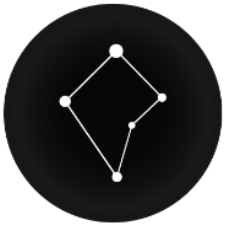
Baseline Report

of the Umunthu Programme implemented by the Arts and Global Health Centre Africa (AGHCA)

November 2017

Prepared by Tariq T. Ambrose and Andres O. Navarrete from One South, LLC.



ONE SOUTH

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The Baseline Study was carried out by **Tariq T. Ambrose**, **Andres O. Navarrete,** and **Rose Nyambi** from **One South, LLC**. The Baseline Study took place in August and September, 2017.

The Evaluation was managed and facilitated by **Helen Todd and Rodger Phiri** from the **Arts and Global Health Centre Africa.**

For any questions related to the Evaluation, please contact:

One South, LLC.

Attn: Tariq Ambrose (Team Leader)
1521 Concord Pike #301
Wilmington, DE 19806
United States of America
www.one-south.org

For questions related to the Umunthu Programme, please contact:

Rodger Phiri (Programme Manager)

Arts and Global Health Centre Africa, Zomba, Malawi

www.aghcafrica.org

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Acronyms

AGHCA	Art and Global Health Center Africa
CSO	Community and Social Organization
CEDEP	Center for the Development of People
DHMT	District Health and Management Team
FGD	Focus Group Discussion
GBV	Gender-Based Violence
HAC	Health Advisory Committee
INGO	International Non-Governmental Organization
KAP	Knowledge, Attitudes and Practices
KII	Key Informant Interview
LGBTI	Lesbian, Gay, Bisexual, Transgender, and Intersex
TTT	Trainers of Trainers Team

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Executive Summary

Introduction

Umunthu[1] is a pan-African concept of humanity that celebrates interconnectedness and interdependence[2]. In Malawi, Umunthu can be understood to mean: "I am because we are"[3]; "To be in someone else's shoes"[4]; and "The feeling I have towards others."[5]. Through these lenses, the Umunthu Programme, implemented by the Arts and Global Health Centre Africa (AGHCA), aims to promote health access as a fundamental human right of LGBTI people in Malawi. The project focuses on reducing stigma and building the capacity of civil society and health care institutions to advocate for and implement inclusive policies and programmes.

To assess the project's contribution to desired outcomes, effectiveness, relevance and sustainability, the project is participating in a three-year evaluation. At Baseline, this evaluation seeks to answer two questions:

(1) Is the project appropriate for its context?

(2) How likely is it that project activities will lead to desired results?

The evaluation will be used by project and partner staff as a primary source on the pre-implementation context, and to inform a management response aimed at improving on-going project learning and implementation.

Background to Project

The Umunthu Programme is implemented by AGHCA across 8 districts of Malawi: Chikwawa, Zomba, Mangochi, Nkhotakota, Dedza, Thyolo, Phalombe, and Mchinji. The project will run from 2017-2019 and aims to promote access to health care as a fundamental human right of LGBTI people.

To achieve this, the project is targeting the following objectives:

- **Objective 1**: Malawian Health Workers (including Health Worker students) consider and better understand LGBTI persons through the local perspective of the Umunthu Programme. They appreciate and act on their responsibilities towards discriminated persons, particularly LGBTI persons.
- **Objective 2**: Members of civil society and community leaders engage with healthcare workers to discuss ways to tackle health access disparities in communities.
- **Objective 3**: The workshop activities will be integrated into civil society, educational institutions or government curricula and trainings

To achieve Objective 1 the project is organizing 31, 3-day workshops with health workers and 9, 2-day workshops with health worker students. Through an innovative and participatory methodology, the workshops aim to enable health workers to discuss and develop a local, cultural, and professional approach to provide treatment to LGBTI and other discriminated and minority populations.

During the workshop participants engage in several activities to unpack discrimination from a health perspective. Participants also hear guest medical, legal and LGBTI speakers and open a discussion on health access for LGBTI populations. On the final day of the workshop, local community leaders and CSO representatives' active in this area are invited to participate alongside members of the local Health Advisory Committee (HAC). Health workers share their discussion with community leaders and CSO representatives and collaboratively develop an action plan to promote non-discrimination towards LGBTI and other key populations in primary health centres.

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[1] Battle, Michael (2007). Reconciliation: The ubuntu theology of Desmond Tutu. Pilgrim Press. ISBN 978-0-8298-1158-2

[2] Umunthu Programme Summary (2016) AGCHA

[3] Performance Story Workshop: What is Umunthu (August, 2017)

[4] Performance Story Workshop: What is Umunthu (August, 2017)

[5] Performance Story Workshop: What is Umunthu (August, 2017)

Six months after the first workshop, the project will organize a 1-day follow up workshop for participants to discuss progress on the action plan and reinforce key learning from the initial workshop.

The project aims to address Objective 2 through the participation of CSO representatives and community leaders in the 3-day performance story workshop. During this concluding session community leaders and participants join small group discussions and interactive role play highlighting the learning that occurred during the workshop and discussing discrimination and health access issues that need to be addressed in the local community. Participants collaboratively develop an action plan aimed at reducing health access disparities of LGBTI and other minority populations in their health centre.

To achieve Objective 3, the project will conduct 6, 1-day training of trainer workshops with civil society, government, and partner representatives. This workshop will aim to familiarize participants with the Umunthu approach to enable them to incorporate it into existing curricula. The project will also develop a communication and advocacy strategy to highlight the achievements of the Umunthu Program in local media outlets, and generate wider interest in the Umunthu approach.

Evaluation Approach

The three-year evaluation will aim to answer the following key questions:

1. Was the project successfully designed and implemented?
2. Has the project influenced desired results?
3. How likely is it that project achievements will be sustained after the project?

To answer the evaluation questions and generate evidence on the project's contribution, the evaluation adopts *contribution analysis* (CA) as its main methodological approach. Contribution analysis is a mixed-methods and participatory approach for inferring project contribution to given outcomes. CA aims to reduce uncertainty about the contribution an intervention is making to observed results through an increased understanding of why observed results have occurred.

The external evaluation is divided into three points: Baseline, Midline and Endline. The Baseline aimed to further the project's understanding of its context, discuss how and why the project expects its activities to lead to desired results, and identify evaluative performance measures. For the purposes of this exercise, two research questions were reformulated for the Baseline:

1. Is the project appropriate for its context?
2. How likely is it that project activities lead to desired results?

Is the project appropriate for its context?

Based on in-depth interviews and focus group discussions, the main health concerns of LGBTI respondents are: (1) right to privacy and non-disclosure, (2) right to non-discrimination, (3) right to relevant health services.

The project's main emphasis is to address discrimination faced by LGBTI and other minority groups when they seek access to health. Through the lens of Umunthu, the programme aims to elicit empathy amongst health workers, health workers students, and community members to promote inclusive policies and practices in health centres and surrounding areas. By adopting a local perspective to understand others, the project aims to enable health workers and community members to improve service delivery for LGBTI. While this primarily addresses the second concern listed by LGBTI informants, a right to non-discrimination, the project believes this will lead to improvements in both upholding of the principals' confidentiality, essential to health access, and to better knowledge of the types of care relevant to LGBTI.

The project targets health workers and community members directly through its design. However, the project does not target LGBTI populations through its activities. Several respondents highlighted this in consultations, expressing the fact that without directly targeting LGBTI populations, the project will only seek to improve the supply of accessible services rather than the demand for it amongst key populations.

Health workers consulted as part of this review, highlighted that they felt that they lacked the necessary medical knowledge about the unique health risks faced by this population, and the types of treatment they should provide.

The project's aims to address these concerns through the inclusion of a guest medical speaker, who will spend significant time discussing the specific unique exposures faced by LGBTI. The workshop is designed in a participatory manner to enable participants to discuss these views as they arise. However, due to the amount of time in the workshop, it is likely that the guest speaker will only be able to superficially cover the main areas of unique health exposures. It may be necessary for the project to consider this further to ensure health workers remain interested in participating in the workshop. The project could consider tapping into existing advocacy actors for additional technical medical knowledge of LGBTI. CEDEP and CHRR, in collaboration with representatives from the College of Medicine, have developed a training manual which is currently under review within the Ministry of Health. The project could integrate components from this manual into the medical lecture to better address this expectation amongst health workers.

Based on this review the project is well suited to address the existing gaps in health service delivery, through its focus on non-discrimination. It is likely that this in turn will lead to a renewed interest in LGBTI as a special health group, meriting targeted, sensitive, and relevant approaches. However, the project should consider additional means through which it can inform LGBTI about relevant health clusters where training has been provided and specific health workers who have agreed to be approached by LGBTI health seekers.

How likely is it that project activities lead to desired results?

Based on a review of each of the project objectives, intervention activities are most likely to lead to results associated with Objective 1. By Baseline, project staff have focused their efforts on developing the Umunthu Workshop curriculum and piloting it with target health workers. Additionally, most activities undertaken by the intervention are centred around the 3-day Umunthu Workshop.

Objective 2, which targets community leaders and CBO representatives, is on the whole, unlikely to lead to desired results as the 1-day mini-workshop with community stakeholders will likely be insufficient to establish the linkages necessary to for communities and health workers to continue to consult each other and identify health needs of minority populations. The project aims to create a sustained engagement between health workers and community representatives through the collaborative development of an action plan. However, by Baseline the project has not developed an approach to ensure sustained engagement takes place.

With regards to replication, the project has yet to develop a communication and advocacy strategy or a training of trainers workshop manual. The project will develop this following on from experience implementing the Umunthu approach. At this stage, it is unclear whether the 1-day training of trainers workshop combined with the advocacy strategy, will be able to generate sufficient interest in the workshop's replication. The project intends to review this further after continued experience implementing the Umunthu Workshop.

To assess the extent to which project activities led to desired results, the Baseline Study put forward several evaluation performance measures to be reviewed at later evaluation points. Evaluation performance measures were associated with each of the project's contribution claims and are shown in the table below. For additional information on the sources for each measure please consult Annex 1.

Table 1. Evaluation Performance Measures

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
A1.1: Interactive workshop program will enable health workers and health worker students to tackle real-life issues and situations focused on the discrimination of minority groups, including LGBTI. Participants will reflect on their role as both a victim and a perpetrator of discrimination.	• Evaluation Performance Measure 1: The extent to which facilitators and guest speakers manage disagreement and build trust amongst participants. • Evaluation Performance 2: The extent to which facilitators and guest speakers are effective communicators.	• Increased levels of trust towards facilitators and guest speakers • Increased levels of participation • Improved attitudes towards participation amongst Health Workers	• What are the most the frequent real-life issues of discrimination that health workers observe? • HW perspectives and reflections on role of victim and perpetrator • Narrative playbacks (participants recall and articulate the

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
	• Evaluation Performance Measure 2: The extent to which participants appreciate the message, finding it both relevant and interesting. • Evaluation Performance Measure 3: The extent to which health workers actively participate in the workshop. • Evaluation Performance Measure 4: The extent to which participants have reflected on their role as both a perpetrator and victim of abuse. • Evaluation Performance Measure 5: The extent to which participants appreciate the value of the message, finding it both relevant and interesting	• Segments of audience members and demographic composition of the audience • Coverage (% of target audience the programme will reach). • Cost-Per-Thousand (CPM) the cost of reaching 1000 persons	narrative or story line) • Talk-back testing (explaining the point of the workshop in their own terms; showing how well the workshop is understood and how easily participants can spread the message) • Overall reaction: how people felt about the workshop including likeability, stimulation, entertaining value, relevance, time-worthiness, uniqueness and believability. • Persuasion; whether respondents found the workshop compelling and engaging. • Types of audience members and composition of the audience
A1.2: One-day follow-up workshop (3-6 months later) will enable participants to reflect on how they have applied the learning from the initial workshop, and how they have implemented their action plan. The follow up workshop will encourage participants to identify implementation challenges and ways to expand upon the initial action plan.	• Evaluation Performance Measure 6: The extent to which participants from the first workshop are successfully re-contacted and attend the follow-up workshop. • Evaluation Performance Measure 7: The extent to which participants report being better prepared to identify and deal with discrimination in health facilities after having attended the workshop. • Evaluation Performance 8: The extent to which participants are increasingly aware of the importance of implementing their action plans.	• Increased proportion of re-contacted participants attend follow-up workshop over time. • Increased proportion of participants report being better prepared to identify and deal with discrimination. • Items on importance and of implementing action plan	• The content and quality of the review and changes made during the follow up workshop to the action plan •

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
	• Evaluation Performance Measure 9: The extent to which the follow-up workshop guides participants to deal with challenges arising from the execution of action plans.		
G1.1: The workshop creates a platform for thoughtful public discourse on contentious human rights issues in Malawi through the lens of "Umunthu".	• Evaluation Performance Measure 10: The extent to which participants can better identify human rights issues in a health context. • Evaluation Performance Measure 11: The extent to which participants are interested in improving human rights in a health context in Malawi. • Evaluation Performance Measure 12: The extent to which participants understand the relationship between Umunthu and Human Rights..	• Items on identifying human rights issues. • Items on participants attitudes towards human rights in Malawi.	• Open answer item on understanding of Umunthu • What human rights issues are brought up in the workshop and what is the content and quality of the discussions which follow? • How do participants understand Umunthu in relationship to human rights?
G1.2: Workshop improves health worker awareness of the need for proper treatment of LGBTI persons.	• Evaluation Performance Measure 13: The extent to which health worker participants demonstrate awareness of the health concerns of LGBTI populations. • Evaluation Performance Measure 14: The extent to which health worker participants demonstrate awareness of unique health exposures faced by LGBTI.	• Knowledge items on health concerns of LGBTI populations • Knowledge items on unique exposures faced by LGBTI	• How have participants changed their awareness of the need for proper treatment of LGBTI people?
G1.3: Workshop results in action plan to improve health access for LGBTI and other minority populations.	• Evaluation Performance Measure 15: The extent to which participants believe they have a responsibility to implement their action plan and that their contribution is necessary to ensure its achievement.	• Behaviour, normative, and control beliefs about implementing action plans in health facilities • Most frequent hindering and facilitating factors to implementing action plans	• Content and quality of action plans. • Who are the stakeholders in health facilities? What support is necessary to sustain and realize an action plan?

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
	• Evaluation Performance Measure 16: The extent to which participants believe they can implement their action plan. • Evaluation Performance Measure 17: The extent to which participants are increasingly able to identify and facilitate hindering factors and react to them. • Evaluation Performance Measure 18: The extent to which participants believe that, should they be realised, action plans will lead to positive results for minority groups. • Evaluation Performance Measure 19: The extent to which participants believe other stakeholders in their health facility (will) approve and support their plans. • Evaluation Performance Measure 20: The extent to which participants believe their action plans were implemented.		• What are the hindering and facilitating factors? • How do participants view the likelihood that their action plan will improve health access for LGBTI and other minority populations?
C1.1: The workshop provides health workers with improved knowledge of issues affecting LGBTI people from a social, medical and legal perspective.	• Evaluation Performance Measure 21: The extent to which participants demonstrate improved knowledge of the legal, medical, and social issues affecting LGBTI people. • Evaluation Performance Measure 22: The extent to which participants perceive the workshop content to be accessible and relevant in terms of legal, medical and social knowledge gaps. • Evaluation performance measure 23: The extent to which participants believe facilitators filled	• Culturally competency items according to culturally-competency framework (CCF). • Knowledge items on social, medical, and legal issues faced by minority groups, incl. LGBTI people.	• Knowledge about culturally competent principles and practices before and after the workshop

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
	their knowledge gaps effectively • Evaluation Performance Measure 24: The extent to which facilitators and guest speakers are equipped to manage knowledge gaps.		
C1.2: Participants gain the knowledge to provide culturally competent health care to LGBTI and other minority populations The Workshop enables participants to critically reflect on their attitudes and role in health delivery, and the impact these have on stigma and discrimination faced by LGBTI populations.	• Evaluation Performance Measure 25: The extent to which participants recognize and affirm the impact of discrimination, stigma, and homophobia on an LGBTI person's well-being. • Evaluation Performance Measure 26: The extent to which participants can recall Umunthu's inclusive principals and practices.	• Culturally competency items according to culturally-competency framework (CCF).	• Knowledge about culturally competent principles and practices before and after the workshop
C1.3: Health workers learn how to engage and consult relevant community stakeholders on health issues.	• Evaluation Performance Measure 27: The extent to which participants feel equipped to engage in community consultations on minority rights. • Evaluation Performance Measure 28: The extent to which health workers believe that community consultations on health issues will lead to better health access for minority populations including LGBTI. • Evaluation Performance Measure 29: The extent to which health workers believe they will not be judged by others if they consult community stakeholders on issues affecting LGBTi. • Evaluation Performance Measure 30: The extent to which participants increasingly want to engage the community in consultations to improve the health access of LGBTI and	• Behaviour, normative, and control beliefs about consulting community stakeholders to improve health access for LGBTI and other minority populations	• How do participants prefer to engage the community in identifying and responding to minority health needs?

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
	other minority populations.		
B1.1: Health workers appreciate and act on their responsibilities towards all discriminated persons, particularly LGBTI persons (Objective 1). Health workers actively seek to make health centres more accessible and inclusive of LGBTI persons.	• Evaluation Performance Measure 31: The extent to which participants increasingly believe that applying the a culturally competency framework will support the health access of discriminated populations, including LGBTI. • Evaluation Performance Measure 32: The extent to which participants believe that actively seeking to improve health access for minority populations is part of their responsibility as health workers. • Evaluation Performance Measure 33: The extent to which participants implement inclusive policies and practices to promote health access of minority populations • Evaluation Performance Measure 34: The extent to which participants have the resources and skills to promote inclusive policies and practices in their health clinics.	• Behaviour, normative, and control beliefs items on acting on responsibilities and improving access of minority populations to health. • Follow up on action plans	• How have participants acted on their responsibilities towards LGBTI and other discriminated populations? • What approaches were most effective? • What are the hindering and facilitating factors associated with these behaviours?
B1.2: Health workers actively engage with community stakeholders to ensure services remain accessible to minority populations.	• Evaluation Performance Measure 36: The extent to which health workers believe it is their responsibility to engage the community to improve health access. • Evaluation Performance Measure 37: The extent to which health workers believe that consulting community stakeholders on minority health needs will lead to better access for minority populations. • Evaluation Performance Measure 38: The extent	• Behaviour, normative, and control beliefs about consulting community stakeholders to improve health access for LGBTI and other minority populations	• How frequently do health workers engage community stakeholders and in what formats? • How important do stakeholders see community engagement for better health access for minority populations? • What models have worked to promote additional community consultation on health issues?

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
	to which health workers regularly consult the community on minority health needs after attending the workshop.		
A2.1: 1-day mini-workshop with community leaders and representatives of CBOs will share learning from wider workshop and open a dialogue on how health centres, health workers and communities, can work together to overcome stigma and improve health access for LGBTI and other minority groups.	• Evaluation Performance Measure 39: The extent to which community participants demonstrate improved awareness of minority populations, including LGBTI. • Evaluation Performance Measure 40: The extent to which community participants demonstrate improved awareness of the concept of Umunthu and its application to reducing discrimination. • Evaluation Performance Measure 41: The extent to which community participants are comfortable to openly discuss how to overcome stigma and discrimination towards minority populations and how to improve health access for these populations.	• Items on community engagement included in Facilitator self-reflection	• Has the awareness of community stakeholders towards minority and LGBTI health needs changed after the workshop?
G2.1: Workshop activities improve community leader and CBO awareness of the need for proper treatment of LGBTI persons.	• Evaluation Performance Measure 42: The extent to which community participants have a greater awareness of the unique health exposures faced by LGBTI populations. • Evaluation Performance Measure 43: The extent to which community participants have a greater awareness of the health concerns of LGBTI populations. • Evaluation Performance Measure 44: The extent to which community participants increasingly believe that LGBTI populations	• Items on community engagement in pre, post and follow up tests	• How many people did the community workshop reach? • What is the composition of the workshop's audience? • How did audience views change after exposure to the workshop?

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
	require tailored approaches to promote health access.		
C2.1: CBO representatives and community leaders will improve their knowledge as to the role of community organizations in LGBTI health access.	• Evaluation Performance Measure 45: The extent to which community stakeholders have an improved knowledge of the role of community organizations and stakeholders in promoting health access for LGBTI and other minority populations. • Evaluation Performance Measure 46: The extent to which community stakeholders believe the community has an important role to play in supporting health access for minority populations. • Evaluation Performance Measure 45: The extent to which community participants report having an improved knowledge as to how to engage health providers to support health access of LGBTI populations.	• Items on community engagement	• Community stakeholder and health worker views on indicators.
C2.2: CBO representatives and community leaders will have improved knowledge as to how to engage health providers and other stakeholders to support health access of LGBTI populations.	• Evaluation Performance Measure 46: The extent to which community participants report having improved knowledge as to how to engage health providers to support health access of LGBTI populations.	• Items on community engagement	• Community stakeholder and health worker views on indicators.
B2.1: Exposure to the project will lead to members of CBO representatives and community leaders engaging actively with health workers to discuss ways to tackle health access disparities for LGBTI and other minority groups	• Evaluation Performance Measure 47: The extent to which community participants believe that consulting health workers on local health access issues will lead to improved health access for minority populations.	• Items on community engagement	• Community stakeholder and health worker views on indicators.

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
in communities (Objective 2).	• Evaluation Performance Measure 48: The extent to which community participants believe that they have a responsibility to support the health access of discriminated populations. • Evaluation Performance Measure 49: The extent to which community stakeholders believe they have the skills and resources to engage with health workers to improve health access for discriminated populations. • Evaluation Performance Measure 50: The extent to which community participants actively seek to inform health workers of relevant local health challenges affecting discriminated populations.		
A3.1: The 1-day training of trainers workshop will improve the knowledge of partner staff on how to address discrimination of minority populations, and LGBTI in particular, through the lens of Umunthu.	• Evaluation Performance Measure 51: The extent to which partners are increasingly interested in the Umunthu approach to addressing issues of discrimination. • Evaluation Performance Measure 52: The extent to which project partners demonstrate an increased awareness of the need for culturally competent approaches to address health needs of discriminated populations, including LGBTI. • Evaluation Performance Measure 53: The extent to which participants view the Umunthu approach as relevant to their on-going activities.	• Items on view and relevance of Umunthu approach • Items on needs of discriminated populations for improved health access.	• How have participants views towards the Umunthu approach changed after the workshop?
A3.2: The project's communication and advocacy strategy will	• Evaluation Performance Measure 54: The extent to which stakeholders	• Number of people targeted by	• How many people did the campaign reach?

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
improve visibility on the Umunthu Workshop and its unique approach to supporting health access for minority populations, particularly LGBTI.	targeted by advocacy and communication strategy demonstrate improved awareness of Umunthu approach to addressing the needs of discriminated populations. • Evaluation Performance Measure 55: The extent to which stakeholders targeted by advocacy and communication strategy are increasingly interested in learning about the Umunthu approach..	communication and advocacy strategy	• What is the composition of the campaign's audience? • How did audience views change after exposure to the campaign?
G3.1: The training of trainers' workshop and media publications will generate interest in the Umunthu approach to addressing LGBTI health access needs amongst partner staff	• Evaluation Performance Measure 56: The extent to which target audiences of communication strategy can articulate the main campaign messages. • Evaluation Performance Measure 57: The extent to which representatives of government and other institutions make declarative statements about the relevance of the Umunthu Workshop or workshop components in their on-going curricular and trainings. • Evaluation Performance Measure 58: The extent to which partners and other targeted audience members demonstrate increased interest in the Umunthu approach.	• Number and composition of those targeted by communication and advocacy strategy	• How many media stories were produced? • How effective were different media outlets in reaching their intended audiences?
C3.1: The training of trainers' workshop will provide participants with the knowledge on how to implement workshop components in their own curricula and trainings.	• Evaluation Performance Measure 59: The extent to which partners believe they have the necessary skills and resources to replicate Umunthu workshop components. • Evaluation Performance Measure 60: The extent to which participants	• Items on participants views towards Umunthu approaches • Knowledge items on implementation of Umunthu approaches, and facilitating and hindering factors.	• Can partners articulate the main messages of the workshop? • Do participants have enough knowledge after the workshop to replicate Umunthu components?

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
	believe the Umunthu workshop is relevant to their on-going activities. • Evaluation Performance Measure 61: The extent to which participants believe the Umunthu approach will lead to improved health access for minority populations. • Evaluation Performance Measure 62: The extent to which participants demonstrate improved knowledge of how to implement workshop components. • Evaluation Performance Measure 63: The extent to which participants demonstrate improved knowledge on how to manage challenges that could arise in implementing Umunthu Workshop components.		
B3.1: Workshop activities will be integrated into civil society, educational institutions, and government curricula and trainings.	• Evaluation Performance Measure 64: The extent to which representatives of government at the local, district, and national level believe the workshop approach is effective at supporting the health rights of discriminated populations. • Evaluation Performance Measures 65: The extent to which representatives of educational institutions believe the workshop approach is effective at supporting the health rights of discriminated populations. • Evaluation Performance Measures 66: The extent to which representatives of government, and other relevant institutions believe they have the resources and skills to	• Review of project records and output achievement with regards to the advocacy and communication strategy.	• How have representatives of government reacted to workshop findings and learning? • How do workshop components facilitate health access objectives of government and educational institutions? • What components are most often replicated and in what format? • How effectively has the project communicated learning from the Umunthu Workshop to improve replication practices?

Contribution Claim	Evaluation Performance Measures	Quantitative Measures	Qualitative Themes and Categories
	implement workshop components.. • Evaluation Performance Measures 67: The extent to which representatives of government and other relevant institutions believe the Umunthu Workshop is consistent and applicable to their specific health access policy objectives.		

Conclusion

Through achievement of the project's three primary objectives, the Umunthu Programme aims to realize several higher-order aims, namely:

- The project will contribute to the creation of a culturally competent environment that is conducive for LGBTI and other minority groups to assert their right to health services.
- The project will contribute to improved health access for LGBTI people.
- The project will contribute to reduced health disparities for LGBTI people.

By focusing on enabling health workers to consider and better understand LGBTI people through the local perspective of Umunthu, the project aims to enable them to appreciate and act on their responsibilities to discriminated populations (Objective 1). Project activities are well targeted to achieve this objective.

Consultations with health workers, district health management teams, and LGBTI respondents highlighted the significant levels of discrimination faced by these populations when seeking health services. Project stakeholders supported the view that homosexuality and sexual 'deviance' are viewed as an external, western, imposition on Malawian culture and norms. By adopting an authentic local construct as it's mantra, Umunthu, aims to provide a culturally competent means to elicit empathy and understanding on the part of health workers. This approach is well targeted to meet this need and challenge existing perceptions through an indigenous device.

LGBTI respondents highlighted the need for (1) non-disclosure and confidentiality, (2) non-discriminatory health services and (3) relevant care. The project aims to integrate these three health concerns into workshop discussions by using a LGBTI guest speaker and short videos documenting real life examples of cases where these health rights have been violated. By improving health worker knowledge and increasing their awareness as to the impact of these health concerns on health access, and ultimately health outcomes, the project aims to motivate them to actively adopt inclusive policies and practices.

However, is important to consider the extent to which these policies and practices will result in improved health access for LGBTI. Several LGBTI respondents and health workers, highlighted the fact that LGBTI in Malawi are a disempowered group. Asserting their right to health access, will require active engagement with these populations, much of which is beyond the scope of the current project. By addressing the supply side of this barrier to health access, the project aims to improve health access for LGBTI, over time. Future programmes should examine the extent to which support can be provided to LGBTI populations to improve their awareness of their health rights and their capacity to assert these rights.

The project also aims to support members of civil society and community leaders to engage with healthcare workers to discuss ways to tackle health access disparities in communities (Objective 2). This is currently supported through the third day of the workshop, where community stakeholders are invited to learn about workshop discussions, and participate in the creation of an action plan to realize improved health access in health facilities. The project believes that by supporting increased engagement between community members

and health service providers, on the issue of health access for minority populations, inclusive policies and practices will remain relevant and sensitive towards local community needs.

It is likely that continued community engagement, and community stakeholder participation in the action plan will result in more sensitive, adaptable, and targeted approaches to improve health access for LGBTI. However, it is unlikely that community members and health workers will have sufficient capacity to continue these engagements independently, beyond the workshop. The project should consider adapting the workshop approach to provide a model through which health workers and community members can continual engage on minority health access rights, in a participatory, open and sustained dialogue. Unless this is made practical for community representatives and health workers, it is unlikely that sustained engagement will be achieved.

The project's final objective is that workshop activities will be integrated into civil society, educational institutions, government curricula and trainings (Objective 3). The likelihood of meeting this objective is difficult to assess at the time of the baseline. However, the project needs to define a communication and advocacy strategy to ensure that workshop learning is well documented and communicated effectively to a wider audience. This strategy should aim to identify relevant government, media, and institutional stakeholders at the district and national level to be targeted in messaging activities as well as define the means through which advocacy engagements will be planned, managed, and documented.

Recommendations

Objective 1:

1. Review the role of guest speakers to ensure it is consistent with wider messaging objectives and with the project's aim of creating an open and safe space for participants. Some participants highlighted this as a significant concern. In the case of the second pilot workshop, many participants perceived the guest speaker to be aggressive. Processes to manage guest speaker engagements, including a review of the topics they will cover and how to manage disagreement, are essential to ensuring this component remains effective at reaching target audiences and delivering project messaging.

2. Providing LGBTI groups and advocacy actors with lists of health workers who had been trained and agree to be approached by LGBTI members seeking non-discriminatory care. The project currently aims to improve the supply of non-discriminatory health services but does little to promote LGBTI's knowledge about their health rights or knowledge about where they can receive accessible services. This area should be examined for future funding sought by the organization.

3. Consider letting participants know that the workshop will discuss improved health access for LGBTI populations. Workshop objectives should be made to participants at an early stage and in a culturally-competent way. The project should pilot this approach and compare it with previous approaches. Several health workers cited that they would have still attended the workshop if the content was made clear in advance. They also cited concerns that they felt the indirect manner, in which a 'sensitive' topic such as LGBTI was raised, led them to feel as if the workshop was contrived and confused the concept of Umunthu (which was originally believed to pertain to all kinds of people, not just LGBTI).

4. Consider inviting previous workshop attendees as guest speakers. Health workers mentioned that listening to fellow 'model' health workers can inform them on how to implement changes in their own health units, deal with issues such as confidentiality and mobilize others in the pursuit of inclusive policies. The programme may benefit from selecting role model participants and inviting them to participate in the workshop as guest speakers.

5. Review the role of the legal guest speaker. Several health workers reported that the information provided by the legal guest speaker was not useful as the majority do not fear any legal consequence of servicing LGBTI persons. If the purpose of the legal speaker was to inform them that this is indeed the case, the project may more efficiently deliver this piece of information through facilitators 4, rather than by engaging an external speaker. This slot could be substituted by fellow health workers guest speakers that are selected as 'champions' of the project.

6. Continually review data collected from Workshop Feedback Forms to ensure the workshop remains relevant and engaging for participants and to reduce potential drop-out during the follow-up workshop.

7. Consider developing a set of ideal action plans and presenting these to participants as examples. It is essential that the process of creating or adapting an action plan is collaborative as this will encourage participant ownership and buy-in. The project could consider allowing participants to develop their own action plan, then sharing an 'ideal' plan and criteria to evaluate it. Participants could then use that criteria to participatorily evaluate the plan they have developed.

8. Consider documenting best practices in action plan development and achievements. This could be used in future workshops to provide real-life examples of what inclusive policies and practices can be adopted and how these can be implemented.

9. Consider periodically monitoring progress on action plans, beyond the follow-up workshop, and identifying ways through which the project can support participants during implementation. Follow up could be done telephonically if a representative was selected during the workshop who could be contacted at key stages for a phone interview.

10. Leverage project partners to share information on health disparities experienced by LGBTI populations, to better inform health workers as to the need for targeted support for these groups. This may be difficult due to the absence of country-level data on health outcomes for LGBTI populations. Whilst, the primary aim of the project is to target the rights of LGBTI to health access, improving health worker awareness of the disparities faced by these populations, could support them to, from a professional and medical perspective, more easily approach LGBTI health seekers.

Objective 2

1. The project should aim to include clear steps and processes to guide health workers and community stakeholders on how to discuss and identify health needs of minority populations, during the 1-day mini workshop. This could be modelled during the third day of the main workshop but should be explicitly targeted at promoting improved and sustained engagement between community stakeholders and health workers.

2. The project should consider appointing a LGBTI health leader within the Health Advisory Committee, who is responsible for following up and monitoring on-going action plan progress. This would provide someone with a mandate to continue to promote LGBTI inclusive health policies and promote continued engagement.

3. The project should consider documenting best practices in target communities during implementation to share these in future workshop settings and enable community representatives to see real life examples of the differences they could make and the role they have in promoting health access for LGBTI. This could be done by inviting health workers that have been successful in implementing their action plans to the workshop and having them share their experiences and challenges faced.

4. The project should consider a more sustained engagement with CBO representatives and community leaders at the health cluster level to ensure they have the capacity to advocate for the health rights of minorities. This may be done in a separate workshop used to disseminate and gather feedback on findings from monitoring or evaluation.

Objective 3

1. The project should develop a comprehensive communications and advocacy strategy to achieve Objective 3. The strategy should identify relevant stakeholders and create advocacy outlets for the project to share learning. This could be done by reviving the Technical Working Group on Key Populations.

2. The project should continuously document learning through quarterly reporting and other monitoring practices to ensure it builds robust evidence on what workshop components are most effective and why. This can be shared with stakeholders identified in the communications and advocacy strategy.

3. The Umunthu approach resonates with the humanistic characteristic of major religions in Malawi. The project may enlist the help of religious leaders supportive of LGBTI rights to persuade to support project advocacy activities. The project could, for example, select 'champion' religious leaders to participate in the technical working group and benefit from evidence-sharing.

Scope

This study is part of a wider external evaluation aimed at providing comprehensive evidence on project outcomes, sustainability, and effectiveness. Evaluation questions were developed and agreed in collaboration with AGHCA project staff. The external evaluation will seek to answer three key evaluation questions:

(1) Was the project successfully designed and implemented?

a. Was the project appropriate for its context?

b. Did the original project design reflect what rolled out on the ground?

c. What were the key lessons learned from the project that can inform the design of related projects in future?

(2) Has the project influenced desired results?

a. Have project objectives and outcomes been attained?

b. What does the preponderance of evidence say about how well the programme is making a difference and is it reasonable to conclude the programme has made a difference?

c. What conditions are needed to make this type of programme succeed?

(3) How likely is it that project achievements will be sustained after the project?

a. To what extent have project approaches and methods been replicated?

b. To what extent have achieved changes been institutionalized?

c. Which activities have had long-term impact and why?

The external evaluation is divided into three points: Baseline, Midline and Endline. The Baseline aimed to further the project's understanding of its context, discuss how and why the project expects its activities to lead to desired results, and identify evaluative performance measures. For the purposes of this exercise, two research questions were reformulated. These questions as well as their associated sub-questions are shown in Table 1.

Table 2. Baseline Research Questions and Sub-questions

Research Question	Sub-Questions
Was the project successfully designed?	**CONTEXT** • How is primary health care delivered in Malawi? • What are the different health concerns of lesbian, gay, bisexual, transgender and inter-sex populations? What makes their concerns a distinctive health topic? • What forms do disparities in health outcomes take for LGBTI populations? • What is the relationship between disease and gender identity and sexual orientation in Malawi? • What similar initiatives, organizations, or advocacy groups exist in Malawi? What activities do they organize? Have they been successful? • How does Umunthu innovate or strengthen the current work of civil society? • What kind of organizations are able to replicate the workshop and why?
	DESIGN • How was the project designed? • What is the projects Theory of Change?

	SYNTHESIS • Is the project design appropriate for its context?
How likely is it that project activities will lead to desired results?	• What contribution claims does the project make and why? • How likely is it that project activities will lead to desired results? • How will contribution claims be assessed at later evaluation points?

The evaluation will be used by project and partner staff as a primary source on the pre-implementation context, and to inform a management response aimed at improving on-going project learning and implementation.

Limitations

1. This study was conducted prior to project implementation. At the time of the Baseline, the project had only begun implementing pilot health worker workshops. Therefore, any findings of this study are limited to the pre-implementation scenario and do not account for future project activities.
2. Health worker participants consulted as part of the study from pilot workshops, only included participants from pilot workshops in Phalombe and Nkhotakota. Therefore the study is limited in the extent to which it can claim findings associated with these interviewees are representative of workshops conducted by the project. Findings reporting pilot workshop participant views are therefore limited to the two pilot workshops that had been conducted at the time of the Baseline Study.

Methodology

Contribution Analysis

To answer the evaluation questions and generate evidence on the project's contribution, the evaluation adopts *contribution analysis* (CA) as its main methodological approach. Contribution analysis is a mixed-methods and participatory approach for inferring project contribution to given outcomes.

CA aims to reduce uncertainty about the contribution an intervention is making to observed results through an increased understanding of why observed results have occurred. Contribution analysis is comprised of six steps:

1. Set out the attribution problem to be addressed
2. Develop a theory of change and risks to it
3. Gather the existing evidence on the theory of change
4. Assemble and assess the contribution story, or performance story, and challenges to it
5. Seek out additional evidence
6. Revise and, where the additional evidence permits, strengthen the contribution story

The result from contribution analysis is not definitive proof, but rather provides evidence and a line of reasoning from which we can draw a plausible conclusion that, with some level of confidence, the program has made an important contribution to the documented results.

Performance Story Workshop

To understand how and why project stakeholders expect activities to lead to desired results, the study organized a Performance Story Workshop at Baseline. The aim of the workshop was to define and develop the project's performance story, through participatory exercises with relevant stakeholder groups.

The Workshop was held in Zomba from August 9 – August 11th, 2017. Workshop participants included 22 representatives of the groups shown in Table 2.

Table 3. Performance Story Workshop Groups

Group	Description: Workshop Particpants
Project and Partner Staff	Participants include the project management team as well as participants from the Umunthu Curriculum Development Workshop. This included representatives from CSOs, legal aid organizations, and health institution representatives.
Health Workers	Health workers who participated in the pilot workshop held in Phalombe were invited to attend the performance story workshop and reflect on their experience of the pilot as well as represent the interests of health workers more generally. Health workers included clinicians, nurses, ART officers, and VCT counsellors.
LGBTI representatives and allies	The project supported in the recruitment of relevant LGBTI representatives who were comfortable attending the workshop. These included representatives of the LGBTI community who had participated in the project's curriculum design workshop as well as LGBTI guest speakers from the 3-day workshop. An LGBTI legal specialist also participated in this group.

Workshop activities are summarized in Table 3. All activities were conducted in the small groups shown above. Small group participants responded to the activity stimulus and prepared a presentation to share in a plenary session. After each presentation time was allocated for group discussion.

Table 4. Performance Story Workshop Activities

Activity	Description
River of Life	A visualization exercise to define and elaborate each community's history and features (health workers, health advocacy actors, and LGBTI)
Problem Tree	A visualization exercise to identify core problems, their causes, and effects.
Vision Tree	A visualization exercise to identify intervention vision, required actions, and characteristics.
Force Field Exercise	Identifying and weighing the effects of all factors influencing intervention activities.
Stakeholder Mapping	Activity to map key stakeholders on axis of influence & interest

In-Depth Interviews and Focus Group Discussions

After conducting the Performance Workshop, the evaluation team developed a series of in-depth interview and focus group guides to collect additional evidence on the Baseline's key research questions. Qualitative sessions were designed to elicit declarative statements on intervention activities, assumptions, or underlying logic from various project stakeholders based on their relevant vantage point. Throughout the research process qualitative tools were adapted and redesigned to respond to on-going findings and changing lines of inquiry.

The qualitative sessions conducted as part of this study are shown in Annex 1. Study participants included:

- Representatives of District Health Management Teams (In-depth Interviews)
- Key Experts including representatives from College of Medicine, CEDEP, CHRR, and other organizations (In-depth Interviews)
- Frontline Health Workers at Primary Health Centers (Focus Group Discussions)
- Frontline Health Workers at Primary Health Centers (In-depth Interviews)
- Transgender Informants (In-depth Interviews)
- Homosexual Informants (In-depth Interviews)
- LGBTI Representatives (Focus Group Discussions)

All qualitative sampling was purposive and heterogeneous. In some cases, recruitment relied on snow-balling. Qualitative sessions were recorded, transcribed in Chichewa, and translated into English. Qualitative data was analyzed using QDA Miner software based on the data analysis (coding) framework.

1. Is the project appropriate for its context?

1.1 Project Context

With a total surface area of 118,484 km2[6] and a population around 18.30 million (2017)[7], the republic of Malawi is a landlocked Southern African country that borders Tanzania, Zambia and Mozambique. Like many other traditional "African" societies, Malawi considers heterosexual activities including childbearing and the subsequent reinforcement of family values, as desired, and other forms of sexualities as deviant and alien to the social and cultural fabric of Africa[8].

Same-sex sexual relations are criminalized in Malawi under Section 153 and 156 of the Penal Code. Section 153, prohibits carnal knowledge of any person against the order of nature and punishes such activities by imprisonment of fourteen years with or without corporal punishment[9]. Section 156, specifically criminalizes 'indecent practices between males' and punishes such activities with five years with or without corporal punishment[10]. In 2010, Malawi's Parliament passed a law criminalizing consensual same-sex activity between women[11].

These measures have contributed to a hostile legal environment for those who practice 'same-sex' sexual relations, including homosexuals, bisexuals, and transgender populations. Although intersex populations do not face the same explicit legal hostility experienced by other key populations reviewed as part of this study, cultural norms and beliefs and lack of awareness has led to documented human rights violations[12]. A hostile legal environment, coupled with non-accepting cultural and religious norms, results in stigma, discrimination, and psychosocial stress, which in turn lead to increased health risk behaviors and poor sexual and reproductive health (SRH) amongst LGBTI populations.

Studies on the provision of quality care to LGBTI populations emphasize the importance of an improved commitment to upholding the rights of LGBTI to health and an improved knowledge of (1) the areas in which LGBTI people are at an increased risk for disease because of unique exposures; (2) areas in which they have

[6] Muula, A. (2007) 'Perceptions about Men Having Sex with Men in Southern African country: Case Study of Print Media in Malawi', Croatian Medical Journal

[7] Worldmeters. (2017). *World Population, Malawi Population*. Retrieved 06 29, 2017, from Worldmeters: http://www.worldometers.info/world-population/malawi-population/

[8] Muula, A. S. (2007). Perceptions about Men Having Sex with Men in Southern African Country: Case Study of Print Media in Malawi. *Croatian Medical Journal, 48*, 398 - 404.

[9] Malawi Penal Code available at: https://www.malawilii.org/mw/consolidatedlegislation/701/penal_code_pdf_14611.pdf

[10] ibid

[11] Malawi Nyasa Times (2011)

[12] CEDEP annual report

high prevalence of diseases or problems that are not caused by unique exposures; (3) areas in which they are not at increased risk for disease but which nevertheless require specialized culturally-competent approaches[13].

While there is little data available on the prevalence of various diseases amongst LGBTI populations in Malawi[14], there is wide agreement amongst experts and stakeholders that LGBTI populations face increased prevalence of HIV/AIDs and other STIs[15], do not practice health-seeking behaviors[16], and face barriers to accessing quality care at health facilities[17].

Stakeholders also widely agree that the focus of targeted interventions for LGBTI populations has been on men who have sex with men (MSM), specifically through HIV/AIDS programming[18]. Programming so far has not focused on addressing the wider health needs of other LGBTI groups. Several stakeholders, in fact, argued that the only way to access funding to support LGBTI health needs, was to focus on MSM and HIV. One expert commented:

"If you don't talk HIV for example you will not get money for LGBTI interventions, but you will have to talk HIV because that where they are putting in money"[19].

PEPFAR's Gender Assessment (2016), which incorporated a literature review of over 30 country level studies, found that "HIV prevalence estimates for MSM in Malawi vary widely"[20]. Despite a focus of donors on HIV/AIDs prevention, treatment, and care for LGBTI populations, and MSM populations especially, very little hard data exists on health disparities in this domain and for these groups.

In a study of 202 homosexual men in Blantyre and Malawi, researchers found an HIV prevalence rate of 21.4%[21]. This study also found that MSM in Malawi very frequently have concurrent relations with both male and female partners[22]. Additional studies have been planned by PEPFAR to map estimated presence and HIV/healthcare needs among MSM, sex workers, and transgender persons[23].

In the absence of wider country level research on health disparities of LGBTI populations, programming should remain sensitive to the expressed health needs of specific LGBTI populations, and other stakeholders engaged in health and health advocacy approaches. With specific regards to HIV, global evidence demonstrates that stigma and discrimination prevent key populations from "(1) seeking and accessing HIV testing, (2) disclosing their HIV status, (3) accessing and practicing prevention, (4) accessing care, and (5) adhering to treatment"[24].

LGBTI members interviewed as part of this study highlighted several key health concerns: right to privacy and confidentiality, right to health access without discrimination, and right to quality care, relevant to their needs.

Right to Confidentiality and Non-Disclosure

The Ministry of Health includes a right to privacy and confidentiality within its policies on patient rights[25]. Similarly, the LGBTI Cultural Competency Framework, widely used in health advocacy programming for this population, highlights the importance of a right to non-disclosure and privacy in encouraging health seeking behaviors, patient access, and non-discrimination[26]. Provisions which protect for patient confidentiality are

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[13] CCF

[14] PEPFAR Gender Assessment (2016)

[15] ibid

[16] ibid

[17] ibid

[18] ibid

[19] LGBTI Key Population Expert (Partner Organization) 1

[20] ibid

[21] Baral et al., 2009

[22] ibid

[23]

[24] Jain

[25] "Will Health Rights Solve Malawi's Health Problems Muula

[26]

expected to improve health outcomes and behaviors by creating an environment where health providers can be accessed without increased risk or fear of harm.

For transgender people, interviewed as part of this study, several cited cases where their privacy was violated by clinicians and other care providers. One transgender women described her experience:

"When I went there [to the clinic], for me to have proper treatment, I had to explain that I am a trans woman and that I have sex from my anus. He [the clinician] went to tell other staff from the hospital. The whole reception was full up and the people were laughing and talking bad words to me. I just walked by but I was afraid to go anywhere to report."[27]

Another transgender woman faced similar circumstances:

"I went to a private clinic and explained to the doctor about complications related to anal sex. He had never heard of a man engaging in sex like this and went to consult others at the hospital. When I left they were calling me names and did not provide me with any treatment"[28].

Homosexual men and women also asserted the importance of their right to confidentiality and privacy. Several gay men listed cases they had heard about, where gay patients were held by clinicians who, upon realizing that they had engaged in anal intercourse, felt obliged to report the case to the police[29].

Many gay mean reported cases where their confidentiality had been violated:

"There is no privacy in health clinics. They will use you as an object of a joke."[30]

"Even the setup of the clinics is… outrageous. Sometimes patients are seated, and I think they take the conditions there. They ask you what is your problem there. There is no confidentiality. It is not like you go to a consultation room… the nurse will be there asking what you are suffering from."[31]

"In the health centers because of the long ques they don't care they will still ask you while your friends are hearing: 'What is your problem?'"[32]

Even when MSM projects had aimed to create spaces where gay men could access health without discrimination study participants reported cases of privacy violations:

"Even in Blantyre… the nurse was asking everyone who has come for same sex project please hurry up and come for testing.. in front of everyone… can you imagine being called in public 'all the gays that have come for testing, please come here'. The people who are in that place at that time will know who are the gays are."[33]

A lesbian participant who tried to access HIV testing in a private clinic reported similar experiences:

"We went to a private clinic because HIV testing is sometimes free even in a private clinic. So, we went there and went into a consultation room. We wanted to get together and we wanted to get tested because we are in a relationship. The nurse said 'We don't do this, if you want us to do this you must give us money. So, we gave the doctor 10,000 to be tested and the doctors went somewhere to another room and called their friends to tell them. After doing all those things, after we were tested there were

[27] In-depth Interview with Transgender Woman Blantyre 2

[28] FGD with LGBTI

[29] ibid

[30] ibid

[31] ibid

[32] ibid

[33] FGD with LGBTI 2

nurses outside looking at us because they had been told. The privacy was no longer there. I can't go their again."[34]

Additional evidence from in-depth participant interviews highlights a sequential pattern with confidentiality violations leading to verbal discrimination. In 4 out of every 5 cases where confidentiality was reported as having been violated by LGBTI informants, they also reported subsequent name calling and verbal abuse on the part of health providers[35].

Right to Non-discrimination

LGBTI participants consulted in the study emphasized the role of discrimination in affecting their comfort and willingness to access health services. Many LGBTI overall feel that they do not have a 'space' in which they are free from discrimination even beyond the health context and highlight the importance of ensuring health centres are able to provide this safe space.

Several LGBTI study participated listed their right to access health without fear of discrimination. While this was mostly associated with confidentiality and non-disclosure, many LGBTI participants emphasized the importance of accessing care free from personal judgement of health workers. A gay informant stated:

"It's high time we claim what belongs to us. We are not asking for special rights. We are asking for the same services that are being given to the heterosexual community. We not asking for something special."[36]

These findings highlight the relevance of the project's overall approach in targeting negative health worker attitudes and malpractices that affect LGBTI health access.

Discrimination experienced by LGBTI is not limited to the health sector. Several homosexual men commented:

"Being an LGBTI person in Malawi is not an easy thing and we are the survivors… we face discrimination everywhere, we've got nowhere to hide. It is really painful to be an LGBT in this country."[37]

"We don't' have space anywhere. When you want to go to Church, people will target you for violence, even the police. every setting in Malawi is not accommodating."[38]

"An LGBTI activist's security is always compromised. Be it in transport, bars, or clinics."[39]

For older LGBTI study participants, accessing health is even more difficult due to their age and the pressure in Malawian society to marry. Several participants emphasized the role of age in the type of discrimination they face when they try and access services, and health services in particular:

"They say 'but you look like you are over 25 years and you are not married'."[40]

"Being LGBT and ageing is very distressing. Where you've lived in a setting that people are so nosey means you are always talked against and there is no safe space for LGBT in Malawi. This overlaps with the issue of health and accessing health services."[41]

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[34] In-depth Interview with Homosexual Woman

[35] Coding Retrieval (One South) – Concurrence 1

[36] In-depth Interview with Homosexual Man 1

[37] In-depth Interview with Homosexual Man 2

[38] FGD with LGBTI 2

[39] ibid

[40] ibid

[41] ibid

"You are hesitant to access services because you know people know you, especially if you are older."[42]

Several participants felt that they face increased discrimination, in rural areas in particular:

"Despite having towns despite having cities Malawi is very rural, we don't' have cosmopolitan places and that makes you the focus of discussion…If you go to a bigger city no one cares about you but in Malawi is everyone is focused on what you do, what you wear, what you put in your hair. That's' what makes LGBTI easy targets."[43]

"Towns and cities make people become individualistic but in a rural area people are nosey they want to know who you are"

One respondent highlighted the effect that discrimination can have on one's mental well-being:

"Even if you want to opt out and access services in a private clinic it brings you down to realize that throughout your life you are been put down."[44]

Lesbian and gay respondents continually highlighted the discrimination faced in health facilities:

"This other time I went to a hospital. I had malaria and then the nurse was asking "are you a boy or a girl" and the nurse was asking… "why are you dressing like this"… I said "that is my choice"…. "you look like a man blah blah blah."[45]

"We have had many cases of people who are denied ARVS. You chose yourself to have this, we would rather give the ARVs to people who deserve."[46]

"One of the worst experiences that we have right now is the referral system that we are using for peer outreach. Usually the peer educators reach out for clients when they have a challenge to get direct access for certain people. What is happening now they are turning down the referral systems or forms because they say, 'we are not going to take this' we are not going to accept this because it is same sex"[47].

"According to the public health policy as long as you don't' have a strange sickness that they will ask you maybe in your anus or some strange place, they would treat you but each time you are explaining some stuff they are not comfortable with… they will start making a scene out of it… you can easily be treated but its when you may be feminine that you can be asked other things apart from what you are telling them"[48]

A lesbian interviewee corroborated these experiences:

"It is the case where they [health providers] say I am wrong, that what I am doing is wrong. That I only need to find a man and that something in my mind is wrong"[49].

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[42] ibid

[43] FGD with LGBTI 2

[44] ibid

[45] ibid

[46] ibid

[47] In-depth Interview with Homosexual Man 2

[48] FGD with LGBTI 1

[49] In-depth Interview with Lesbian Woman 1

Respondents also highlighted the key role that discrimination plays in their willingness to seek health services. As one respondent put it:

"The friends I have that have suffered discrimination they are concerned and express that they do not want to go back to health centers because when you have an illness in your anus they usually ask you how did you get it"

Transgender study participants emphasized that they feel they face unique risks of discrimination in health centres because the fact that they are transgender is explicit when they attempt to access care. Transgender participants commented:

"Here in Malawi it's very difficult to access treatment for trans, mainly for trans. For gays, like for bisexuals, its easy because they can just go to the hospital as any person but with a trans woman you have problem at the anus if you go to the hospital they will ask you a number of questions and then it will be difficult for you."[50]

"if you go to the hospital they will ask you a number of questions and then it will be difficult for you so people are dying they have lost a number of friends because they could not get their proper treatment because they are afraid of going to the hospital because they torture us a lot."[51]

"The trans community they face a lot of stigma and discrimination because people charge them according to how they look. So going into a crowded hospital everyone will identify you by the way you look, they way you are dressing…. Stigma and discrimination is always easy for such people."[52]

To better understand the causes of this discrimination, the study consulted all project stakeholders including LGBTI people, health workers, relevant experts, and advocacy actors. As with previous studies elaborating these root causes, religion, colonialism, and an interpretation of Malawi's cultural norms were listed as being significant influencing factors.

According to the Malawi Religion Project, 69% of Malawians identify as Christian, 26% as Muslim, and 6% as other. Several key informants highlighted the role of religion as an explanation of why LGBTI groups face discrimination:

"It's not biblical. The Quran and the bible are against sodomy"[53]

"Religion…is getting worse. We discussed some religious leaders from the west that are establishing very homophobic and discriminatory institutions in Africa and perpetrating the stigma and discrimination"[54]

"In Malawi, religion is a key factor, which frames the negative views society has towards LGBTI. It is seen as wrong and unnatural in the eyes of god."[55]

"The religious background of most of the health workers is another problem because if you go there with an STI or some kind of strange disease that they are not aware of… they are not trained on some of the diseases an LGBT can suffer… so when you go there you become a center of attraction.."[56]

These findings are in line with the literature. Muula (2007) found that "most people who opposed homosexuality during the constitutional review process argued on the basis of religion and culture, saying

[50] In-depth Interview with Transgender Woman Blantyre 1

[51] In-depth Interview with Transgender Woman 2

[52] ibid

[53] Group 3 problem tree presentation

[54] ibid

[55] In-depth Interview with Transgender Woman 2

[56] In-depth Interview with Homosexual Man 1

homosexuality is against Malawi's cultural values and norms and against the 'creation of man and woman as god designed them to be'"[57].

A second more critical perspective, shared by LGBTI representatives, several advocacy actors and relevant experts consulted, focused on the legal institutions, specifically the penal code, inherited during colonialism. A gay activist summarized the view during the 'problem tree' discussion:

"The legal framework is the biggest challenge and actually perpetrates most of the stigma and discrimination because each time you go to the health centre, if someone denies you the service, they will actually quote the penal code that doesn't allow them to treat you. Even the police and the courts would use that as well so our biggest problem is the legal framework. In most of the cases, the problem that emanates from this."[58]

This view is supported by Muula's article (2007): "In the case of Malawi, much of the revulsion of homosexuality can be traced to our colonial past". He focused specifically on the penal code in this regard. His work further found that the oppression of homosexuality continued under Malawi's first regime following independence. Muula argues this was maintained by the "four cornerstones" upheld by the regime: unity, loyalty obedience and discipline, all of which promoted conformity.

The third and more eclectic root causes often listed for discrimination towards LGBTI populations in Malawi, is culture and traditions. In this view homosexuality is seen as "un-Malawian". Several health workers commented on this:

"It's strange in the Malawian culture for men to have intercourse with fellow men, even in our background its strange, so because of that anybody who does it, does it in secret afraid that if they come in the open people will laugh at them that's why they hide, that people will be pointing fingers at them they come out."[59]

"We've never actually found them, but being the lakeshore area and with the coming of tourist we have proof that they are being done (all laughs)."[60]

"They say… we are just borrowing it from outside there, and they call it from mzungu, from Europe or from elsewhere because they say in Malawi we don't have that culture."[61]

The first view finds homosexuality to be "strange". The root cause in this example of the exclusion of homosexuals, is their strangeness, or difference to what would be viewed as acceptable. The second view and third view specifically see deviant sexualities as being caused by tourists, an external force, in this case 'spreading' alternate sexualities in Malawi. This view was expressed throughout district consultations, with 'azungus' seen as the bringers of these practices.

A gay man elaborated that health workers do not understand the love that can be experienced between two men of the same sex:

"You see, when you talk about gay, many people just think about anal sex. They don't think that there could be love, that two men can love each other. So even when you are trying to access health services they just see the anal part, they don't see that okay, this is a person like any other person who has a problem."[62]

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[57] Muula 2007

[58] In-depth interview with Homosexual Activist

[59] FGD with Health Workers 2

[60] ibid

[61] In-depth interview with Transgender Woman

[62] In-depth Interview with Homosexual Man 1

Each of these factors, play a role in contributing to the discrimination faced by LGBTI populations in health clinics. During the Performance Story Workshop, each participant was asked to list and rate various negative and positive influencing factors affecting the intervention's health advocacy. Ratings were done individually on a scale of 1-10 with 1 representing the lowest degree of influence and 10 representing the highest. Mean results by each of the workshop groups are shown in Table 4. As found during stakeholder consultations, the highest negative influencing factors listed across all groups were religion, penal code, and culture.

Table 5. Force Field Analysis: Influencing Factors

Negative Influencing Force	Mean Influence Score (10 = highest degree of influence)
Religion	9.9
Culture/Traditions	9.7
Penal Code / Legal System	9.7
Politics / Politicians	8.4
Police	7.1

Right to Relevant Care

The final health concern of LGBTI populations consulted as part of this study, was the right to quality care, relevant to their specific health needs. This was raised as a key issue in the Performance Story Workshop "vision tree" exercise. Participants were asked to describe a vision of how they would like to see health provision for LGBTI in five and ten years. Specifically, they were asked to describe the features and characteristics of their vision with regards to health access and health care.

For the LGBTI group a right to quality and relevant care included: having health workers aware of their unique health needs and being able to access lubricants and dental dams at health providers.

As informants put it:

"We have a right to expect health workers to know about diseases that affect people like us."[63]

"Sometimes they do not know how to treat anal infections and we are left with everyone in the clinic knowing that we are gay."[64]

The case for relevant quality care was especially important for transgender study participants. Several discussed the difficulty of transitioning in Malawi, due to lack of hormonal treatment and expert care. They cited that the only place they could adequate care to transition was in neighboring South Africa. For those who can't afford to travel, or the treatment, they rely primarily on private clinics, as being paying customers, they feel they are less likely to face discrimination. However, this is not always the case:

"To access the care I need, my only hope is a private clinic. Even there we face discrimination and can get no help to change to be who we are."[65]

An advocacy activist furthered:

"In this country, the issue of trans people hasn't been commonly talked about and for your own information I don't think the system is even prepared enough to address the issues of trans people."[66]

[63] FGD with LGBTI 1

[64] ibid

[65] In-depth interview with Transgender Woman

[66] In-depth interview with Homosexual Activist

Other initiatives and actors

Several advocacy actors in Malawi actively aim to support the rights and empowerment of LGBTI populations.

The Centre for the Development of People (CEDEP), was established to address the needs and challenges of minority groups in Malawi with a focus on human rights, health and social development. CEDEP specifically targets LGBT populations, prisoners, sex workers, and street children. CEDEP has played an active role in the promotion of LGBT rights across the country. Amongst LGBTI interviewees all mentioned receiving or knowing of the support provided by CEDEP. As one gay activist stated,

"Others say we are all CEDEP's children."[67]

The Centre for Human Rights and Rehabilitation (CHRR) is a leading human rights organization in Malawi. CHRR aims to contribute to the protection, promotion and consolidation of good governance by empowering rural and urban communities to be aware of and exercise their rights through research, advocacy, and networking. CHRR's work has had a strong focus on supporting the rights of LGBT populations.

In 2010 CHRR and CEDEP jointly organized a conference targeting religious leaders to discuss issues faced by LGBT population. The conference included a variety of stakeholders including human rights lawyers, journalists, government representatives, academia, the private sector, the faith community, and civil society. The conference faced some difficulties on the first day, where police arrived and demanded a copy of the list of participants. However, this was later resolved, and delegates were able to engage in several discussions focused on homosexuality, HIV/AIDS, and human rights. The conference resulted in the establishment of a taskforce to further dialogue on LGBT issues and lead advocacy efforts, the Technical Working Group on Most at Risk Populations (MARPs). Groups targeted by the task force include LGBT, sex workers, prisoners and other marginalized groups.

Several participants interviewed highlighted the relevance of a project implemented by John Hopkins which focused specifically on training health workers to provide accessible care to MSM health seekers. Many LGBTI participants stated that they are comfortable accessing the John Hopkins facility in Blantyre because they know about this initiative:

"We are lucky that we have John Hopkins which assists especially MSM. So you go there when you have any problem and they serve you when you have any problem but that is the only facility we have in Malawi."[68]

Several key informants also highlighted initiatives in other African countries and the need for Malawi to learn from these:

"Malawi is not an island. They must learn from what others are doing. Look to conservative countries like Kenya, like Ethiopia. Malawi can learn."[69]

"In Malawi we say a lot of things because of poverty. There are many poor places but people are doing things. So why not Malawi? In Malawi we love our poverty. Poverty contributes but Malawi needs exposure to see how things are done in other countries."[70]

Participatory Exercises on Project Context

Through the Performance Story Workshop, the study gathered key feedback from a wide variety of stakeholders on the project's context.

The first exercise focused on defining each community's history through the metaphor of a *River of Life*. Participants were divided into three groups based on their affiliation: project and partner staff (group 1), health workers (group

[67] In-depth Interview with Transgender Woman 1

[68] FGD with LGBTI 2

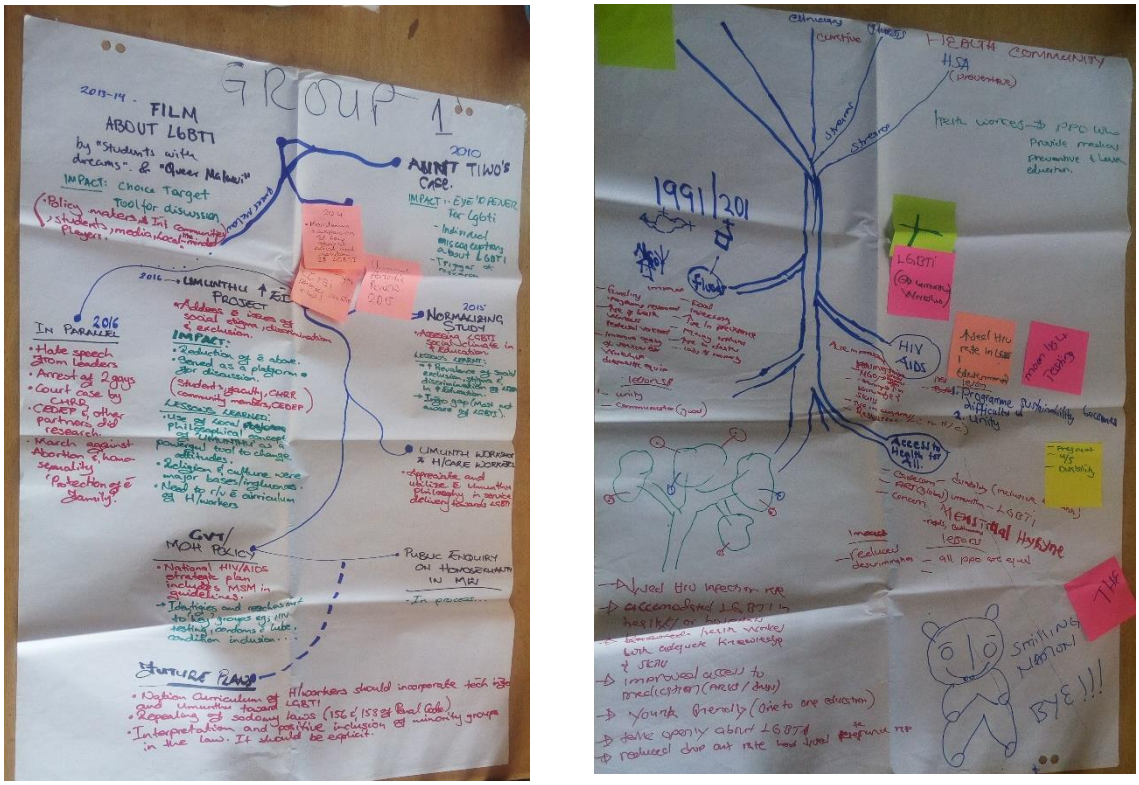
[69] ibid

[70] ibid

2), and LGBTI representatives (group 3). The river of life for Project Staff and for Health Workers are shown in Figure 1.

For project and partner staff, the river of life focused on the wider LGBTI discourse in Malawi. In their narrative, LGBTI issues were brought to the national stage in 2010 through a caught case in which a gay defendant was accused of 'unnatural' acts, such as sodomy. This rasied the issue for LGBTI throughout Malawi and influenced the political discourse with many misconceptions about LGBTI being voiced by politicians and other public icons. In 2013, 'Students with Dreams' and 'Queer Malawi' partnered to create a film about LGBTI which continued to fuel national discussions and was used as a tool to raise the issue amongst students, policy makers, and other actors. In 2014 a moratorium was placed to suspend the prosecution and arrests of LGBTI in Malawi. There was some disagreement as to whether the moratorium was still in place. In 2016, the Umunthu Film was released. The film aimed to discuss homosexuality from an African perspective and was used as a tool for discussion with students and other policy makers across Malawi. Project partners also highlighted that the new National HIV/AIDs policy mentions MSM directly as a key population, furthering the visibility of homosexuality in the national health discourse.

Figure 1. River of Life for Project Staff & Health Workers

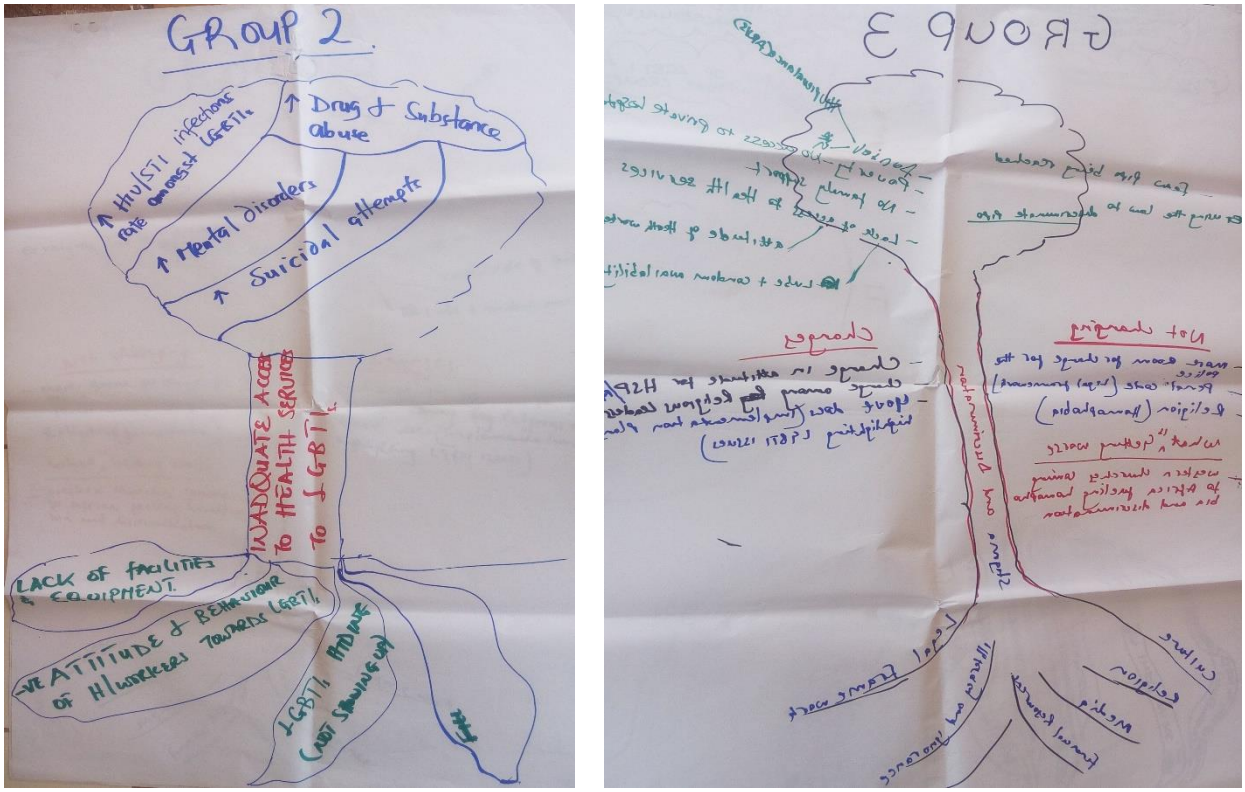


The River of Life developed by Health Workers focused on key events that influenced subsequent health policy. In 1991 floods affected health workers in Phalombe and resulted in a greater degree of coordination between various health units in the response. Health workers tended to highlight how key events influenced their views and the views of the colleagues on health outcomes. They continued to mention the role of HIV/AIDs in the mid-to-late nineties and the renewed focus that was placed on stigma and discrimination particularly against people living with HIV (PLHIV). Interestingly, they concluded their river of life with the Access to Health for All initiative, a nation-wide initiative to promote health access. Discussions on this initiative indicated that the Umunthu Programme was highly relevant to their current work as on-going health policy is at a crossroads, with renewed emphasis being placed on inclusion.

LGBTI participants began their story with the role of the colonizer. As one respondent mentioned, "When they came to Malawi they came with their laws". This discussion focused on the penal code and various elements that had been inherited from the British which negatively affected the lives of LGBTI. The discussion also highlighted the key role of religion as a negative factor influencing the stigma and discrimination faced by LGBTI people in Malawi. Respondents concluded by mentioning the recent review of the constitution and the fact that while the constitution had been reviewed, the penal code had not. For LGBTI legalization of sexual difference was a key source of on-going discrimination.

The second workshop exercise aimed to unpack key barriers to health faced by LGBTI. Each group created problem trees highlighting the root causes of the problem (roots) and the effects of the problem (branches). Problem trees for the health workers and LGBTI are shown in Figures 2.

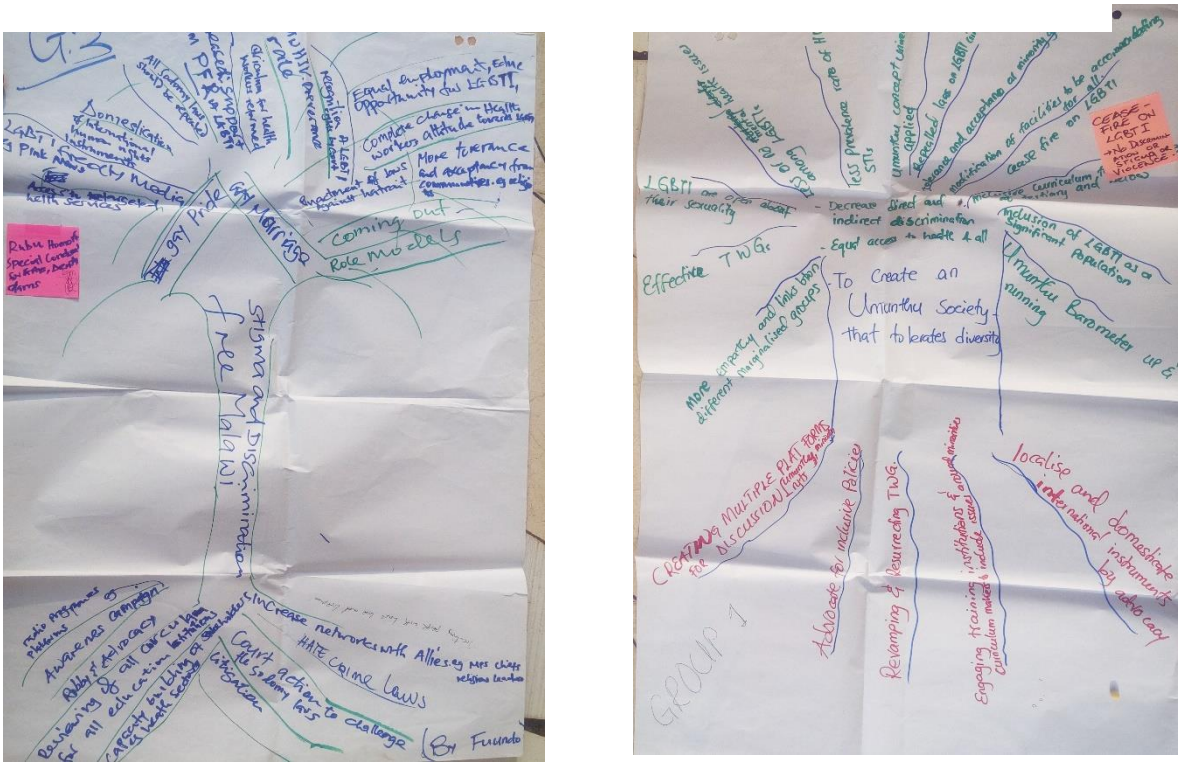
Figure 2. Problem Trees for Health Workers and LGBTI Representatives



All three groups highlighted the role of religion, cultural norms, and attitudes of health workers as key barriers for health access for LGBTI populations. All groups highlighted the role this had on impacting the health outcomes of LGBTI. Both health workers and LGBTI highlighted the impact this had on the psychological health of LGBTI people, with both listing increased suicide, drug and substance abuse, and mental disorders/depression as key effects. HIV/AIDS and STIs were the most common mentioned effect of inadequate health access. The LGBTI group chose to focus their discussion more broadly on wider stigma and discrimination, beyond the domain of health.

The third exercise aimed to create a vision tree with a core vision (the trunk), activities to reach the vision (roots) and the characteristics of what would happen if the vision was achieved (effects). Vision trees for health workers and LGBTI participants are shown in Figure 3.

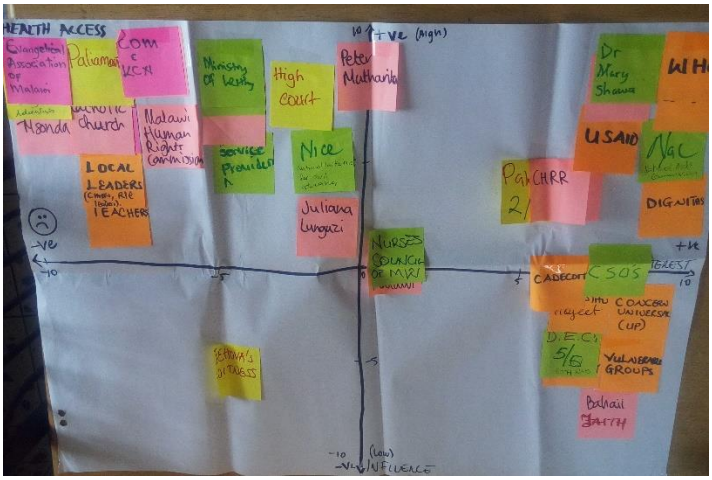
Figure 3. Group 3 Vision tree for Project Staff and LGBTI



For LGBTI the overall vision selected was "to create an Umunthu society that tolerates diversity". For project staff and partners the overall vision selected was for a "stigma and discrimination free Malawi". For health workers the vision selected was for "an environment conducive for health access for all including LGBTI". Project staff and partners highlighted the role of creating multiple platforms for discussion about LGBTI in Malawi, advocating for inclusive policies, revitalizing the role of the TWG, and engaging training institutions to incorporate training on inclusive policies into their curricula. For LGBTI key activities included lobbying and advocacy activities, supporting court actions to challenge sodomy laws, advocating for hate crime laws, and improving the capacity of key stakeholders including health service providers. Generally, LGBTI participants strongly believed that legalization was a key source of legitimacy and would lead to reduced discrimination.

The final exercise was a discussion of relevant stakeholders in the pursuit of equal health access for LGBTI. Participants mapped each stakeholder on two axes: influence and interest. The results of this mapping exercise are shown in Figure 4.

Figure 4. Stakeholder Mapping Exercise on Degree of Influence (Y) and Interest (X)



1.2 Project Design

The Umunthu Programme specifically aims to address the discrimination faced by LGBTI when they access health services. Through training provided to health workers and community members, the project aims to create an environment conduce for LGBTI to access health and primary health care centers across Malawi.

To better understand the project's Theory of Change, the Baseline Study aimed to gather robust feedback on the central assumptions surrounding how project activities will lead to desired results. This process was informed by the Performance Story Workshop held with project stakeholders, as well as subsequent key informant interviews and focus group discussions conducted as part of the project's Baseline.

For the purposes of defining the project's Theory of Change, the study adopted a framework advocated for by Mayne (2015). Based on a wide understanding of processes used to generate intervention TOCs, Mayne's framework focuses on combining two key features: the causal pathway from activities to outputs, to outcomes and to impact and the "causal assumptions showing why and under what conditions the various links in the causal pathways are expected to work"[71].

This study adopts Mayne's approach and utilizes the following definitions provide by Mayne (2015):

- **Impact Pathways** describe causal pathways showing the linkages between the sequences of steps in getting from activities to impact.
- A **Theory of Change** adds to an impact pathway by describing the causal assumptions behinds the links in the pathway.

Due to the varied number of groups directly targeted by intervention activities, impact pathways were developed for each main target group. The ToC for the Umunthu Programme therefore combines three central impact pathways: health workers & health worker students, civil society and community leaders, and educational and government institutions. Each impact pathway is structured based on Mayne's central framework and incorporates the following elements:

- **Activities**: actions undertaken by the intervention
- **Goods and Services**: goods and serviced produced as a result of the activities undertaken
- **Reach and reaction**: target groups intended to receive goods and services and initial reaction
- **Capacity changes**: changes in knowledge, attitudes, skills, aspirations and opportunities of those who have received the goods and services
- **Behavior changes**: changes in actual practices and behaviors of target group
- **Direct benefits**: improvements to the state of individual beneficiaries
- **Well-being changes**: longer-term cumulative improvement in overall well-being of beneficiary

The three impact pathways are shown on the following pages.

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Umunthu Project Impact Pathway #1: Health Workers & Health Worker Students

Well-being Change: Improved Health for LGBTI and Other Minority Groups

Assumptions

- Health-based approaches may be the best way to advance discussion on the rights of LGBTI persons in Malawi "public health now, human rights later" approach.
- The Malawian health sector is at a crossroads with regards to LGBTI health provision.

Direct Benefits:

- D1: The project will contribute to the creation of a culturally competent environment that is conducive for LGBTI and other minority groups to assert their right to health services.
- D2: The project will contribute to improved health access for LGBTI persons.
- D3: The project will contribute to reduced health disparities for LGBTI persons.

Assumptions:

- Denying health care leads to increased health risk.
- When LGBTI persons feel comfortable with a health service provider they are more prone to seek and access health services.
- Habits of self-awareness and reflection, ongoing professional development, and implementation of best practices are all essential to providing culturally competent care for LGBTI people.

Behavior Change:

- B1.1: Health workers appreciate and act on their responsibilities towards all discriminated persons, particularly LGBTI persons (Objective 1). Health workers actively seek to make health centres more accessible and inclusive of LGBTI people.
- B1.2: Health workers actively engage with community stakeholders to ensure services remain accessible to minority populations.

Assumptions:

- The workshop methodology aims to place discrimination against LGBTI persons in the context of other forms of discrimination help participants draw parallels between other types of discrimination in society including those that they may have faced themselves. Interactive and discursive methodology allows health workers to gain a personal understanding of the situation of LGBTI and other discriminated persons, and their responsibilities towards them
- By generating a discussion on the treatment of LGBTI persons from an African perspective, a deep tolerance can be created from indigenous roots in health workers and local communities that, beyond immediate benefits to LGBTI persons, can build a platform for future acceptance.
- Using process theatre, film, story narration and role-playing, participants will critically explore and reflect on their attitudes and roles in providing culturally competent care to marginalized people and encouraging an environment that enables LGBTI persons to access quality healthcare.
- AGHCA has an accurate idea of the knowledge gaps of workshop participants and the workshop is able to satisfactorily fill those knowledge gaps.
- Reappraising controversial issues, that are often seen as externally imposed, through an indigenous cultural lens (supported with practical knowledge) will allow the development of a local and professional response to challenges facing discriminated communities and the LGBTI community in particular.

Capacity Changes:

- C1.1: The workshop provides health workers with improved knowledge of issues affecting LGBTI people from a social, medical and legal perspective. Participants gain the knowledge to provide culturally competent health care to LGBTI and other minority populations
- C1.2: The Workshop enables participants to critically reflect on their attitudes and role in health delivery, and the impact these have on stigma and discrimination faced by LGBTI populations.
- C1.3: Health workers learn how to engage and consult relevant community stakeholders on health issues.

Reach Assumptions

- DHMT representatives from all 8 districts are consulted and approve workshop implementation in target health clusters.
- Health workers and other stakeholders remain interested in participating in Umunthu Workshop.

Reach and Reaction:

- R1.1: The workshop will engage 930 frontline health workers and 270 health worker students (clinicians, ART officers, VCT counsellors) across 8 districts of Malawi and reach staff from approximately XX health clusters.

Assumptions

- Umunthu is an understandable and relatable construct for health workers in Malawi.
- Health workers do not have an understanding of the unique health needs of LGBTI.
- Health workers do not have a platform to explore and address issues of discrimination in health service provision.
- Health workers find the workshop facilitation, content and approach relevant to their on-going professional and personal growth.

Goods and Services:

- G1.1: The workshop creates a platform for thoughtful public discourse on contentious human rights issues in Malawi through the lens of "Umunthu".
- G1.2: Workshop improves health worker awareness of the need for proper treatment of LGBTI persons.
- G1.3: Workshop results in action plan to improve health access for LGBTI and other minority populations.

Assumptions

- Participants feel that the workshop is an open and safe space to explore discrimination through interactive methods.
- Participants want to improve their ability to provide quality and accessible health services to discriminated populations.
- Activities elicit empathy and bring awareness of sense of oneness with others, including discriminated populations such as LGBTI.
- Workshop provides platform to discuss health needs of various discriminated populations and personal experience of health workers catering to those needs.
- Workshop participants actively engage and participate and contribute to a shared space.
- Direct discussion of LGBTI rights can be considered a Western imposition.

Activities:

- A1.1: Interactive workshop program will enable health workers and health worker students to tackle real-life issues and situations focused on the discrimination of minority groups, including LGBTI. Participants will reflect on their role as both a victim and a perpetrator of discrimination
- A1.2: One-day follow-up workshop (3-6 months later) will enable participants to reflect on how they have applied the learning from the initial workshop, and how they have implemented their action plan. The follow up workshop will encourage participants to identify implementation challenges and ways to expand upon the initial action plan.

Umunthu Project Impact Pathway #2: Community Leaders & CBO Representatives

Well-being Change: Improved Health for LGBTI and Other Minority Groups

Assumptions

- Health-based approaches may be the best way to advance discussion on the rights of LGBTI persons in Malawi "public health now, human rights later" approach.
- The Malawian health sector is at a crossroads with regards to LGBTI health provision.

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Direct Benefits:

- D1: The project will contribute to the creation of a culturally competent environment that is conducive for LGBTI and other minority groups to assert their right to health services.
- D2: The project will contribute to improved health access for LGBTI persons.
- D3: The project will contribute to reduced health disparities for LGBTI persons

Assumptions:

- Discriminatory practices result in reduced health access for minority populations.
- Habits of self-awareness and reflection, ongoing professional development, and implementation of best practices are all essential to providing culturally competent care for LGBTI people.
- Community representatives are essential to improving health access by promoting a culture of tolerance and acceptance of diversity.

Behavior Change:

- B2.1: Exposure to the project will lead to members of CBO representatives and community leaders engaging actively with healthcare workers to discuss ways to tackle health access disparities for LGBTI and other minority groups in communities (Objective 2). Community stakeholders actively engage health providers to ensure services remain accessible to minority populations.

Assumptions:

- Community leaders and health workers will act based on workshop discussions. There is an interest in actively working to improve health access for discriminated populations.

  By generating a discussion on the treatment of LGBTI persons from an African perspective, a deep tolerance can be created from indigenous roots in health workers and local communities that, beyond immediate benefits to LGBTI persons, can build a platform for future acceptance.
- Using process theatre, film, story narration and role-playing, participants will critically explore and reflect on their attitudes and roles in providing culturally competent care to marginalized people and encouraging an environment that enables LGBTI persons to access quality healthcare.
- Reappraising controversial issues, that are often seen as externally imposed, through an indigenous cultural lens (supported with practical knowledge) will allow the development of a local and professional response to challenges facing discriminated communities and the LGBTI community in particular.

Capacity Changes:

- C2.1: CBO representatives and community leaders will improve their knowledge as to the role of community organizations in LGBTI health access.
- C2.2: CBO representatives and community leaders will have improved knowledge as to how to engage health providers and other stakeholders to support health access of LGBTI populations.

Reach and Reaction:

- R2.1: The one-day workshop will reach 310 CBO representatives and community leaders across 31 health clusters.

Reach Assumptions

- DHMT representatives from all 8 districts are consulted and approve workshop implementation in target health clusters.
- Health workers and other stakeholders remain interested in participating in Umunthu Workshop.
- Discussions with community leaders are able to fill knowledge gaps and correction misconceptions of LGBTI populations.

Goods and Services:

- G2.1: Workshop activities improve community leader and CBO awareness of the need for proper treatment of LGBTI persons.

Assumptions

- Umunthu is an understandable and relatable construct for community members and health workers in Malawi.
- Health workers and community members do not have an existing platform to discuss the health concerns of LGBTI health seekers.
- .Health workers and community members have a vested interest in proving the health access of LGBTI and other discriminated populations.

Activities:

- A2.1: 1-day mini-workshop with community leaders and representatives of CBOs will share learning from wider workshop and open a dialogue on how health centres, health workers and communities, can work together to overcome stigma and improve health access for LGBTI and other minority groups.

Assumptions

- Participants feel that the workshop is an open and safe space to explore discrimination through interactive methods.
- Participants want to improve their ability to provide quality and accessible health services to discriminated populations.
- Activities elicit empathy and bring awareness of sense of oneness with others, including discriminated populations such as LGBTI.

Umunthu Project Impact Pathway #3: Educational, Governmental, & Health Institutions

Well-being Change: Improved Health for LGBTI and Other Minority Groups

Assumptions

- Health-based approaches may be the best way to advance discussion on the rights of LGBTI persons in Malawi "public health now, human rights later" approach.
- The Malawian health sector is at a crossroads with regards to LGBTI health provision.

Direct Benefits:

- D1: The project will contribute to the creation of a culturally competent environment that is conducive for LGBTI and other minority groups to assert their right to health services.
- D2: The project will contribute to improved health access for LGBTI persons.
- D3: The project will contribute to reduced health disparities for LGBTI persons

Assumptions:

- Denying health care leads to increased health risk.
- When LGBTI persons feel comfortable with a health service provider they are more prone to seek and access health services.
- Habits of self-awareness and reflection, ongoing professional development, and implementation of best practices are all essential to providing culturally competent care for LGBTI people.

Behavior Change:

- B3.1: Workshop activities will be integrated into civil society, educational institutions, and government curricula and trainings.

Assumptions:

- The workshop methodology successfully improves partner capacity to replicate the workshop and workshop components in their training activities.
- The workshop equips partners with strategies that can be implemented independentl and workshop participants have an interest in learning these strategies.
- The workshop is sensitive to the existing needs of partners and partner staff to improve existing curriculua and trainings.

Capacity Changes:

- C3.1: The training of trainers' workshop will provide participants with the knowledge on how to implement workshop components in their own curricula and trainings.

Reach and Reaction:

- R3.1: The training of trainers' workshop will reach 180 partner staff. The communication and advocacy strategy will reach XX district stakeholders, XX national stakeholders, and result in XX media pieces.

Reach Assumptions

- The project has adopted and implemented an advocacy and communication strategy to document and share learning from the Umunthu Workshop.
- The project effectively communicates learning from the Umunthu Workshop including the relevance of the Umunthu approach to key actors targeting improved health service delivery for discriminated populations.

Goods and Services:

- G3.1: The training of trainers' workshop and media publications will generate interest in the Umunthu approach to addressing LGBTI health access needs amongst partner staff

Assumptions

- Umunthu is an understandable and relatable construct for CSOs and other partners to better target health workers in Malawi.
- Partners have an understanding that LGBTI require tailored and culturally-competent approaches to health service delivery.
- Participants have been exposed to learning from the Umunthu workshop.

Activities:

- A3.1: The 1-day training of trainers workshop will improve the knowledge of partner staff on how to address discrimination of minority populations, and LGBTI in particular, through the lens of Umunthu.
- A3.2: The project's communication and advocacy strategy will improve visibility on the Umunthu Workshop and its unique approach to supporting health access for minority populations, particularly LGBTI.

Assumptions

- Participants see the value in adopting an local approach to address discrimination against LGBTI populations.
- Participants are interested in finding effective approaches to improve health workers' capacity to provide health services free from discrimination.
- Participants are aware of the discrimination faced by LGBTI populations when they seek to access health in Malawi.
- Participants feel that the workshop is an open and safe space to explore discrimination through interactive methods.
- Workshop participants actively engage and participate and contribute to a shared space.

1.3 Is the project appropriate for its context?

We began this discussion by reviewing the key health concerns of LGBTI study participants. Based on in-depth interviews and focus group discussions, the main health concerns of these target groups are: (1) right to privacy and non-disclosure, (2) right to non-discrimination, (3) right to relevant health services.

The project's main emphasis is to address discrimination faced by LGBTI and other minority groups when they seek access to health. Through the lens of Umunthu, the programme aims to elicit empathy amongst health workers, health workers students, and community members to promote inclusive policies and practices in health centres and surrounding areas. Through a local perspective to understand others, the project aims to enable health workers and community members to improve service delivery for LGBTI. While this primarily addresses the second concern listed by LGBTI informants, a right to non-discrimination, the project believes this will lead to improvements in both upholding of the principals' confidentiality, essential to health access, and eventually to better knowledge of the types of care relevant to LGBTI.

The project targets health workers and community members directly through its design. However, the project does not target LGBTI populations through its activities. Several respondents highlighted this in consultations, expressing the fact that without directly targeting LGBTI populations, the project will only seek to improve the supply of accessible services rather than the demand for it amongst key populations. Respondents stated:

"LGBTI do not know they have a right to demand health services. They have no knowledge of their human rights."[72]

"If people are empowered they know their rights. They know that access to health is a right to life. If so, they would know that they can go to a public hospital and demand that 'this is my right'."[73]

"If you meet most of the LGBTI youth in the country, apart from those in the closet, most of them would either be a school drop out or a school leaver, or someone who is struggling….They're in a dilemma. If you don't' have money you either sit at home and die or you get courageous and go to the hospital."[74]

This is a significant concern of LGBTI populations who feel they do not have a platform through which they can directly engage with health workers or demand improved treatment. Several respondents cited that it'd be useful if the project could distribute a list of health workers who agree to be approached by LGBTI. Although the project does not have the capacity to actively target key populations, this may be a useful approach to consider incorporating.

To better highlight the concerns of LGBTI to health workers through the workshop, the project will develop a series of short videos documenting LGBTI perspectives on their right to privacy and non-disclosure and their right to non-discrimination. The aim of this will be to improve health worker awareness of the specific needs of LGBTI populations.

Health workers consulted as part of this review, highlighted that they felt that they lacked the necessary medical knowledge about the unique health risks faced by this population, and the types of treatment they should provide. Health workers commented:

"When we were coming from college we had knowledge, but when we came here, the situations we found are different from what were taught in class, so there is a need for an organization to update us on new methods… there is a need that organizations dealing with homosexuals should also update us on how to treat such people because the knowledge we have can not make us give out 100% treatment."[75]

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[72] FGD with LGBTI 2

[73] In-depth Interview with Homosexual Activist

[74] FGD with LGBTI 2

[75] FGD with Health Workers 3

"All in all, we need to be updated on such issues because at first we didn't know that men could get married to one another, so with such issues coming up now we need to be updated so we can give our best treatment."[76]

The project's aims to address these concerns through the inclusion of a guest medical speaker, who will spend significant time discussing the specific unique exposures faced by LGBTI. The workshop is designed in a participatory manner so as to enable participants to discuss these views as they arise. However, due to the amount of time in the workshop it is likely that the guest speaker will only be able to superficially cover the main areas of unique health exposures. It may be necessary for the project to consider this further so as to ensure health workers remain interested in participating in the workshop. The project could consider tapping into existing advocacy actors for additional technical medical knowledge of LGBTI. CEDEP and CHRR, in collaboration with representatives from the College of Medicine, have developed a training manual which is currently under review within the Ministry of Health. The project could integrate components from this manual into the medical lecture to better address this expectation amongst health workers.

Based on this review the project is well suited to address the existing gaps in health service delivery, through its focus on non-discrimination. It is likely that this in turn will lead to a renewed interest in LGBTI as a special health group, meriting targeted, sensitive, and relevant approaches. However, the project should consider additional means through which it can inform LGBTI about relevant health clusters where training has been provided and specific health workers who have agreed to be approached by LGBTI health seekers.

2. How likely is it that project activities will lead to desired results?

To assess the extent to which project activities will lead to desired results, the study explored the key assumptions associated with each contribution claim the project makes. The primary sources of evidence for this review included evidence from the Performance Story Workshop, and from consultations with a wide variety of project stakeholders including project partners, health workers across target districts, DHMT staff, participants from the project's pilot workshops, and LGBTI representatives.

For each of the contribution claims the study discusses the central assumptions associated with the claim against stakeholder expectations and identifies evaluative performance measures to be assessed throughout project implementation.

[76] ibid

Objective 1: Malawian Health Workers (including Health Worker students) consider and better understand LGBTI persons through the local perspective of the Umunthu Programme. They appreciate and act on their responsibilities towards discriminated persons, particularly LGBTI persons.

A1.1: Interactive workshop program will enable health workers and health worker students to tackle real-life issues and situations focused on the discrimination of minority groups, including LGBTI. Participants will reflect on their role as both a victim and a perpetrator of discrimination.

Several workshop activities aim to enable health workers to engage with and discuss discrimination as it happens in day to day life and at health care centres. Workshop activities focus on eliciting empathy amongst health workers by discussing their role in discrimination both as perpetrators and as victims.

The workshop begins with activities focused on creating a harmonious, safe and open environment where all health workers feel comfortable participating. This is followed on by several exercises aimed at eliciting empathy amongst participants. For example, participants engage in a balloon exercise where they inflate a balloon and then play a game to protect their balloon while stomping on others. This exercise is followed by a group discussion where participants reflect on what it means to infringe on the rights of others. Participants are encouraged by workshop facilitators to share personal stories of discrimination, both as a perpetrator and as a victim, throughout the workshop.

There are several assumptions underlying these types of activities and this claim. Participants need to feel safe and comfortable sharing their personal experiences in the workshop setting. To support in the creation of this type of environment, the workshop does not begin by explicitly addressing LGBTI as a target group. Interviews with project staff highlight a perceived need that the workshop should begin by addressing general concerns about discrimination and the impact it has on minority populations. Project staff adopted this approach to ensure participants are "not immediately defensive" or "offended" by the project's central objectives.

Stakeholders participating in the Performance Story Workshop, including some participants from a pilot workshop, strongly agreed with this sentiment. Health workers who had participated in the pilot workshop in Phalombe, particularly supported this view, stating that:

"Many would have left the workshop had they known in advance what was to be addressed"[77]

However, some participants in the second pilot workshop found that the lack of an explicit discussion of the workshop objectives led to disinterest and a lack of engagement from participants. One health worker commented:

"But I wasn't happy with their presentation. The reason being, instead of them going straight to the point, they would beat about the bush. They were giving us activities and asking us what Umunthu was all about. From there, we answered but all along they knew what they wanted so I didn't like the facilitation"[78]

This view was shared by other participants in the second pilot. Another participant commented:

"The problem was hide and seek"[79]

[77] FGD with Health Workers 3

[78] ibid

[79] FGD with Health Workers 3

One participant was asked whether he would have attended the workshop if he knew it was about LGBTI. He stated:

"Yes we would have come, cause we would have known why we were coming, but it's like they lied to us"[80]

A common feature of this view is a sense that the conversation about LGBTI was "contrived" and that participants were led into it.

In the case of the second pilot workshop, however, this may have been caused by the guest LGBTI speaker, who advocated strongly for the acceptance of LGBTI persons in Malawi, beyond the domain of health. The project plans to review the role of guest speakers to ensure it is consistent with wider messaging objectives and with the project's aim of creating an open and safe space for participants.

The study would additionally recommend that the project develops an alternate model, one in which the objectives are made explicit at an early stage of the workshop and in a culturally competent way. The project could then pilot this approach and compare it before wider implementation.

Based on a review of this claim, there are several evaluation performance measures the project should track at Midline and Endline. These, as well as their sources, are shown in Table 5.

Table 6. A1.1 Evaluation Performance Measures

Performance Measures	Sources
Evaluation Performance Measure 1: The extent to which facilitators and guest speakers manage disagreement and build trust amongst participants. **Evaluation Performance 2: The extent to which facilitators and guest speakers are effective communicators.**	These items will be assessed both quantitative and qualitatively. Workshop review items include scales to measure participants perception of facilitators. Monitoring tools also include facilitator and guest speaker reflections on workshop activities. Qualitative sessions will seek to triangulate and further explain these findings.
Evaluation Performance Measure 2: The extent to which participants appreciate the message, finding it both relevant and interesting. **Evaluation Performance Measure 3: The extent to which health workers actively participate in the workshop.** **Evaluation Performance Measure 4: The extent to which participants have reflected on their role as both a perpetrator and victim of abuse.** **Evaluation Performance Measure 5: The extent to which participants appreciate the value of the message, finding it both relevant and interesting**	This will be assessed qualitatively through several in-depth interviews and focus group discussions with workshop participants and quantitatively through workshop review items.

A1.2: One-day follow-up workshop (3-6 months later) will enable participants to reflect on how they have applied the learning from the initial workshop, and how they have implemented their action plan. The follow up workshop will encourage participants to identify implementation challenges and ways to expand upon the initial action plan.

The one-day follow-up workshop aims to reinforce some of the same concepts covered during the initial workshop. It also aims to provide a space for participants to follow-up on their learning since the first workshop. This includes activities designed to encourage participants to identify challenges in implementing their action plan and to discuss strategies that can be put in place to promote non-discrimination towards LGBTI and other minority populations.

[80] ibid

At the time of the Baseline, the project had yet to pilot a follow-up workshop. However, there are several assumptions that are important to mention underpinning the logic of this claim.

Firstly, the project assumes that the same participants will be able and willing to attend the follow-up workshop. However, it is likely that some participants will not attend the follow-up workshop. The project should therefore continually review Workshop Feedback Forms to ensure the workshop remains relevant to participants.

Secondly, the project assumes that a one-day follow up workshop will be sufficient for workshop participants to discuss the progress they have made on their action plan. This is most likely because the project believes the effects of the initial workshop will reverberate after the workshop ends, and participants will be able to re-engage with the action plan during follow-up. To ensure this takes place, the project should support participants to define roles and responsibilities in implementing the action plan during the initial workshop. The project should also consider supporting participants to identify ways to measure progress and continuing to ensure the action plan is relevant the target community. Action plans are discussed in more depth in claim G1.3.

The proposed performance measures for this claim are shown in Table 6.

Table 7. A1.2 Evaluation Performance Measures

Performance Measures	Sources
Evaluation Performance Measure 6: The extent to which participants from the first workshop are successfully re-contacted and attend the follow-up workshop.	This will be assessed primarily through project monitoring activities. Where participants drop-out of the workshop, the evaluation will seek to understand reasons for drop-out. qualitatively through in-depth interviews and focus group discussions with workshop participants.
Evaluation Performance Measure 7: The extent to which participants report being better prepared to identify and deal with discrimination in health facilities after having attended the workshop.	This will be assessed qualitative through in-depth interviews with workshop participants and workshop facilitators. Quantitatively several items on the pre-, post-, and follow-up tools address this construct.
Evaluation Performance 8: The extent to which participants are increasingly aware of the importance of implementing their action plans.	This will be assessed qualitative through in-depth interviews with workshop participants and workshop facilitators. Quantitatively several items on the pre-, post-, and follow-up tools address this construct.
Evaluation Performance Measure 9: The extent to which the follow-up workshop guides participants to deal with challenges arising from the execution of action plans.	This will be assessed through in-depth interviews with workshop participants and workshop facilitators. Monitoring activities should also aim to capture the extent to which action plans are implemented and challenges that arise.

G1.1: The workshop creates a platform for thoughtful public discourse on contentious human rights issues in Malawi through the lens of "Umunthu".

A central good and service provided by the workshop is the platform for public discussion on the rights of minority populations. On day 3 of the workshop, local CBO representatives and community leaders are invited to participate alongside health workers. This engagement aims to promote increased dialogue between the two groups and focuses on sharing the learning of the workshop more broadly. Activities encourage participants to discuss discrimination through the lens of Umunthu, and attempt to understand the need for the protection of the rights of LGBTI and other minority groups.

This claim assumes that the concept of Umunthu and its application as an authentic cultural device, will enable participants to open a discussion on the rights and health rights of minority populations. By Baseline, there is little available evidence on whether the workshop will achieve this objective, beyond a consensus understanding that the concept of Umunthu can be used to understand the rights of others. However, future evaluation points will seek to better understand this claim.

Several respondents reported that being homosexual, or having an alternate sexuality, is seen as a western imposition, as discussed in the study's review of the project concept. As one gay informant stated:

> *"These people think 'AH, they have come from the western countries with their gay marriage. Now they want you to divorce your husbands."*[81]

The fact that the concept of Umunthu is a local construct adopted by the project, aims to address this concern. The project argues that, if Umunthu can be understood as a local response to intolerance, it can be leveraged to promote inclusion and an understanding of those who are different.

However, the study has put forward several evaluation performance measures to assess this claim at later evaluation points. These are shown in Table 7.

Table 8. G1.1 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 10: The extent to which participants can better identify human rights issues in a health context. **Evaluation Performance Measure 11: The extent to which participants are interested in improving human rights in a health context in Malawi.** **Evaluation Performance Measure 12: The extent to which participants understand the relationship between Umunthu and Human Rights.**	This will be assessed qualitatively through in-depth interviews and focus group discussions with workshop participants. Several open answer responses on the surveys also aim to address these constructs.

G1.2: Workshop improves health worker awareness of the need for proper treatment of LGBTI persons.

To ensure health workers understand and contextualize the need for non-discrimination in health centres, the project aims to improve their awareness of the health needs of LGBTI. Through this study, the project aims to identify the key health concerns of LGBTI populations and develop messaging to health workers around these health concerns. This study identified three key health concerns: right to non-disclosure, right to non-discrimination, and right to relevant treatment. These constructs are discussed in depth in Section 1.3. The project will aim to present these health concerns to workshop participants through a series of short videos documenting LGBTI perspectives. These will also be addressed through guest speakers active participation including the medical, legal and LGBTI guest speaker.

However, beyond informing health workers of the health concerns of LGBTI health users, the project should additionally aim to improve health worker knowledge of health disparities faced by these sub-populations. While this may be addressed through the medical guest speaker, the project can consider tapping onto existing medical expertise of project partners, including CEDEP and CHRR.

Several health workers interviewed requested that this information be included in the workshop to better contextualize LGBTI needs from a health perspective. A health worker stated:

> *"In terms of medicine you bring reference materials. When you bring the material to the audience, you need to have references… like this study was done at such and such place. It can be from the books or from surveys… When they were delivering the topic it's like they were blindsided. They wanted us to brainstorm"*[82]

This may be difficult to provide due to the lack of country-level data on any of the key LGBTI populations. However, the project should report global cross-country findings or provide additional evidence on the likely relationships between sexuality, gender identity, and disease in this context. Additionally, the project should remain sensitive to

[81] FGD with LGBTI 1

[82] FGD with Health Workers 1

other studies on LGBTI populations that may be taking place in Malawi and where possible attempt to share these findings through the workshop.

Whilst, the primary aim of the project is to target the rights of LGBTI to health access, improving health worker awareness of the disparities faced by these populations, could support them to, from a professional and medical perspective, more easily approach LGBTI health seekers. A health worker in Chikwawa reiterated her view on this as a medical professional:

> *"Everyone has a right to receive medical help. So if we can find such a person and we refuse him, he has a right to sue us because we refused him medical help. It's like we are denying him his rights."*[83]

Additionally, the workshop would like to maintain the interest and curiosity of participants, these expectations should at least be partially addressed. Health workers see themselves as medical professionals primarily and the project could risk losing their interest if they perceive the workshop to be irrelevant to their role as medical professionals.

Several participants highlighted that due to their ethics, they had a responsibility to ensure health access for all. Ensuring the project can leverage this interest by supplementing it's activities with technical knowledge, would further engage health workers who are interested in improving their technical capacity as well as their ability to deliver accessible services.

To assess this claim at later evaluation points, the study has put forward the performance measures shown in Table 8.

Table 9. G1.2 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 13: The extent to which health worker participants demonstrate awareness of the health concerns of LGBTI populations.	This will be assessed qualitatively through in-depth interviews and focus group discussions with workshop participants. This will be assessed quantitatively through several items on the pre-,post- and follow-up workshop surveys.
Evaluation Performance Measure 14: The extent to which health worker participants demonstrate awareness of unique health exposures faced by LGBTI.	This will be assessed qualitatively through in-depth interviews and focus group discussions with workshop participants. This will be assessed quantitatively through several items on the pre-,post- and follow-up workshop surveys.

G1.3: Workshop results in action plan to improve health access for LGBTI and other minority populations.

The workshop aims to produce an action plan for health workers to implement to improve health access for LGBTI and other minority populations.

This claim assumes that the action plan will contain clear implementable steps and actions, and determine roles and responsibilities of various participants in its implementation. As a pre-step to creating the action plan the project works with participants to develop a series of personal pledges to make based on learning from the workshop.

The pilot workshop in Nkhotakota culminated in all participants pledging to uphold the rights of LGBTI populations. Workshop participants interviewed as part of this study did not report creating an implementable action plan or discussing how to achieve these pledges in detail. Participants in pilot workshops made personal as opposed to group pledges. One health worker described her pledge:

[83] FGD with Health Workers 2

> *"I pledged that everyone needs to be helped and since it is their decision [to be LGBTI], they should be able to explain it to their friends."*[84]

Interestingly, in this example, the onus is placed on the LGBT health seeker to be open about their sexuality rather than on the health worker to change her specific attitudes or behaviour.

Another participant felt forced into making the pledge:

> *"We were asked personally if we could assist a homosexual person who has an STI. We agreed that we would because of the oaths we took as medical practioners, but spiritually we can't do that cause that is a sin… They told us to have a good perception ... I wasn't comfortable honestly at the end cause they ruined the whole workshop."*[85]

The project develops action plans through a discussion of (1) barriers to health access, (20 What should be done to remove these barriers (4) who will do what need sto be done (4) what is the timeframe for achieving these objectives. The action plan should include clear steps participants can implement to improve health access. It is essential that the process of creating an action plan is collaborative as this will encourage participant ownership and buy-in. The project should additionally consider periodically monitoring progress on action plans, beyond the follow-up workshop, and identifying ways through which they can support participants during implementation.

Evaluation performance measures associated with this claim are shown in Table 9.

Table 10. G1.2 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 15: The extent to which participants believe they have a responsibility to implement their action plan and that their contribution is necessary to ensure its achievement. **Evaluation Performance Measure 16: The extent to which participants believe they can implement their action plan.** **Evaluation Performance Measure 17: The extent to which participants are increasingly able to identify and facilitate hindering factors and react to them.** **Evaluation Performance Measure 18: The extent to which participants believe that, should they be realised, action plans will lead to positive results for minority groups.** **Evaluation Performance Measure 19: The extent to which participants believe other stakeholders in their health facility (will) approve and support their plans.** **Evaluation Performance Measure 20: The extent to which participants believe their action plans were implemented.**	This will be assessed quantitative through items included on the post- and follow-up survey aimed at reviewing workshop action plans. As much as possible, findings will be triangulated with monitoring reports prepared by the project team. Qualitative the study will explore these dimensions through several in-depth interviews and focus group discussions with workshop participants at later evaluation points.

[84] FGD with Health Workers 3

[85] ibid

R1.1: The workshop will engage 930 frontline health workers and 270 health worker students (clinicians, ART officers, VCT counsellors) across 8 districts of Malawi and reach staff from approximately 32 health clusters.

The project aims to reach these participants during the three years of implementation. Participant records will be used to track the number of participants reached as well as their specific health worker background. These records will be used to report on key output indicators associated with the project.

In addition to these output achievements, the study will use both qualitative and quantitative methods to assess the extent to which the project was able to elicit participants interest and engagement in the workshop. This will allow the study to assess the extent to which the project was able to reach and cause reaction in various health worker groups.

C1.1: The workshop provides health workers with improved knowledge of issues affecting LGBTI people from a social, medical and legal perspective. Participants gain the knowledge to provide culturally competent health care to LGBTI and other minority populations

The workshop engages a guest medical, legal, an LGBTI speaker with the aim of improving participants knowledge of the medical, legal, and social issues affecting the lives and health access of LGBTI populations. Whilst the workshop includes guest speakers from each of these domains, it does not prescribe the content of what each guest speaker should speak about. This has led to variation in the quality of implementation between pilot workshops.

During the second pilot workshop, the LGBTI guest speaker strongly advocated for the rights of LGBTI populations, beyond the health context. Whilst the workshop should empower LGBTI voices to ensure their needs are expressed and that it remains relevant to LGBTI concerns, the project should further develop this component to ensure its messaging is clear and focused, and not confrontational.

Several workshop participants in this workshop felt the guest LGBTI speaker was too forceful:

> *"Of course, we are people of different perceptions with those [Umunthu] guys … I have no problem if I can know someone like that personally. We can greet each other if we meet, but these guys were like trying to personally convince us that no discrimination against the gays."*[86]

> *"It was like being imposed on us."*[87]

Some participants also felt as if they were not allowed to ask all the questions they wanted to ask the LGBTI guest speaker:

> *"We started but eventually we were obstructed. They said we were free to ask questions and we had many questions. People ask a lot questions but he defended himself then he stopped and said, 'That's who I am' and then he sat down."*[88]

Other participants found challenges with the guest speakers approachability. In this case the guest speaker, focused on providing verses from the bible which contradict popular belief in Malawi that the bible rejects homosexuality.

> *"He said, those who have questions you should find me aside that's where you will be given verses."*[89]

Based on this review, the project should provide clear guidance to guest speakers as to the content of the lecture and how to manage different types of questions. The project should decide if the focus of the guest speaker should be on highlighting specific health concerns of LGBTI or advocating for LGBTI rights more generally. This should aim to enable both the LGBTI guest speaker to feel comfortable and allow workshop participants to ask questions. Facilitators could also discuss with participants, prior to the LGBTI guest speaker, how to formulate questions to ensure they are not offensive.

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[86] FGD with Health Workers 3

[87] ibid

[88] ibid

[89] ibid

The medical lecture could incorporate information about health disparities faced by LGBTI populations (see contribution claim A1.1). This would also improve health worker's perception that the workshop is "evidence-based" a claim several questioned.

The evaluation performance measures associated with this claim are shown in Table 10.

Table 11. C1.1 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 21: The extent to which participants demonstrate improved knowledge of the legal, medical, and social issues affecting LGBTI people.	
Evaluation Performance Measure 22: The extent to which participants perceive the workshop content to be accessible and relevant in terms of legal, medical and social knowledge gaps.	This will be assessed quantitative through several items included in the workshop review section of the post- and follow-up surveys. Qualitatively the study will inform this inquiry through in-depth interviews and focus group discussions with workshop participants.
Evaluation performance measure 23: The extent to which participants believe facilitators filled their knowledge gaps effectively	
Evaluation Performance Measure 24: The extent to which facilitators and guest speakers are equipped to manage knowledge gaps.	This will be assessed through a review of feedback forms provided by facilitators and guest speakers as well as a review of project monitoring reports. In-depth interviews with facilitators and guest speakers will also be conducted at later evaluation points.

C1.2: Participants gain the knowledge to provide culturally competent health care to LGBTI and other minority populations The Workshop enables participants to critically reflect on their attitudes and role in health delivery, and the impact these have on stigma and discrimination faced by LGBTI populations.

The workshop aims to improve the attitudes of health workers towards LGBTI health users, with the aim of reducing discrimination. Several health workers who participated in the pilot workshop cited that they had critically reflected on their role and had a broader understanding of its impact on LGBTI populations since attending the workshop. A participant summarized a common sentiment:

> *"I pledged that these people [LGBTI] need to be loved like everyone else. It's only that they are not open enough. It might be my brother, my cousin, somewhere there my friend, but we can't know cause they are not open about who they are."*[90]

However, despite some participants citing improvements, others still did not understand why the workshop targets health workers when the problem "originates" in the community. Several participants made this point an argued that the workshop should rather target community members, before health workers. The project believes in the 'health rights first' approach. Health workers likely feel under pressure through the focus of the workshop, and want to acknowledge that community discriminatory attitudes also play a role. As one health worker explained,

> *"You have to start with the community. Don't deal with the problem from the end point. Take it from the beginning because it's like you guys wants to end this thing from the end when actually you don't know where its coming from."*[91]

[90] ibid

[91] ibid

To best address this concern, the project should explicitly contextualize its approach to improving the health rights of LGBTI populations during the workshop. It is likely that some workshop participants are more comfortable placing the blame for discrimination on the wider community. While addressing this is not the aim of the project, acknowledging the role of community attitudes and norms is important to ensure participants remain engaged and feel validated to some degree.

The evaluation performance measures associated with this claim are shown in the table following.

Table 12. C1.2 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 25: The extent to which participants recognize and affirm the impact of discrimination, stigma, and homophobia on an LGBTI person's well-being. **Evaluation Performance Measure 26: The extent to which participants can recall Umunthu's inclusive principals and practices.**	This will be assessed qualitatively through in-depth interviews and focus group discussions with workshop participants. The study will also review results from items included on the pre-,post-,and follow-up workshop tests.

C1.3: Health workers learn how to engage and consult relevant community stakeholders on health issues.

On the third day of the workshop, community leaders and CBO representatives are invited to participate. During these activities workshop participants share their learning with community members and discuss their perspectives on the discrimination of LGBTI and how to best address this. Through this exercise the project aims to encourage health workers to engage and consult community stakeholders on health issues to ensure community health needs for minorities are identified and discussed.

This exercise was not included during the pilot workshop. However, the claim assumes that the one-day consultation with community stakeholders will be sufficient for health workers to develop local linkages with the community to continue the discussion on minority rights.

The project should aim to include clear steps and processes to guide participants on how to consult the community. This can include approaches or exercises to identify minority group needs, as an example. It is difficult at this stage to assess the likelihood planned activities will lead to desired results.

The evaluation performance measures for this claim are shown in the table below.

Table 13. C1.3 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 27: The extent to which participants feel equipped to engage in community consultations on minority rights. **Evaluation Performance Measure 28: The extent to which health workers believe that community consultations on health issues will lead to better health access for minority populations including LGBTI.** **Evaluation Performance Measure 29: The extent to which health workers believe they will not be judged by others if they consult community stakeholders on issues affecting LGBTi.** **Evaluation Performance Measure 30: The extent to which participants increasingly want to engage the**	This will be assessed through several quantitative items on workshop surveys. Qualitatively the study will conduct additional in-depth interviews and focus group discussions with participants and facilitators to explore these constructs.

community in consultations to improve the health access of LGBTI and other minority populations.	

B1.1: Health workers appreciate and act on their responsibilities towards all discriminated persons, particularly LGBTI persons (Objective 1). Health workers actively seek to make health centres more accessible and inclusive of LGBTI persons.

At the behaviour change level, the project aims to enable health workers to act on their responsibilities towards all discriminated populations, particularly LGBTI. The project aims to provide health workers with the knowledge and skills to actively seek to make health centres more accessible and inclusive of LGBTI persons.

This claim assumes that health workers have been provided with sufficient capacity changes to enable them to act in a non-discriminatory way towards LGBTI health seekers. Whilst capacity changes will be assessed separately, the study proposes several approaches to assess behaviour change. These are shown in the Table 13.

Table 14. B1.1 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 31: The extent to which participants increasingly believe that applying the a culturally competency framework will support the health access of discriminated populations, including LGBTI.	This will be assessed through several quantitative items on workshop surveys. Qualitatively the study will conduct additional in-depth interviews and focus group discussions with participants and facilitators to explore these constructs.
Evaluation Performance Measure 32: The extent to which participants believe that actively seeking to improve health access for minority populations is part of their responsibility as health workers.	
Evaluation Performance Measure 33: The extent to which participants implement inclusive policies and practices to promote health access of minority populations	
Evaluation Performance Measure 34: The extent to which participants have the resources and skills to promote inclusive policies and practices in their health clinics.	

B1.2: Health workers actively engage with community stakeholders to ensure services remain accessible to minority populations.

To assess the extent to which participants actively engage community stakeholders to ensure services remain accessible to minority populations, the study proposes the below performance measures.

Table 15. B1.2 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 36: The extent to which health workers believe it is their responsibility to engage the community to improve health access.	This will be assessed through a review of project monitoring data along with quantitative data collected through follow-up and post- surveys. Qualitatively this will be assessed through in-depth interviews and focus group discussions with workshop participants.
Evaluation Performance Measure 37: The extent to which health workers believe that consulting	

community stakeholders on minority health needs will lead to better access for minority populations.	
Evaluation Performance Measure 38: The extent to which health workers regularly consult the community on minority health needs after attending the workshop.	

Objective 2: Members of civil society and community leaders engage with healthcare workers to discuss ways to tackle health access disparities in communities.

A2.1: 1-day mini-workshop with community leaders and representatives of CBOs will share learning from wider workshop and open a dialogue on how health centres, health workers and communities, can work together to overcome stigma and improve health access for LGBTI and other minority groups.

This activity occurs on the third day of the Umunthu Workshop. Community leaders, including members of the Health Advisory Committee, and active CBOs are invited to participate in the workshop and learn about what has taken place in the activities and discussions as well as participate in the creation of an action plan. This activity claim assumes that community leaders and CBO representatives will feel comfortable and safe participating in the workshop.

To assess the extent to which community leaders feel safe and comfortable future studies will rely on a review of qualitative evidence based on consultations with community stakeholders. Performance measures are detailed in the table below.

Table 16. A2.1 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 39: The extent to which community participants demonstrate improved awareness of minority populations, including LGBTI.	This will be assessed qualitatively through in-depth interviews with community workshop participants.
Evaluation Performance Measure 40: The extent to which community participants demonstrate improved awareness of the concept of Umunthu and its application to reducing discrimination.	
Evaluation Performance Measure 41: The extent to which community participants are comfortable to openly discuss how to overcome stigma and discrimination towards minority populations and how to improve health access for these populations.	

G2.1: Workshop activities improve community leader and CBO awareness of the need for proper treatment of LGBTI persons.

The workshop aims to raise awareness amongst community leaders and CBOS as to the need for proper treatment of LGBTI persons. To achieve this the project will highlight the specific health concerns of LGBTI populations including the right to non-disclosure and privacy, the right to non-discrimination, and the right to relevant health treatment.

As with health workers, the project should additionally seek to include messaging on the specific health disparities experienced by LGBTI populations, where country-level data is available or where there is significant evidence from

cross-country literature and research. This will work to deepen stakeholder awareness as the specific needs of LGBTI populations.

Performance measures for this claim are outlined in the table below.

Table 17. G2.1 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 42: The extent to which community participants have a greater awareness of the unique health exposures faced by LGBTI populations.	This will be assessed qualitatively through in-depth interviews and focus group discussions with community stakeholders.
Evaluation Performance Measure 43: The extent to which community participants have a greater awareness of the health concerns of LGBTI populations.	
Evaluation Performance Measure 44: The extent to which community participants increasingly believe that LGBTI populations require tailored approaches to promote health access.	

R2.1: The one-day workshop will reach 310 CBO representatives and community leaders across 32 health clusters.

The project will target a total of 310 CBO representatives and community leaders. Community representatives will be recruited to participate in the workshop through consultations with the DHMT and the relevant health cluster officials.

The project's logframe will track two key performance measures associated with this indicator: the number of community leaders and representatives attending the workshop, and the number of health access issues raised in discussions and documented by facilitators.

C2.1: CBO representatives and community leaders will improve their knowledge as to the role of community organizations in LGBTI health access.

The project will also aim to improve CBO representative and community leaders' knowledge as to their role in influencing LGBTI health access. This will be achieved through a participatory process where workshop participants share their key learning based on their participation in the workshop and highlight key roles they think the community can play. The group will additionally develop a shared action plan to implement at the community and health facility level to promote improved access.

The project should consider documenting best practices in target communities during implementation. This will enable facilitators to share these in future workshop settings and enable community representatives to see real life examples of the differences they could make and the role they have in promoting health access for LGBTI.

Table 18. C2.1 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 45: The extent to which community stakeholders have an improved knowledge of the role of community organizations and stakeholders in promoting health access for LGBTI and other minority populations.	This will be assessed qualitatively through in-depth interviews and focus group discussions with community stakeholders who participate in the workshop.
Evaluation Performance Measure 46: The extent to which community stakeholders believe the community has an important role to play in supporting health access for minority populations.	

Evaluation Performance Measure 45: The extent to which community participants report having an improved knowledge as to how to engage health providers to support health access of LGBTI populations.	

C2.2: CBO representatives and community leaders will have improved knowledge as to how to engage health providers and other stakeholders to support health access of LGBTI populations.

As with health workers, community participants require additional knowledge as to how they can engage health workers through consultations to support the health access of LGBTI populations. The project should seek to develop these activities further to ensure community stakeholders feel empowered to participate in the identification of minority health needs and have a stake in the implementation of the action plan.

Practical examples need to be provided to community members and health workers as to how they can continue to collaborate on the issue moving forward. This could include assigning various responsibilities to bother stakeholder groups. The project could also develop several activities which could be used in the future to identify and explore health needs of specific minority populations. To achieve higher order objectives associated with this claim, community participants will need clear steps through which they can access the discourse on health rights of minority populations.

Table 19. C2.2 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 46: The extent to which community participants report having improved knowledge as to how to engage health providers to support health access of LGBTI populations.	This will be assessed qualitatively through in-depth interviews and focus group discussions with community stakeholders who participate in the workshop.

B2.1: Exposure to the project will lead to members of CBO representatives and community leaders engaging actively with healthcare workers to discuss ways to tackle health access disparities for LGBTI and other minority groups in communities (Objective 2).

The project expects that exposure to the workshop will lead to community leaders and CBO representatives actively engaging healthcare workers to identify and discuss ways to tackle health access disparities for LGBTI. This behaviour change is expected to be achieved through the one-day mini workshop with community leaders, where they participate in the creation of the action plan.

The project should consider more sustained engagement with CBO representatives and community leaders at the health cluster level to ensure they have the capacity and develop an interest in advocating for the health rights of minorities, and LGBTI in particular. This could involve appointing a HAC representative to be responsible for LGBTI health access issues.

Table 20. B2.1 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 47: The extent to which community participants believe that consulting health workers on local health access issues will lead to improved health access for minority populations. **Evaluation Performance Measure 48: The extent to which community participants believe that they have a**	This will be assessed qualitatively through in-depth interviews and focus group discussions with community workshop participants.

responsibility to support the health access of discriminated populations.	
Evaluation Performance Measure 49: The extent to which community stakeholders believe they have the skills and resources to engage with health workers to improve health access for discriminated populations.	
Evaluation Performance Measure 50: The extent to which community participants actively seek to inform health workers of relevant local health challenges affecting discriminated populations.	

Objective 3: The workshop activities will be integrated into civil society, educational institutions, government curricula and trainings

A3.1: The 1-day training of trainers workshop will improve the knowledge of partner staff on how to address discrimination of minority populations, and LGBTI in particular, through the lens of Umunthu.

The project's training of trainers' workshop will aim to provide partner staff with approaches to address discrimination of minority populations, particularly LGBTI.

Although the project has yet to develop a curriculum for the training of trainers' workshop, project staff report that this will focus on highlighting key learnings from the Umunthu Workshop regarding what works well and why.

Project partners including representatives at the College of Medicine, District Health Management Team members, and others, all cite a need for improved knowledge of how to address the health access needs of LGBTI groups.

The study proposes several performance measures to assess the achievement of this claim. These are outlined in the table below.

Table 21. A3.1 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 51: The extent to which partners are increasingly interested in the Umunthu approach to addressing issues of discrimination.	This will be assessed through in-depth interviews with participants as well as through responses on the Workshop Review Form.
Evaluation Performance Measure 52: The extent to which project partners demonstrate an increased awareness of the need for culturally competent approaches to address health needs of discriminated populations, including LGBTI.	
Evaluation Performance Measure 53: The extent to which participants view the Umunthu approach as relevant to their on-going activities.	

A3.2: The project's communication and advocacy strategy will improve visibility on the Umunthu Workshop and its unique approach to supporting health access for minority populations, particularly LGBTI.

The project will prepare a communications and advocacy strategy mapping specific partners and stakeholder to be targeted for replication. The strategy will identify relevant outlets for the project to share learning and findings on relevant project learning including what approaches work well and why.

At the time of the Baseline, it is difficult to assess the project's strategy to achieving this claim. However, the study has proposed performance measures in the below table.

Table 22. A3.2 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 54: The extent to which stakeholders targeted by advocacy and communication strategy demonstrate improved awareness of Umunthu approach to addressing the needs of discriminated populations. **Evaluation Performance Measure 55: The extent to which stakeholders targeted by advocacy and communication strategy are increasingly interested in learning about the Umunthu approach.**	This will be assessed through in-depth interviews with project staff and a document review of relevant sources consulted in the creation of the communication and advocacy strategy. Findings will also be collated from project monitoring reports and key informant interviews with project staff.

G3.1: The training of trainers' workshop and media publications will generate interest in the Umunthu approach to addressing LGBTI health access needs amongst partner staff

The project aims to generate interest in the Umunthu approach from relevant stakeholders where replication could further improvements in health access for LGBTI. Evaluation performance measures for this claim are shown in the table below.

Table 23. G3.1 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 56: The extent to which target audiences of communication strategy can articulate the main campaign messages. **Evaluation Performance Measure 57: The extent to which representatives of government and other institutions make declarative statements about the relevance of the Umunthu Workshop or workshop components in their on-going curricular and trainings.** **Evaluation Performance Measure 58: The extent to which partners and other targeted audience members demonstrate increased interest in the Umunthu approach.**	This will be assessed through in-depth interviews with project staff and relevant partners as well as a document review of relevant requests (meeting minutes etc.). Additional consultations will be conducted with key audience members to assess the extent to which messaging activities have been successful.

R3.1: The training of trainers' workshop will reach XX partner staff. The communication and advocacy strategy will reach XX district stakeholders, XX national stakeholders, and result in XX media pieces.

The workshop will reach XX partner staff throughout the three years. Partner staff will be identified by XX. The communication and advocacy strategy will reach XX district stakeholders, XX national stakeholders, and result in XX media pieces.

The logframe tracks the number of partners trained in the Umunthu Workshop approach to assess this claim. Additionally, the study will review how these participants were selected through several in-depth interviews.

C3.1: The training of trainers' workshop will provide participants with the knowledge on how to implement workshop components in their own curricula and trainings.

The workshop aims to provide participants with the knowledge on how to implement workshop components in their own curricula and trainings.

To assess this claim, the study has put forward performance measures shown in the table below.

Table 24. C3.1 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 59: The extent to which partners believe they have the necessary skills and resources to replicate Umunthu workshop components. **Evaluation Performance Measure 60: The extent to which participants believe the Umunthu workshop is relevant to their on-going activities.** **Evaluation Performance Measure 61: The extent to which participants believe the Umunthu approach will lead to improved health access for minority populations.** **Evaluation Performance Measure 62: The extent to which participants demonstrate improved knowledge of how to implement workshop components.** **Evaluation Performance Measure 63: The extent to which participants demonstrate improved knowledge on how to manage challenges that could arise in implementing Umunthu Workshop components.**	This will be assessed through in-depth interviews with workshop participants and responses on the Workshop Review Form. Monitoring reports provided by the project will also be used to inform this review.

B3.1: Workshop activities will be integrated into civil society, educational institutions, and government curricula and trainings.

At the behaviour change level, the project aims to empower partners to adopt workshop activities into their own curricula and trainings.

The study proposes the below performance measures to assess this claim.

Government, educational, and civil society institutions replicate workshop components in their on-going activities.

Table 25. B3.1 Evaluation Performance Measures

Performance Measure	Source
Evaluation Performance Measure 64: The extent to which representatives of government at the local, district, and national level believe the workshop approach is effective at supporting the health rights of discriminated populations. **Evaluation Performance Measures 65: The extent to which representatives of educational institutions believe the workshop approach is effective at supporting the health rights of discriminated populations.** **Evaluation Performance Measures 66: The extent to which representatives of government, and other**	This will be assessed through a review of relevant monitoring reports and other document requests as well as in-depth interviews with relevant stakeholders and project staff.

relevant institutions believe they have the resources and skills to implement workshop components..	
Evaluation Performance Measures 67: The extent to which representatives of government and other relevant institutions believe the Umunthu Workshop is consistent and applicable to their specific health access policy objectives.	

Conclusion

Through achievement of the project's three primary objectives, the Umunthu Programme aims to realize several higher-order aims, namely:

- The project will contribute to the creation of a culturally competent environment that is conducive for LGBTI and other minority groups to assert their right to health services.
- The project will contribute to improved health access for LGBTI people.
- The project will contribute to reduced health disparities for LGBTI people.

By focusing on enabling health workers to consider and better understand LGBTI people through the local perspective of Umunthu, the project aims to enable them to appreciate and act on their responsibilities to discriminated populations (Objective 1). Project activities are well targeted to achieve this objective.

Consultations with health workers, district health management teams, and LGBTI respondents highlighted the significant levels of discrimination faced by these populations when seeking health services. Project stakeholders supported the view that homosexuality and sexual 'deviance' are viewed as an external, western, imposition on Malawian culture and norms. By adopting an authentic local construct as it's mantra, Umunthu, aims to provide a culturally competent means to elicit empathy and understanding on the part of health workers. This approach is well targeted to meet this need and challenge existing perceptions through an indigenous device.

LGBTI respondents highlighted the need for (1) non-disclosure and confidentiality, (2) non-discriminatory health services and (3) relevant care. The project aims to integrate these three health concerns into workshop discussions by using a LGBTI guest speaker and short videos documenting real life examples of cases where these health rights have been violated. By improving health worker knowledge and increasing their awareness as to the impact of these health concerns on health access, and ultimately health outcomes, the project aims to motivate them to actively adopt inclusive policies and practices.

However, is important to consider the extent to which these policies and practices will result in improved health access for LGBTI. Several LGBTI respondents and health workers, highlighted the fact that LGBTI in Malawi are a disempowered group. Asserting their right to health access, will require active engagement with these populations, much of which is beyond the scope of the current project. By addressing the supply side of this barrier to health access, the project aims to improve health access for LGBTI, over time. Future programmes should examine the extent to which support can be provided to LGBTI populations to improve their awareness of their health rights and their capacity to assert these rights.

The project also aims to support members of civil society and community leaders to engage with healthcare workers to discuss ways to tackle health access disparities in communities (Objective 2). This is currently supported through the third day of the workshop, where community stakeholders are invited to learn about workshop discussions, and participate in the creation of an action plan to realize improved health access in health facilities. The project believes that by supporting increased engagement between community members and health service providers, on the issue of health access for minority populations, inclusive policies and practices will remain relevant and sensitive towards local community needs.

It is likely that continued community engagement, and community stakeholder participation in the action plan will result in more sensitive, adaptable, and targeted approaches to improve health access for LGBTI. However, it is unlikely that community members and health workers will have sufficient capacity to continue these

engagements independently, beyond the workshop. The project should consider adapting the workshop approach to provide a model through which health workers and community members can continual engage on minority health access rights, in a participatory, open and sustained dialogue. Unless this is made practical for community representatives and health workers, it is unlikely that sustained engagement will be achieved.

The project's final objective is that workshop activities will be integrated into civil society, educational institutions, government curricula and trainings (Objective 3). The likelihood of meeting this objective is difficult to assess at the time of the baseline. However, the project needs to define a communication and advocacy strategy to ensure that workshop learning is well documented and communicated effectively to a wider audience. This strategy should aim to identify relevant government, media, and institutional stakeholders at the district and national level to be targeted in messaging activities as well as define the means through which advocacy engagements will be planned, managed, and documented.

Recommendations

Objective 1:

1. Review the role of guest speakers to ensure it is consistent with wider messaging objectives and with the project's aim of creating an open and safe space for participants. Some participants highlighted this as a significant concern. In the case of the second pilot workshop, many participants perceived the guest speaker to be aggressive. Processes to manage guest speaker engagements, including a review of the topics they will cover and how to manage disagreement, are essential to ensuring this component remains effective at reaching target audiences and delivering project messaging.

2. Providing LGBTI groups and advocacy actors with lists of health workers who had been trained and agree to be approached by LGBTI members seeking non-discriminatory care. The project currently aims to improve the supply of non-discriminatory health services but does little to promote LGBTI's knowledge about their health rights or knowledge about where they can receive accessible services. This area should be examined for future funding sought by the organization.

3. Consider letting participants know that the workshop will discuss improved health access for LGBTI populations. Workshop objectives should be made to participants at an early stage and in a culturally-competent way. The project should pilot this approach and compare it with previous approaches. Several health workers cited that they would have still attended the workshop if the content was made clear in advance. They also cited concerns that they felt the indirect manner, in which a 'sensitive' topic such as LGBTI was raised, led them to feel as if the workshop was contrived and confused the concept of Umunthu (which was originally believed to pertain to all kinds of people, not just LGBTI).

4. Consider inviting previous workshop attendees as guest speakers. Health workers mentioned that listening to fellow 'model' health workers can inform them on how to implement changes in their own health units, deal with issues such as confidentiality and mobilize others in the pursuit of inclusive policies. The programme may benefit from selecting role model participants and inviting them to participate in the workshop as guest speakers.

5. Review the role of the legal guest speaker. Several health workers reported that the information provided by the legal guest speaker was not useful as the majority do not fear any legal consequence of servicing LGBTI persons. If the purpose of the legal speaker was to inform them that this is indeed the case, the project may more efficiently deliver this piece of information through facilitators 4, rather than by engaging an external speaker. This slot could be substituted by fellow health workers guest speakers that are selected as 'champions' of the project.

6. Continually review data collected from Workshop Feedback Forms to ensure the workshop remains relevant and engaging for participants and to reduce potential drop-out during the follow-up workshop.

7. Consider developing a set of ideal action plans and presenting these to participants as examples. It is essential that the process of creating or adapting an action plan is collaborative as this will encourage participant ownership and buy-in. The project could consider allowing participants to develop their

own action plan, then sharing an 'ideal' plan and criteria to evaluate it. Participants could then use that criteria to participatorily evaluate the plan they have developed.

8. Consider documenting best practices in action plan development and achievements. This could be used in future workshops to provide real-life examples of what inclusive policies and practices can be adopted and how these can be implemented.

9. Consider periodically monitoring progress on action plans, beyond the follow-up workshop, and identifying ways through which the project can support participants during implementation. Follow up could be done telephonically if a representative was selected during the workshop who could be contacted at key stages for a phone interview.

10. Leverage project partners to share information on health disparities experienced by LGBTI populations, to better inform health workers as to the need for targeted support for these groups. This may be difficult due to the absence of country-level data on health outcomes for LGBTI populations. Whilst, the primary aim of the project is to target the rights of LGBTI to health access, improving health worker awareness of the disparities faced by these populations, could support them to, from a professional and medical perspective, more easily approach LGBTI health seekers.

Objective 2

1. The project should aim to include clear steps and processes to guide health workers and community stakeholders on how to discuss and identify health needs of minority populations, during the 1-day mini workshop. This could be modelled during the third day of the main workshop but should be explicitly targeted at promoting improved and sustained engagement between community stakeholders and health workers.

2. The project should consider appointing a LGBTI health leader within the Health Advisory Committee, who is responsible for following up and monitoring on-going action plan progress. This would provide someone with a mandate to continue to promote LGBTI inclusive health policies and promote continued engagement.

3. The project should consider documenting best practices in target communities during implementation to share these in future workshop settings and enable community representatives to see real life examples of the differences they could make and the role they have in promoting health access for LGBTI. This could be done by inviting health workers that have been successful in implementing their action plans to the workshop and having them share their experiences and challenges faced.

4. The project should consider a more sustained engagement with CBO representatives and community leaders at the health cluster level to ensure they have the capacity to advocate for the health rights of minorities. This may be done in a separate workshop used to disseminate and gather feedback on findings from monitoring or evaluation.

Objective 3

1. The project should develop a comprehensive communications and advocacy strategy to achieve Objective 3. The strategy should identify relevant stakeholders and create advocacy outlets for the project to share learning. This could be done by reviving the Technical Working Group on Key Populations.

2. The project should continuously document learning through quarterly reporting and other monitoring practices to ensure it builds robust evidence on what workshop components are most effective and why. This can be shared with stakeholders identified in the communications and advocacy strategy.

3. The Umunthu approach resonates with the humanistic characteristic of major religions in Malawi. The project may enlist the help of religious leaders supportive of LGBTI rights to persuade to support project advocacy activities. The project could, for example, select 'champion' religious leaders to participate in the technical working group and benefit from evidence-sharing.