RURAL COMMUNITY ENGAGEMENT EDUCATION INTERVENTION FOR BRINGING SOCIAL/CULTURAL CHANGE TO REDUCE TEENAGE PREGNANCY AND INCREASE GIRLS' ACCESS TO EDUCATION AMONG KAPIRI PRIMARY SCHOOLS IN KAPIRI-MCHINJI, MALAWI:

COLLABORATION PROJECT BETWEEN:

KACODO – KAPIRI, MCHINJI, MALAWI

&

GLOBAL HEALTH SECTOR CAPACITY BUILDER -UK

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1.1 Introduction & Aim of the project

First unwanted teenage pregnancy among primary school girls in Malawi continues to ruin attainment of their education dreams as many of them tends to be withdrawn with no prospects of returning to education. Lack of completion of these girls education contributes to many negative impacts to themselves, their current and future families and to the country as a whole. Such negative impacts include: lack of future job prospects, increasing country's illiteracy rates between men and women, increasing poverty levels because of their failure to effectively contribute to Malawi's economic and social development and poor health outcome. However, Dr Fletcher Phiri's PhD (2009) study results showed that girls who are encouraged to return to their studies after the delivery of their first child, (with support of their parents, community members, teachers and leaders of the church and community), particularly in the rural areas, are more likely to succeed in completing their studies which improves their future job prospects and their ability to contribute to economic and social development of their families and the country. The aim of this project is to engage parents, teachers and community and church leaders to change prevailing negative social/cultural norms and create positive and conducive social/cultural norms and school environment that encourage and support girls to return to education after delivery of their first baby. This intervention will initially start in primary schools of Kapiri in Mchinji District of Malawi. The project if successful has a prospect of rolling out to other rural parts of the country where primary school girls withdraw is a major problem. On the whole the project is aimed at increasing girls' access to and completion of their education.

1.2 Background

Dr Fletcher M Phiri is from Malawi currently living and working in UK as a Senior Associate Lecturer for Glyndwr University. He is one of the directors of Global Health Sector Capacity Builders (GHSCB) working on health related issues focussing on developing, delivering and evaluating evidence based interventions as well as building capacity of education and health care professionals through designing, delivering and evaluating training programmes. He did his PhD research in Malawi with fieldwork in Uganda and Tanzania. The research focussed on designing, delivering and evaluating education intervention aimed at enhancing primary school pupils' HIV, STIs and Teenage pregnancy related knowledge and influencing them to change their sexual attitudes and change their sexual behaviours to protect themselves and others from HIV, STIs and unwanted pregnancies in rural and urban primary schools and communities in Malawi. The delivery of the intervention involved community

engagement aimed at changing prevailing social cultural norms of adult Malawians not to talk about sexual related issues in front of young people or in public, schools, communities, churches and other public places.

1.3 Two of the most important research findings

First the most important finding from the research was the reduction in school withdrawal of girls due to pregnancy which was significantly higher in rural primary schools compared to urban. Dr Phiri developed interest in what can be done to get the girls back to school after the delivery of their first baby. This interest was due to the fact that I educated myself as an adult and I felt more motivated because I had a wife and children who were looking to me for help. I therefore followed up few girls and had active discussion with their parents to influence them to support the idea that their daughters should go back to school after the delivery of the first child rather than allow them not to return to school. Therefore they should support the girls because if they do not do that then the children would remain burden on them and poverty will continue. This had positive outcome and the girls who went back to school ended performing very well, completed their studies and got better jobs and more stable families with the consequences of improving their income and that of the family as a whole. Now they are able to feed themselves, their children and provide support to their parents. Hence, second most important finding from the research. In this way, this has helped to reduce poverty and contributed to reduction in the number of girls in Malawi not achieving their education ambition. If many of them are allowed to return to school after delivering the first baby, would help to close the current gap in education attainment between boys and girls and reduce number of future illiterate women in the society.

1.4 Teenage pregnancy problem in Malawi

Teenage pregnancy continues to be a public health problem among primary school girls in Malawi especially in the rural areas. The accurate and reliable data is not to easy to find Malawi. However the available and accessible source is Malawi Demographic Health Survey (MDHS). The 2008 MDHS report shows that among female teenagers aged 15 to 19 years of age: the percentage of those found to have had live birth were ranged from 1.6 to 57.2%; those who were pregnant for the first child ranged from 2.0% to 6.3% with highest those aged 18 at 9.0%; and those who had begun childbearing

were ranged 3.5% to 63.5%. The same report showed than the percentages were much higher in the rural (21.0% had live birth; 5.8% were pregnant with first child and 26.8% had begun childbearing) compared to urban area (16.0% had live birth; 4.5% were pregnant with first child and 20.5% had begun childbearing) (MDHS, 2010). This evidence support that teenage pregnancy continues to be a public health problem and is worse in the rural compared to urban area. Evidence from my PhD work showed that girls who become pregnant receive hostile reception from parents and community at large as well as schools themselves making it not conducive to return to education for these girls. As a result, opportunity to educate these girls is lost and these future mothers' poverty prevails which will affect their own future families and children too. This also has subsequent impact on their community and country as a whole in terms of failure to effectively contribute to social and economic development of Malawi. This provide strong justification that doing nothing is not an option for these girls

1.5 Teenage pregnancy Problem in Mchinji

The 2008 MDHS report shows that in Mchinji District, in which Kapiri is located, teenage pregnancy is also a public health problem as in 2008, 20.9% had live birth; 5.4% were pregnant with first child and 26.4% had begun childbearing(MDHS, 2010).

On the whole the 2008 MDHS showed that the proportion of teenage pregnancy is inversely related to level of education. Those girls who had no education had high percentage of teenage pregnancy than those who had education. The report also shows that teenage girls have high level of knowledge of available protection methods that can prevent them becoming pregnant but their usage is very low. There was also a proportion of girls who used traditional protection methods to protect themselves from pregnancy. This suggests that there is a need to promote the usage of modern methods and discourage usage of traditional methods to help in reducing the incidence of pregnancy among these teenagers. The evidence also suggests that if girls are encouraged to return to school after first pregnancy, they are very unlikely to be withdrawn again due to second subsequent pregnancy.

1.6 Teenage pregnancy and primary school dropout

Since I completed my PhD research in 2010, I have been wanting to do something about this so that I can target the girls who withdraw from primary school due to pregnancy to get back to school

and use community engagement education to create more receptive environment in the community, families and primary schools so that these girls can be supported and be given a second chance to complete their education which in the long term could help to fight poverty among women in the rural areas of Malawi as well as closing the existing gap in education qualifications between men and women in Malawi. Also to enable girls effectively contribute socially and economically in the country.

1.7 The Partnership formation

This year, 2015 the Global Health Sector Capacity Builders (GHSCB) has collaborated with Kapiri Community Development Organization (KACODO) organisation in Malawi to work on project aimed at reducing primary school girls' withdrawals due to pregnancy and promote the return of teenage mothers to education after delivery of their first baby through creating more positive and supportive community and school environment through community engagement that changes prevailing social cultural norms of treating girls who become pregnant as outcasts. The project will target all the 20 primary schools in and around Kapiri area and will last for 3 years with a potential to rollout to other parts of the country.

1.7.1 KACODO Organizational Profile

Kapiri Community ' Development Organization (KACODO) is a community based organization duly incorporated under the Trustees incorporation Act Chapter 5:03 ct the laws of Malawi. KACODO commenced its activities on I3 September 2012 after Action Aid Malawi and KACO DO conducted a Participatory Vulnerability Analysis (PVA) involving communities in identifying some key developmental challenges affecting people in Kapiri and also identifying solutions to these challenges. Upon dissemination of the PVA results (report), the community local leadership, and government officials agreed to set up KACODO to coordinate development efforts and compliment government efforts in the area

1.7.2 KACODO Vision and Mission

KACODO's vision is healthy and literate community which is self-reliant. Its mission is to facilitate development interventions in education, health and environmental management

1.7.2.1 Primary Goals, Objectives and strategies

KACODO primary goal is to increase access to education for girl child in TA Dambe, Kapiri area. Its key objectives are to promote girl child education; promote literacy and promote good governance. KACODO applies Human Right Based Approach to programming, which centres on building the active agency of people living in poverty, empowering them to be become rights activists, conscious of their rights in solidarity with stakeholders engage duty bearers to fulfil their obligations. KACCJDO believes in strengthening solidarity with organisations and institutions at community level including girls' initiatives in schools, mother groups, reflect circles, CBOs, School Management Committees, PTA, teachers' organisations and linking them across national regional and international levels.

1.7.2.2 Management structure

KACODO has 8 permanent staff members, 32 sponsorship volunteers assigned by *Action Aid* Malawi to provide capacity building support on Human Rights Based Approach. The organisation is headed by a woman. Hence offers good role model for motivating girls to return to education. On the whole, the above analysis provide strong evidence that KACODO is the right organisation as it shares the same vision and passion for improving girls education access in Kapiri.

1.7.3 Global Health Sector Capacity Builders, (GHSCB) Profile.

GHSCB is Training & Consultancy organisation aimed at developing capacity of public, private and nongovernmental organisations in Education and Health Sectors through Training and Consultancy worldwide. It is a Training Consultant registered and based in UK. Its value is to help improve lives of the communities and safeguarding the vulnerable members through providing skills to professionals and non-professionals to deliver high quality services and help improve knowledge, understanding, skills, and competences and save lives.

1.7.3.1 Work Location

GHSCB has been in operation since in 2010, and has been working independently in UK, and the rest of the Globe with local African based CBO from Kenya, Malawi, Cameroon, Zimbabwe, Nigeria, Angola, Uganda and Zambia on small local projects to major national and international work. It offers a full range of services, ranging from small local projects, and local community groups to major national and international work.

1.7.3.2 Nature of work

GHSCB offers full range of services in the following fields: Education, Public health, Nutrition, Food security, Economic development, and Project management, Reproductive sexual health including HIV and Family planning, community interventions and building capacity in emergency settings.

GHSCB offers consultancy in Training, Nutrition interventions including CMAM, needs assessment, Project Management, Conducting Survey, Research activities, Health needs assessment, Training of Trainers, Business Planning, Distance learning, Facilitation; Financial management, Project evaluations, Impact evaluation and designing and implementing community behaviour change interventions.

1.8 The Project

This project will run for three years and the following are three phases and their respective activities, intended objectives or outcomes and justification:

Year 1: Baseline Survey & Marketing of the project

There is clear evidenced that there is lack of accurate data to assess the true nature of the problem of primary school girls' withdrawal due to teenage pregnancy in the area. Also the causes of the problem are multiple and varied. Therefore this first phase will focus on baseline survey to obtain accurate data from all the 20 primary schools in addition to reasons that influence girls to engage in

unprotected sex and become pregnant and consequently withdrawal from school. The data obtained will also be used for comparison to assess the impact of the subsequent intervention to reduce teenage pregnancy as well as inputting into evidence based intervention to be used in the subsequent years. The results will also be used to identify relevant performance indicators to be used for monitoring and evaluation of the intervention. The survey will be conducted using questionnaire interviews and community focus groups. This phase will last for 6 to 8 months and the remaining 4 months of the year will be used to produce teaching and learning material, analyse data, produce the report and disseminate it to schools, community leaders and health care professionals.

Year 2: Recruitment, training & preparation of teaching & learning material & delivery

Will be recruiting 100 girls per year who are pregnant and possibly those who have just delivered, training them to become peer educators to help in selling the project to the community leaders, schools and other relevant stake holders and testing the teaching and learning materials.

This will be followed by actual implementation of the programme which involves the trained pregnant mothers themselves learning about care of their own pregnancy, importance of antenatal clinics, vaccinations and care of their babies. They will also be learning about HIV, STIs etc. These girls will also act as peer educators to go to 20 primary schools (5 girls per primary school) and teach girls how to protect themselves from becoming pregnant and importance of the need to continue with their studies. They will also be actively carrying out parents, community and school leaders' engagement meetings to change their negative attitudes towards letting girls return to school after delivery of their first babies and create supportive environment in the homes, communities and schools for those girls who return to school after delivering their first babies.

Year 3: Completion of delivery and Evaluation and dissemination

At the end of third year we will evaluate the programme to assess its impact of reducing teenage pregnancy, increasing girls' access to school through teenage mother school returns and others variable we would see fit from the base line survey. The findings will be documented and disseminated to the community and schools and help to inform policy change of post teenage pregnancy access to education in Malawi.

1.9 Resources, Costs and Budget

Physical, human and financial resources are required as detailed in table 1 on budget.

A total budget of US $ 60,520 (table 1) has been estimated spread over 3 years.

Table 1: Proposed project budget

Table 1: Proposed Budget **Activities / deliverables**	**Year 1**	**Year 2**	**Year 3**	**Total proposed Budget**
1. Baseline	3,400	0	0	3,400
Instruments preparation / pilot	300	0	0	300
Baseline data collection:	1,550	0	0	1,550
Facility Survey 1 (20 schools)	950	0	0	950
Community survey (20 focus groups)	500	0	0	500
Other survey (secondary data)	100	0	0	100
2. Project implementation & evaluation	0	1,300	2,000	3,300
Material preparation	0	500	0	500
Training/teaching	0	400	1,000	1,400
participant recruitment	0	200		200
Training facility	0	200		200
facility survey 2 (20 schools)	0	0	1,000	1,000
3. Data documentation	0	0	200	200
4. Staff and Consultants	7,200	7,800	10,800	25,800
Principal Investigator s(3)	3,000	0	3,000	6,000
project manager	2,400	2,400	2,400	7,200
Project supervisor & Coordinator	1,800	1,800	1,800	5,400
Teachers (2)	0	3,600	3,600	7,200
5. Travel	15,000	500	4,800	20,300
International	13,200		**3,000**	16,200
Local	1,500	500	1,500	3,500
Hotel + Per diem	300	0	300	300
6. Dissemination	0	0	200	200
Workshop, meeting	0	0	100	100
Reports	0	0	100	100
7. Other expenditures (if not listed please specify):	4,540	100	100	2,100
Capacity building / training	**200**	**0**	**0**	200
Institutional Review Board/Ethics Committee	**100**	**0**	**0**	100
computer	**1,000**	**0**	**0**	1000
library & books	**500**	**0**	**0**	500
Contingencies (10 %)	2,740	1,270	1,510	5,530
Total (USD)	**30,140**	**13,870**	**16,510**	**60,520**

1.10 Implementation work plan

A three year work plan (table 2) is envisaged with the first year dedicated to baseline data collection and analysis to understand the project area and the foundation of the problem. The second year is the project implementation period while year 3 will finalise the project with evaluation to draw lessons on best practices, and share the same with the primary schools and wider community including parents and local leaders.

Table 2: Proposed project work plan

Deliverables	**Year 1**	**Year 2**	**Year 3**
Instrument preparation			
Baseline survey			
Project implementation			
Project evaluation			
Data documentation and dissemination			

1.11 GHSCB Team Members:

Dr Fletcher M Phiri (ABE, CIM, MBA, PhD) Training and Consultancy Lead with working experience in Africa and UK. His knowledge base includes Clinical Medicine, Public Health, Sexual and Reproductive Health and building community, individual and organisation capacities, designing, delivering, monitoring and evaluating training and research. In his 24 years career has worked for Naz Project London, Queen Elizabeth Central Hospital, Zomba General Hospital, The College for Venereal Disease Prevention, University of Malawi, National Institute For African Studies, University of Durham, ShareWorld Institute of Management, Children & Women in Need and African Women & Children Support Organization and various UK tutoring agencies.

Dr Gertrude Anyango Wafula (B. Ed., DLSHTM, MSc, PhD). **Dr Gertrude has a** Health Emergency and Nutrition, Gender, HIV, reproductive and sexual health expert with work experience in Africa, Asia and UK. Her knowledge base includes Public Health Nutrition, Nutrition health emergency, Food Security, health education, gender, Rural Development, Research, Family planning and HIV/AIDS and monitoring and evaluation of programs. Her career spans over 14 years and has worked for World Vision International in Angola, JC Flowers Foundation New York, Merlin International in UK, DRC Congo and Pakistan, Mildmay International, BHA UK, NaZ Project London, Manchester University, and Kenya teachers' service commission

Dr Jacinta Lemba (BSc. AgricEcon., MSc. AgriDev., PhD). Dr Jacinta is an expert in Food security analysis, Project design, management and evaluation, Agribusiness management, Agricultural finance, Agricultural value chain analysis and Policy analysis. Jacinta has over 20 years' experience in training and research; and has conducted several project evaluations on Agricultural development, Nutrition and health education and Microfinance under DANIDA. She has international work experience including Kenya, Belgium and Tanzania; and has made several publications in her field of expertise.

1.12 KACODO Team Members.

See their CV attached

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