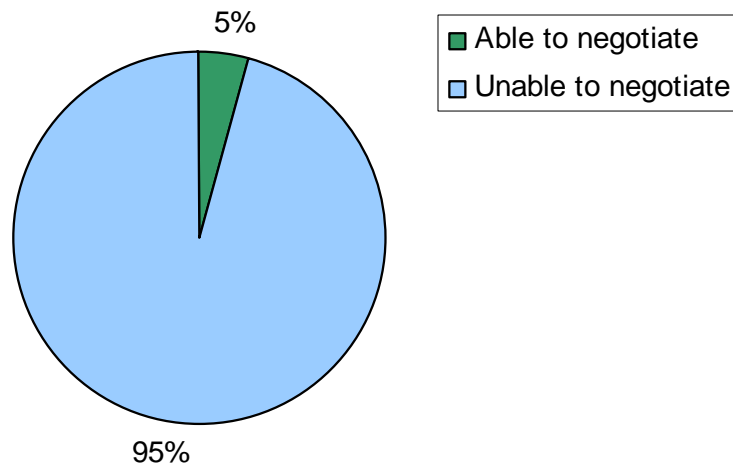
#### ENDLINE (December 2007)



100% of trainees demonstrated the ability to refuse sex assertively and convincingly during the endline survey. Body language, voice, eye contact and language were all used intelligently and, where necessary, forcefully. The greatest improvement was observed among the young women of the group, the majority of whom have translated their new skills into a passionate commitment to educate their peers in sexual rights. Also of note was the increased awareness among the young men of the group that they were also entitled to, and capable of, saying no to sex when they did not want it, thereby significantly reducing what was previously perceived as an unavoidable risk.

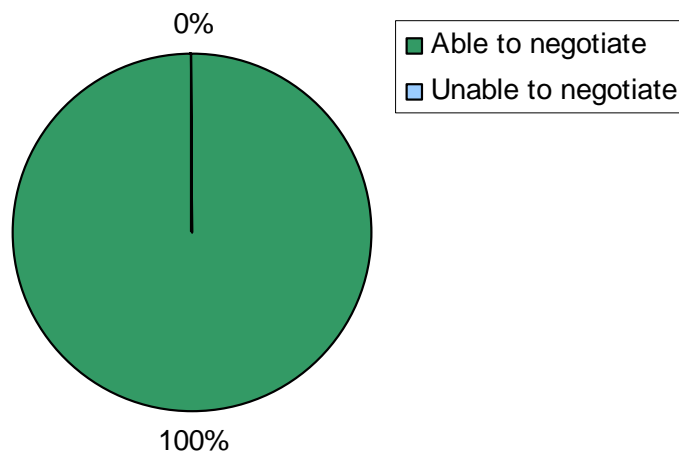
**17. Ability to negotiate for condom use**

**BASELINE (September 2007)**



Only 5% of respondents to the baseline survey were capable of assertively negotiating condom use, with the remaining 95% becoming immediately defensive in role play. All respondents acknowledged their difficulty with the issue in interviews and many reported the various negative or prohibitive cultural attitudes towards condom use in Malawi.

**ENDLINE (December 2007)**

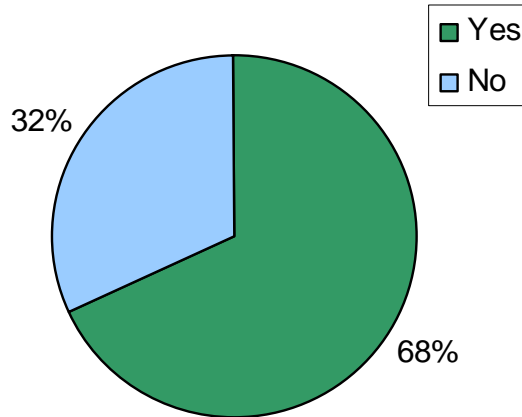


Trainees demonstrated a vastly improved ability to negotiate for condom use during the endline assessment, with 100% able to use voice, body language and eye contact effectively. Of particular note was ability among trainees to modify their negotiation strategy as the situation demanded, ranging from affectionate suggestion to stubborn insistence. Subsequent group discussions also indicated a willingness among trainees to promote condom use as an equal preventative measure to abstinence and being faithful.

**PART D – GENDER AND SEXUAL RIGHTS**

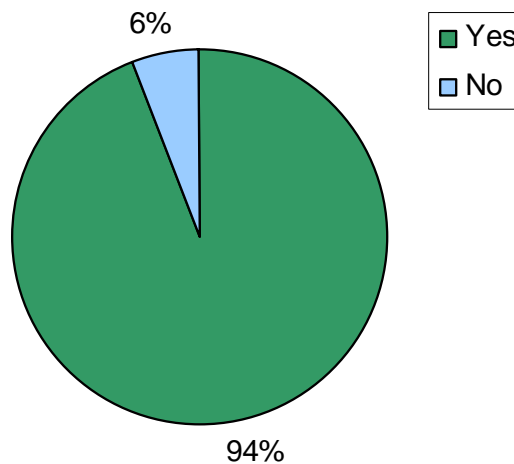
**18. “Do you practice your gender rights?”**

**BASELINE (September 2007 - interview)**



During interview based assessment 68% of the baseline respondent group stated that they practised their gender rights and were able to provide examples and experiences of doing so. Despite this, the number of women practising their gender rights was significantly lower than that of men, with several expressing genuine surprise upon learning of the basic gender equality of human, social, civil, political and financial rights. The majority of male respondents were confident in the practice of their own personal rights, though the concept of gender based rights was new to many. There were a high number of recounted cases where these young men had directly, though minorly, infringed on the rights of women in the past.

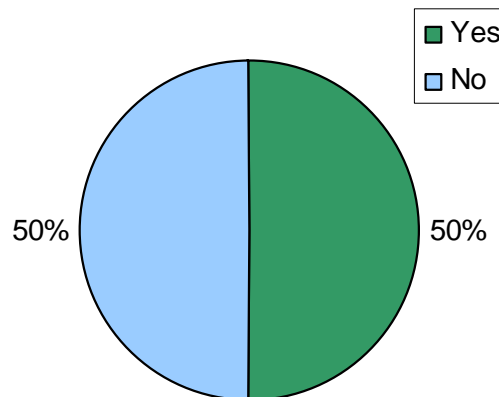
**ENDLINE (December 2007 - interview)**



The endline survey demonstrated significantly increased ability among the trainees to both identify and practice their gender rights. The most substantial improvement was observed among the female trainees who, despite living in often highly patriarchal, hierarchical environments, had all become passionate and committed to acting as role models for their peers. This change represents another major success for TfaC given the low level of rights-based education or experience among the trainees at the beginning of the Seeding Project.

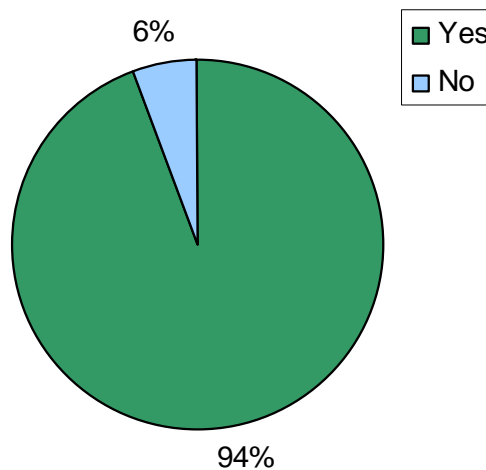
**19. “Do you promote your gender rights?”**

**BASELINE (September 2007)**



Though 82% of respondents believed they promoted their gender rights, only 50% were able to provide examples of doing so. Several of the women who had been prevented from practising their own gender rights in their home environment, had been active in the promotion of women’s rights elsewhere. Conversely, several of the men who had a higher than average understanding of gender equality had actively avoided promoting women’s rights in the past. Examples of rights promotion tended to be social, involving direct familial intervention with the aim of redressing gender imbalances, the protection of abused or harassed women and pushing for equal right to resources, finance or property.

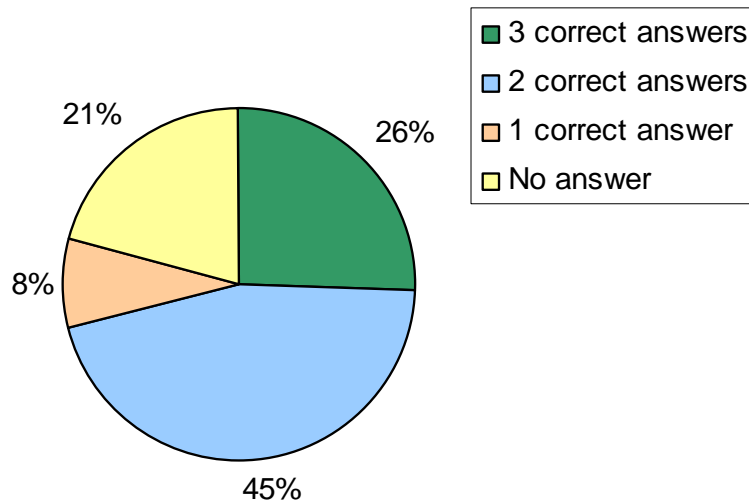
**ENDLINE (December 2007)**



The endline survey demonstrated a significantly increased involvement among all trainees in gender rights promotion and a greater depth of awareness and understanding around rights issues. The range of examples given was significantly broader than in the baseline, this time including direct political advocacy, developmental work with disadvantaged social groups, facilitation of behaviour change workshops and focus groups, as well as the existing examples of social or communal promotion.

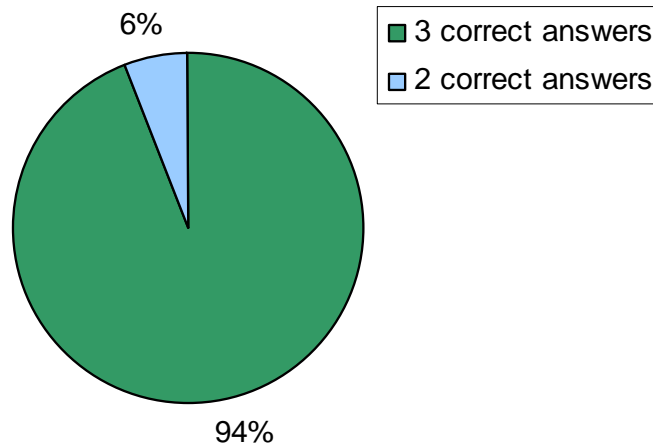
**20. "State up to three components of gender rights."**

**BASELINE (September 2007)**



Only 26% of respondents to the baseline survey were able to list three components of gender rights, indicating comprehensive understanding and practise was low. Answers were typically simplistic, with none of the trainees making a connection between gender rights and HIV prevention.

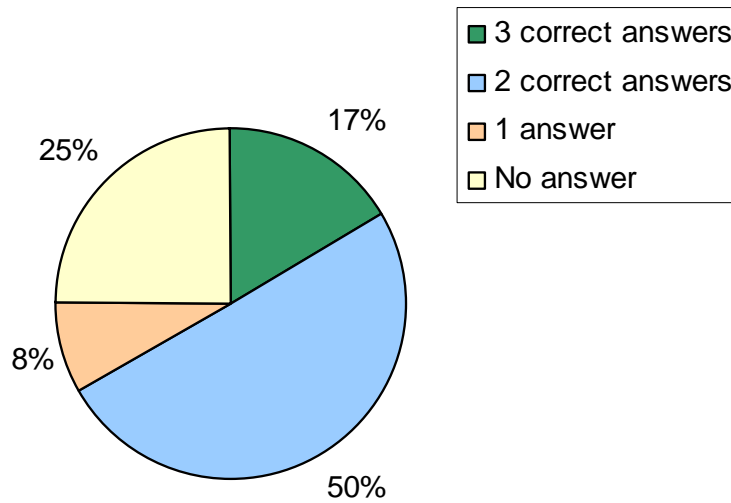
**ENDLINE (December 2007)**



Trainees demonstrated a significantly increased understanding of the complexities of gender rights both in the endline survey and in observation of day-to-day training. Whereas a typical example of a baseline response may have been "right to own a house", responses in the endline survey included details on the social, familial and economic benefits of equal property and financial rights for women, as well as a strong commitment to the promotion of such rights within a Malawian cultural context. Encouragingly, awareness of gender rights was broadly similar across both sexes, with all trainees able to speak and present articulately on the issue.

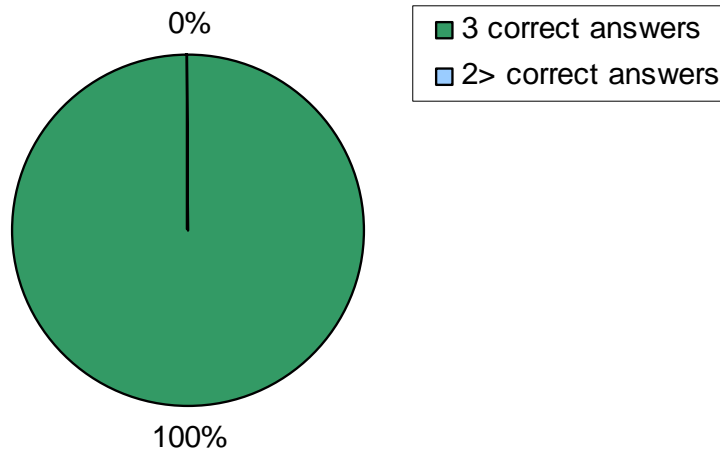
**21. "State up to three components of sexual rights."**

**BASELINE (September 2007)**



Basic awareness of the issues surrounding sexual rights was relatively high with 75% of respondents able to list at least one component. However, less than one fifth of respondents were able to list three components of sexual rights, indicating comprehensive understanding and practice was low. Interviews indicated that women in the group struggled to identify their own sexual rights, particularly those within a relationship. The right to say "no" to sex with one's partner came as a surprise to many respondents.

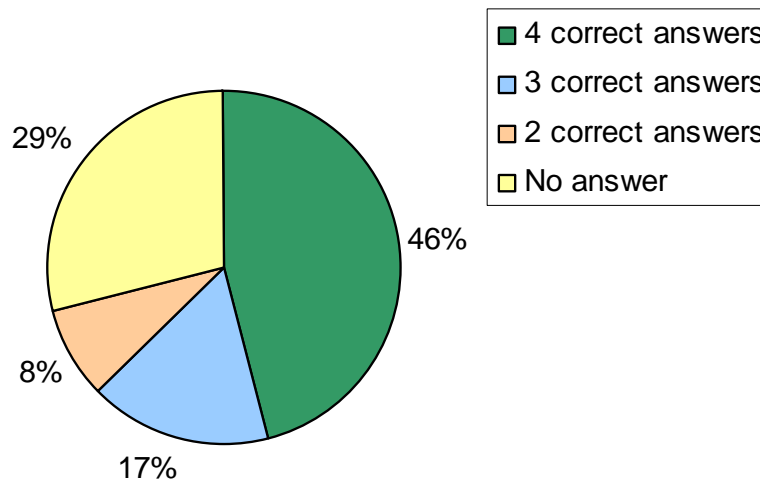
**ENDLINE (September 2007)**



All trainees were able to list three components of sexual rights, while interviews and workshop observation demonstrated the articulacy and passion with which the group can now work in this area. In addition to developing an advanced understanding of women's sexual rights, trainees were able to talk eloquently and convincingly on strategies for their promotion.

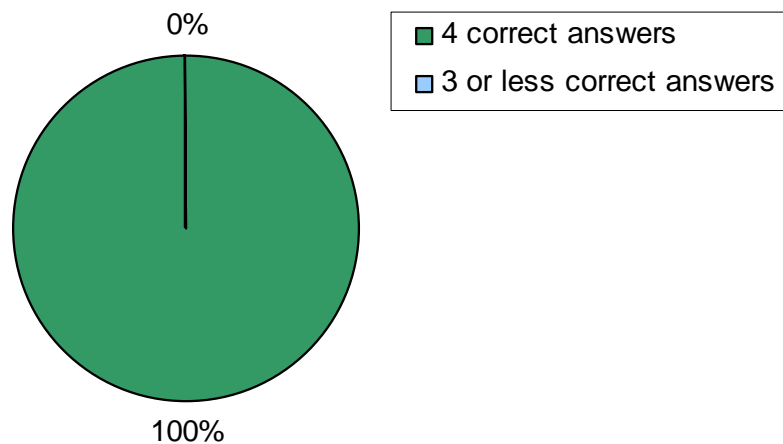
**22. “State up to four ways you can advocate for the gender and sexual rights of young people.”**

**BASELINE (September 2007)**



Though almost half of the respondent group could list four gender and sexual rights advocacy strategies, almost one third could not list any. Though valid, the majority of correct answers were simplistic in nature, such as “speak to the government”. Subsequent interviews and workshop assessments indicated a cursory understanding of engagement with local and national power structures, but very little understanding of the methods for doing so.

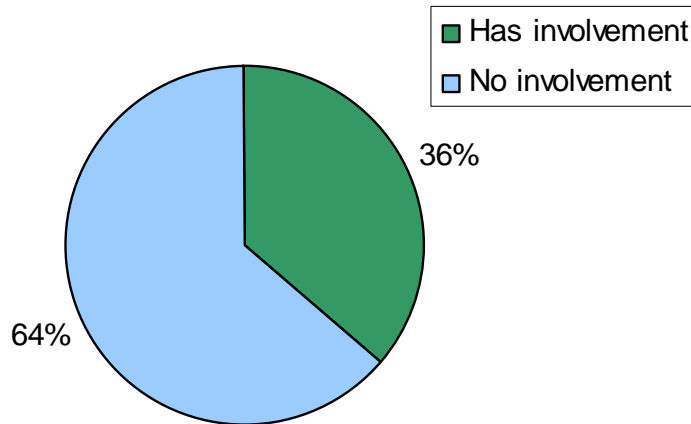
**ENDLINE (December 2007)**



100% of trainees were able to list four gender and sexual rights advocacy strategies in the endline survey, with several going on to volunteer more. Trainee interviews indicated a substantially improved understanding of advocacy issues and strategies, while in workshop assessments participants demonstrated high levels of commitment and creativity to the promotion of gender and sexual rights.

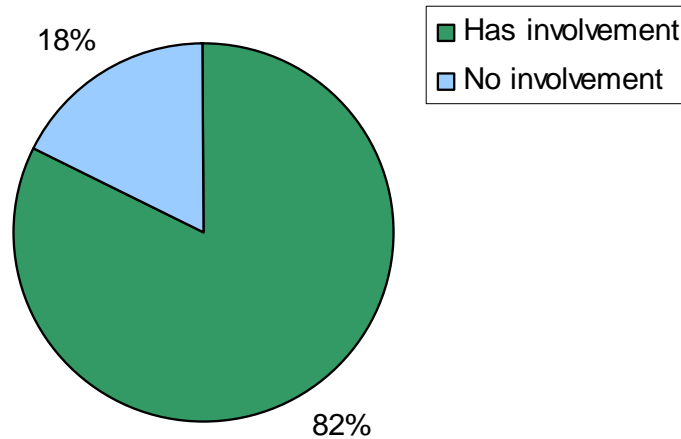
**23. “What involvement, if any, do you have with decision makers and people in authority?”**

**BASELINE (September 2007 - SSI)**



Though 50% of respondents stated that they had some involvement with leaders, decision makers or people in authority, only 36% could provide valid examples in interview. Typical involvement included local leaders such as church pastors, chiefs, Traditional Authorities or local healthcare NGOs.

**ENDLINE (December 2007 - SSI)**



Though trainees were responsible for facilitating focus group workshops for only one day per week during the Seeding Project, over 82% were able to give solid examples of involvement with decision makers, leaders, or people in authority. The nature of this involvement had also shifted significantly, from personal or short-term professional relationships to direct working partnerships. Several of the trainees were also able to give examples of work with high level contacts at NAC, national and local government and major domestic and international development agencies, including the UN.

## **SUMMARY**

### **Knowledge**

#### **Baseline**

Trainee awareness of HIV and AIDS at the outset of the Seeding Project was relatively high, though lacked depth. Less than two thirds could correctly identify the words of the two acronyms, while understanding of transmission and prevention was typically low. Prejudices or biases against particular social groups were apparent in the baseline questionnaire and interviews, with several trainees regularly stating that undefined “immorality” could have an impact on HIV-risk. Women who drank alcohol or had male friends were particularly singled out as being at risk of, or indirectly responsible for, HIV infection.

#### **Endline**

The endline survey indicated a significantly increased level of knowledge and awareness in all key areas of HIV knowledge. As a result of personal research and workshop discussions, all trainees were able to talk articulately on HIV physiology, transmission, prevention, symptoms and treatment, with many also suggesting intelligent strategies on tackling the pandemic in Malawi.

### **Attitudes**

#### **Baseline**

During the baseline, attitudes to HIV and AIDS among trainees were mixed, with the majority expressing their commitment to prevention, care and treatment but with a tendency to negatively judge people who were HIV positive or engaged in risky behaviours. Women were portrayed negatively by both genders, while “ignorance” was regularly quoted as the overriding causative factor of HIV infection.

#### **Endline**

The shift in trainee attitudes observed in the endline survey was substantial, and a strong validation of the TfaC methodology as a tool for attitudinal learning. Discussions around living with HIV were typically framed in language that emphasised “living positively” as opposed to general immorality, while gender was not stated as an influencing factor in terms of HIV risk – 100% of trainees stated that everyone was at some risk.

A significant evolution in trainee attitudes to prevention was also observed in endline observations, with all trainees speaking passionately on the need for participatory, inclusive and open strategies, not the didactic approaches that had been favoured previously.

## **Behaviour**

### Baseline

Despite their stated commitment to HIV-prevention work and high levels of education, the baseline indicated an entrenched resistance to meaningful engagement with sexual health and gender issues among the trainees. Confidence and articulacy on these issues was extremely low, with the majority unwilling or incapable of reflecting on their behaviour. Attitudes to condom use were varied, though many trainees stated their active opposition to their use in any form. Attitudes to VCT ranged from mild discomfort to staunch and often frightened refusal to engage with the issue. Virtually none of the trainees were capable of convincingly saying “no” to a variety of sexual advances, or of successfully negotiating for the use of condoms during role play.

### Endline

The endline survey demonstrated an almost complete reversal of these negative behaviours, and represents powerful validation of the TfaC methodology. Of the several behaviour change successes indicated by the baseline, the most notable has been the transformation of trainee attitudes to VCT and their own sexual health. While the national average for voluntary testing in Malawi is less than 5%, by December 2007 100% of trainees had volunteered for confidential testing and received their results. A by-product of this experience has been a vastly increased commitment to living positively and taking responsibility for their own sexual relationships. Many of the trainees expressing greatest resistance to VCT during the baseline have now conveyed their passion for guiding their peers through a similar process.

Another major success was demonstrated in the significantly increased ability among all trainees to negotiate and protect themselves during sexual encounters. While the majority stated their ability to refuse sex or negotiate for condoms at the outset, several role play and workshop observations indicated that only 5% could actually do so, with most favouring retreat. In endline observations, 100% of trainees were capable of saying no to sex in a variety of relationship and non-relationship situations. 100% were also able to negotiate for condom use convincingly and skilfully, having advanced from the stubborn insistence strategies of the early weeks to modifying their strategies depending on circumstance. Informal evidence of trainees applying these skills in their personal lives was also apparent, with several reporting improvement in partner relationships due to increased sexual respect, and use of condoms in sexual encounters with untested partners.

## **Gender and Sexual Rights**

### **Baseline**

Knowledge and practice of gender and sexual rights in the baseline was low. While many trainees were active in practising or occasionally promoting their rights, this was typically considered a matter of personal choice and not an issue defined entitlement. At the outset, there was a strong gender imbalance throughout the group, with men typically dominating discussions and exercises. Evidence of mild, though unintentional, intimidation among the women was also apparent. The majority of trainees demonstrated various degrees of difficulty in drawing comparisons between their behaviour within the group and their personal lives, while gender equality and the right to sexual choice were entirely new concepts for several members of the group. Involvement with decision makers and understanding of advocacy issues was also limited.

### **Endline**

Of the four primary focus areas for the survey, the change in attitudes to gender and sexual rights was most noticeable. All trainees were capable of confidently speaking on a variety of rights issues including; child rights, equality, cultural context, women's rights and advocacy and had gained direct, though limited, experience of promoting gender and sexual rights in their focus groups. The importance of, and commitment to, gender balance within the group was also evident, with discussions and activities carried out with a high degree of sensitivity. Male trainees were willing and able to reflect openly about past behaviours that infringed on other people's gender rights, while female trainees were visibly and ardently committed to practising and promoting gender rights in their daily lives.

## **CONCLUSION**

The success of the Theatre for a Change Seeding Project and the personal and professional development among its participants are, in my opinion, strong indicators of the organisation's future success, both in the medium and long term. It is clear that the TfaC methodology and training structures are effective not only in terms of personally empowering participants but also in cascading this training and eventual empowerment to local communities.

As of January 2008, TfaC has 15 trainees with three months of facilitation and behaviour change training, with 15 more joining the programme in early February. In April 2008, TfaC will select 18 of these 30 trainees to become Training and Monitoring Officer staff, two of whom will be posted to each of the nine teacher training colleges in Malawi.

The results of this impact assessment indicate that, in addition to its methodology, TfaC's strategic plan is sound and capable of making a substantial impact on the HIV-prevalence among Malawi's teacher population. It has developed working partnerships with the Ministry of Education, Science and Technology and the Department of Teacher Education and Development, in addition to its existing implementing partnerships with the British Council and GTZ. The core team in Malawi is committed and have demonstrated their professionalism and ability in their successful management of the programme so far.

A handwritten signature in black ink that reads "A. Stevenson". The signature is written in a cursive style with a horizontal line underneath the name.

**Andrew Stevenson, January 2008**  
**HIV and AIDS Programme Officer**  
**British Council Malawi**