

PD-ABF-862
72310

MIDTERM EVALUATION REPORT
1990 - 1992
for
CHILD SURVIVAL VI PROJECT
OTR 0500-A-00-0098-00
MALAWI, NSANJE DISTRICT, NORTHERN HALF



Submitted to:

United States Agency for International Development
Washington, D.C.

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October 1992

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Glossary

AAA	Angeline Absolute Accounting
ADD	Agriculture Development Division
ADRA	.....	Adventist Development and Relief Agency
AIDS	.....	Acquired Immune Deficiency Syndrome
CDD	.....	Control of Diarrheal Disease
CSAC	.....	Child Survival Advisory Committee
DIP	.....	Detailed Implementation Plan
EPI	.....	Expanded Program of Immunization
HI	.....	Health Inspector
HIV	.....	Human Immune-deficiency Virus
HSA	.....	Health Surveillance Assistants
IEF	.....	International Eye Foundation
M.D.	.....	Medical Doctor
MOH	.....	Ministry of Health
MPH	.....	Master of Public Health
NGO	.....	Non-governmental Organization
ORS	.....	Oral Rehydration Solution
ORT	.....	Oral Rehydration Therapy
PHAM	.....	Private Hospital Association of Malawi
SDA	.....	Seventh-day Adventist
SEAU	...	Southeast Africa Union (of Seventh-day Adventists)
TA	.....	Technical Assistance
TALRES	.....	Trans-Africa Leprosy
TOT	.....	Training of Trainers
USA	.....	United States of America
USAID	..	United States Agency for International Development
VHC	.....	Village Health Committee
WHO	.....	World Health Organization
RN	.....	Registered Nurse

I. Executive Summary

The mid-term evaluation of the Nsanje Child Survival Project operated in southern Malawi by Adventist Development and Relief Agency International (ADRA) was conducted in early April 1992. This evaluation was conducted by a team including members with extensive experience in Malawi as well as in other international projects. The evaluation entailed extensive field visits as well as interviews of project staff.

The evaluation found the infrastructure in place for the success of the project. The community development model is being followed by the project and very extensive coordination with others working in the provision of medical and health care in the project area is being done. Refinement and simplification of the health information system is needed to measure that success.

Recommendations are being made to enhance the effectiveness of this project.

The major drought that is affecting the project area will interfere with meeting project objectives. Project infrastructure may be needed to help facilitate provision of food aid. Because of this complication, an extension of the project is recommended.

II. General introduction to the Project

A. Geography

The project is in the northern half of the Nsanje District which is located in the extreme southern tip of Malawi. It is a very rural area with several small trading centers. The district administrative center is at Nsanje, about 50 km south of the project area. The Nsanje District is said to be among the most heavily populated in Malawi with over 200,000 residents. In addition, there are estimated to be over 300,000 refugees in this District. (Most of the refugee population is in the southern half of the District, outside the project area.) Estimated literacy rates for adults 20 to 64 years of age is 55% for men and 14% for women.

The Shire valley is a low altitude area where daytime temperatures can reach the mid-forties (C). It is bisected by the Shire River. The project area extends from the northern boundary of the District to a line west from Tengani.

Most of the population are engaged in subsistence farming, growing maize, sorghum, millet and sweet potatoes. According to WHO/MOH figures, over half of the existing housing provides poor protection against bad weather.

B. Indicators of Need

The area was chosen for a child survival project for the following reasons:

1. its leading causes of death in children under five years of age are preventable (malaria, respiratory diseases, diarrhea, malnutrition)
2. it has lower immunization levels than does Malawi as a whole
3. its under five mortality rate is 31% higher than the national average in Malawi--25% higher than the highest national rate in the world
4. the very low literacy rate in women (14% literate)
5. there were no other extensive child survival initiatives in the area
6. ADRA had been previously involved in the district through association with:
 - a) the Trans-Africa Leprosy Research and Education Service (TALRES), a 20 year-long project of Malamulo Hospital, and
 - b) through flood relief in 1989
7. there is increased pressure being put on the District's scarce resources by large numbers of refugees from Mozambique
8. the project was requested and welcomed by the Ministry of Health (MOH) and other Non-Government Organizations (NGOs) working in the area.

C. Description of Project

The Adventist Development and Relief Agency (ADRA) is a non-governmental organization (NGO) associated with the Seventh-day Adventist church (SDA) based in the U.S.A. Its structure includes Regional and Country offices. The local Regional office is in Harare and the country office is in Blantyre. The ADRA-Malawi Child Survival Project is largely funded by USAID with match provided through ADRA. The project uses the country office in Blantyre and has its field office at Ngabu in the Lower Shire Valley.

For the sake of organization of the work, the target area in Northern Nsanje has been divided into two operational areas: 1) the east bank of the Shire River and 2) the west bank as far south as Tengani. Key interventions provided by the project are:

1. an expanded program for immunization (EPI),
2. oral rehydration therapy (ORT) and control of diarrheal diseases (CDD),
3. child spacing (family planning),
4. nutrition education including promotion of exclusive breast feeding for infants until at least four months of age,

5. promotion of gardening for protective foods,
6. Vitamin A provision,
7. malaria prevention and intervention,
8. sanitation, and
9. HIV/AIDS education.

Project operations follow a community development model with strong coordination with the population being served, the use of community-based volunteers, and collaboration with other government and private agencies that operate in the project area.

D. History

The project began in October 1990. A Manager was appointed and assumed responsibility for the project in early December 1990. All supervisory personnel were selected and trained during the first project year. An Advisory Committee was selected and began meeting quarterly within the first six months of the project. Child Survival volunteers were selected and trained within the first year and a half of the project.

III. Project Objectives

A. Measurement of Project Objectives

Several of the project objectives have not been measured to date. Obviously this must be corrected in order to be able to evaluate the success of the project. The team analyzed the indicators that are currently tracked that could contribute to the evaluation of project objectives. Note was also taken of the technical review by USAID of the project DIP and its recommendations. Because the project has not directly responded to the technical review the team has chosen, as part of our evaluation, to provide responses to some of the technical review recommendations.

The first step in the analysis of the project objectives was to determine whether each objective is being measured and whether the indicator is appropriate. Specific indicators, periodicity, and means of collecting them are recommended for each of the objectives:

1. Percentage of 0 to 35 month old children who are fully immunized for their ages. The project has done a household registry that included specific attention to all children of 0 to 35 months. Reference is made to the mechanics of data collection and analysis in the information system section of this report. Data for this indicator should be readily available in the villages on immunization record cards. Adequate management information could be available through a cluster sample survey for this data every six months.

2. Percentage of 0 to 35 month old children who receive appropriate Oral Rehydration Therapy (ORT). Questions about diarrhea and its treatment have been included in the monthly reports being made by volunteers. The monthly report includes ten items in this area. The data collected are poorly defined and more extensive than appears necessary. Refinement and simplification of the monthly reports should make it possible to collect an adequate indicator for this objective. Since diarrhea tends to be seasonal, monthly data collection is appropriate.

3. Percentage of high risk families receiving biweekly home visits by project volunteers. The project has considered that all families with children less than three years of age or that include a pregnant woman are considered at high risk. While the team is sympathetic with this project concern, one of the strengths of focusing on high risk families is that it allows more intensive efforts to be addressed to those at greatest need. If high risk is defined too broadly, then it is not possible to focus efforts on those with higher than average risk. The team believes it is unrealistic to expect volunteers to visit all families twice a month.

Among the factors that are often cited as significantly increasing risk are:

- a. more than one child under three years of age,
- b. prior death of child under five years of age,
- c. female head of household,
- d. incompletely immunized children.

If the definition of high risk family could be made using factors such as these, it would be possible for volunteers to concentrate their efforts on fewer families who are at higher risk. Normal risk families could be visited monthly and volunteers could make weekly or biweekly home visits to families at higher risk. The data could be collected from monthly activity reports of the volunteers.

4. Percentage of targeted households using latrine. This indicator is not readily amenable to direct observational measure. Monthly reports by volunteers have included data on latrines available. Although it is not a precise measure of usage, data on the availability of latrines is more easily and more reliably obtained. Since the construction and presence of latrines is not usually transient, collecting data on the presence of latrines every six months should be quite adequate to measure this project objective.

5. Percentage of mothers exclusively breast feeding for at least the first four months. No indicator for this objective has been collected to date. As a major determinant of infant health, this is an important objective. Data could be collected through a cluster sample survey every six months.

6. Percentage of children less than three years of age who have severe malnutrition. No specific indicator has been identified and collected to measure

this objective. Data are being collected on all children, however, as they are weighed and the results plotted on their growth cards. A commonly used measure of severe malnutrition is weight for age that is greater than two standard deviations below average. This could be assessed by a cluster sample survey every six months and still provide adequate information to manage the program.

7. Percentage of eligible families using modern family planning. No specific indicator has been identified and collected to measure progress toward reaching this objective. Because there are only a few clinical service points providing modern family planning, it should be possible to gather data on use of these services from them. It would also be relatively easy to include a survey question about this in the cluster sample survey that should be done every six months.

8. Percentage of households with a home garden. This should be relatively easy to measure by direct observation. Data could be collected at time of sampling survey every six months.

9. Percentage of fevers (presumed from malaria) in mothers and children less than three years of age. The team has been told that fever in this area is presumed to be malaria until proven otherwise by its lack of response to the standard malaria treatment regimen. Data on the presence of these fevers in children less than three years of age and in mothers can be collected through simple questioning of the mothers about fevers during the past two weeks. Since malaria tends to be seasonal, it would be appropriate to collect this data monthly in the villages targeted for malaria control.

B. Progress Toward Meeting Project Objectives

It is difficult to know what progress is being made to meet the objectives since several have not been measured to date. Regular collection and comparison of the data is extremely important. A sample report could have the following form:

	Baseline data	Objective	Current data
1.	_____	(80%)	_____
2.	_____	(60%)	_____
3.	_____	(< 5%) ¹	_____
4.	_____	(>40%) ²	_____

¹ the symbol "<" indicates an increase from the baseline figure

² the symbol ">" indicates a decrease from the baseline figure

C. General Comments

Although significant progress has been made in establishing the infrastructure to make measurement of project objectives possible, it is not possible to know that progress is in fact being made without regular collection of at least one indicator for each objective.

IV. Infrastructure supporting project

A. Staffing

The project is administered by a Manager based at the Ngabu field office. The Manager is supported by a secretary, a part-time office housekeeper, a driver-mechanic and a watchman. The Manager has resigned effective in May 1992 and will be returning to the U.S.A. Recruiting efforts are under way to locate a suitable replacement.

There are two field supervisors, one in each operational area. They are Health Inspectors (HI), both having been trained by and worked with MOH previously. They supervise 20 Health Surveillance Assistants (HSAs), nine in the east bank area and eleven in the west bank areas. The HSAs supervise and provide support to 483 volunteers in 220 of the 273 villages of the project area. The garden promotion portion of the project includes one gardening specialist who reports to the project Manager and who supervises two gardening trainers, one in each operational area.

B. Counterparts

With the exception of the project Manager and the driver-mechanic, both overseas volunteers from the USA, all project staff is Malawian. The intent of the DIP was that the Manager will train a Malawian replacement, but a suitable candidate has not yet been found.

C. Accounting

Accounting for the project is done by the Manager in the field office and in the country office of ADRA-Malawi in Blantyre. Further discussions of accounting can be found in the Fiscal Status section of this report.

D. Purchasing

Purchasing for the project is done by the Manager in consultation with ADRA-Malawi administration. Although the project began with the use of purchase orders for many purchases, under current policies, the item to be purchased is paid for by a project check.

E. Personnel

1. Supervision

The various levels of supervision are described in the project description section. Supervision is designed to include regular face-to-face visits and by the supervisor accompanying staff during a sample of their regular activities.

2. Policies

Personnel policies are those developed for ADRA-Malawi. There has been an attempt to keep the policies, particularly compensation policies, consistent with MOH policies for comparable workers.

3. Payroll System

A regular payroll system has been developed with accounting for the basic compensation as well as the various allowances provided.

F. Conclusions

Project operations had to begin without a pre-existing infrastructure. Due to the good work of the project Manager, an infrastructure is now in place. This will make the work of future managers much easier.

V. Technical Assistance

A. Listing of Technical Assistance used

The project has benefitted from technical assistance from a number of sources both from within Malawi and elsewhere. The following list has been provided by the project:

- Orientation/Implementation Workshop, Laurel, MD
by ADRA International
- Health Information Systems
by Child Survival Program, Save the Children, Mbalachanda, Malawi
- Health Information System and Household Survey
by Center for Social Research, University of Malawi
- Training of Volunteers
by Community Health Services, Malamulo Hospital
- Coordination of Training Health Surveillance Assistants
by MOH, Regional and District personnel
- Nutrition in Children in Malawi
by Blantyre Adventist Hospital
- Development of Detailed Implementation Plan
by ADRA International

- Literacy Testing for HSAs
by Primary school teacher, Makwasa
- Program Coordination, High-risk Indicators
by ADRA International
- Training of Trainers
by ADRA International
- Malaria Intervention
by London School of Tropical Medicine & Bridge International, Inc.
- Agronomy
by World Vision International, Blantyre
- Health Information System
by Hubert Allen Associates
- Health Information System
by private consultant, Blantyre

B. Perceived Value of Technical Assistance

The project staff reports that the TA provided by ADRA-International, as well as that provided by others, has been very useful in orienting project staff to the local conditions and situation as well as to assisting in specific areas.

C. Implementation of Recommendations

With the exception of the Health Information System, which continues under development, recommendations on specific program areas seem to have been implemented.

D. Listing of Technical Assistance Planned for Remainder of Project

With the imminent change in project manager, the needs for TA will likely change because each manager brings a particular set of strengths, experience, and interests. It seems to the team that additional TA will be needed for the Health Information System, for malaria interventions, for HIV/AIDS education, for sustaining volunteer programs, and for project management. The scope of work and timing of the TA must await the new project Manager.

E. Conclusions

Considerable TA has been used by the project. Much of it has been from within Malawi and many of these providers remain available to continue their assistance. This is very positive. Future TA needs of the project remain to be determined by the new project Manager.

VI. Information system

A. Data Collection

All staff are involved in data collection. The established pattern has been for volunteers to collect data on a four page form each month. These are collected by HSAs during their supervisory visits and compiled into unified reports submitted by each HSA to their respective supervising Health Inspectors monthly. These compile and submit their data monthly to the Project Director who compiles and analyzes the resulting data. The reports received by the project manager, however, do not specify the volunteers or HSAs who are (or are not) reporting.

One of the first tasks of the volunteers was to register all families that include children less than three years of age. Information on the immunization status of these children was included on the registration reports. These reports were entered into a database, "EPI INFO," for analysis. Data entry was done under contract by a service in Lilongwe.

B. Quality of Data

Team members analyzed a one-seventh sample of the data available (approximately 30 villages.) The sample was of children aged 12 to 23 months who have been incompletely immunized for their age. Projected to the whole, this included 630 children, approximately 13%. (According to census projections, there should be approximately 5000 children in this age cohort in the project area.) It was not possible to determine whether the sample represented the true percentage of incompletely immunized children of this age group. The team understands that not all villages in the project area are being served by the project. There is an unknown percent of children omitted from the registration because they were missed by the volunteers or because their village is not being served.

There appeared to be problems with quality of the records available since some included information that was not credible, eg. a child of less than one month who is recorded as having already received measles immunization. It has been assumed that the persons compiling records are providing some quality control in the process. Our quick review indicates that more attention must be given to quality assurance of the data. Errors could be entering at any point from the volunteer to data entry. Each step must have quality safeguards built in if the data collected is to have value.

A potential area for data quality problems is the heavy dependence on the volunteers to collect and record the data. It may be too much to expect volunteers to gather extensive data on a multi-page form every month. Experience elsewhere would indicate that the fewer the data items and the simpler the expectation, the

greater the likelihood the data collected will be of high quality. Recommendations are being made to revise the monthly reporting expectation.

C. Birth and Death Registry

It appears to some team members that the monthly report form has been an attempt to create a birth/death/disease registry for the project area. Such a registry does not exist; it would be useful information for planning health services. It is, however, beyond the scope of this project. We recommend that a project proposal be prepared and funding sought separately for a birth/death registry.

D. Conclusions

Data collection has been both a major effort and a major difficulty of this project. Enough data must be collected to monitor the project objectives, but too much is hazardous. Minimal data collection should be kept as simply as possible. The quality of the data must be checked at every step. Dependence on computers for data analysis requires some local expertise. The automated system is not yet functional.

VII. Training

A. Listing of Training that has been Done

Health Surveillance Assistants were trained for a nine (9) week period (May through July 1991). This was the standard MOH training using the MOH training manual, plus three additional weeks to provide project specific emphases on vitamin A and nutrition, leprosy, and record keeping and supervision.

Since their initial training, HSAs have been receiving quarterly update refresher courses lasting 2 to 3 days each. These have been aimed particularly at team building as well as at health technical skills.

Training has been through team teaching effort using staff not only of the project but also of MOH, IEF and TALRES.

Volunteer training included three days of basic training in nutrition/growth monitoring, malaria management, immunizations, and control and management of diarrhea. This was done from November 1991 through January 1992. Since then, there have been monthly one day meetings which have included focuses on sanitation, vitamin A interventions and record keeping. Training has been provided by the HSAs who received the TOT training first.

Garden trainers (2) were employed in January 1992. One serves the eastern bank areas and the other the western bank. They were trained for their job by garden specialists from Ngabu ADD and from IEF. They were oriented in the importance of breast feeding and in vegetable horticulture for health purposes.

B. Listing of Training that is Planned for Remainder of Project

ADRA supports annual professional development for their senior staff. These are encouraged to participate in available seminars and workshops and are provided with paid leave for this purpose. The project and its mid-level management are actively looking for suitable in-country management training to more fully develop their skills.

It is planned that there will be a continuation of quarterly updates for HSAs. Among topics under consideration are AIDS, scabies, intestinal parasites, and nutrition education. HSAs are also taught informally during supervisory visits by their Health Inspectors.

It is planned that the monthly one day meetings for volunteers will continue. These will be used for team building and for updates on technical areas as well as presentation of additional focus areas. Topics under consideration are preventive eye care, disease prevention, and health promotion. Team teaching by staff from ADRA, MOH, and PHAM institutions will continue to be encouraged.

Garden Trainers are to attend a two week training in horticulture that will be organized by Ngabu ADD.

Training of the Village Health Committees is planned for the next six months. Training sessions to train project staff for doing this were recently held. Village Health Committees will have a one day session covering the roles of the VHC as well as establishing priorities to address community health problems.

C. Conclusions

Regular updates of all levels of staff are planned and encouraged.

The involvement of cooperating agencies, including the MOH and other government agencies and PHAM staff in planning and presenting the training, helps ensure coordination and is encouraged.

Supervision of staff appears to be relatively adequate but may require additional monitoring to assure that it does occur at the frequency expected and needed.

VIII. Coordination of effort

One of the strengths of the project appears to be its attempt to foster coordination of efforts with other services and agencies that operate in the project area. In addition to coordination with the communities involved, with various government agencies and with other NGOs, a Child Survival Advisory Committee (CSAC) has been formed. It has representation from people in the area, from various levels of the MOH, and from other NGOs that operate in the area. The CSAC meets quarterly.

A. Community Participation

Community leaders perceive the project as a worthwhile effort addressing some of the prevailing problems in their communities, especially the health of the children. It is regarded as very helpful in saving children's lives. The project has made it possible to deal with some problems such as diarrhea and eye disease at home, thus alleviating the bother of walking for long distances to health posts. The medication provided through the volunteers has thus far been limited to ORS. Requests have been made that additional medications be provided. This shows a lack of understanding or appreciation of the preventive focus of primary health care. It is important for project staff to clearly present this focus.

From observations made by the team and the answers obtained about community participation in planning and implementing the project, it is difficult to establish that there has been significant community participation in planning. The communities have definitely been involved in implementing the project through membership in village health committees and through the selection of volunteers for the project. The majority of community members, however, appear to be passive participants in the project. Despite their lack of involvement in the initial planning of the project, community leaders seem very keen to see that the project succeeds. Although nearly half of the planned village health committees have been formed, none have yet received the planned one day of instruction on their function.

Team members met a number of volunteers in their villages. Despite their relatively low education (they are required to be literate in the Chichewa language), they seem happy with their work and very motivated for the work in their respective communities. Volunteers were selected by the members of the communities in which they live. They are trained for specific tasks in an initial three day training program which is followed by refresher training and additional topics every month. They seem eager to learn skills to serve their communities.

On average, volunteers work with about fifteen families, although some have more than twice that number. They are said to visit their assigned families often,

nearly every fortnight as expected, to give advice on general sanitation and hygiene and to advise them when there is a case of diarrhea. They supply ORS and instruct on home management of the diarrhea to prevent dehydration. When this fails, they refer the family to medical care at the nearest health center or hospital. In some areas, the team was told by health center staff that when the patients arrive at a health center because of diarrhea they are now bringing with them referral notes from the volunteers stating that ORS has been tried but that further care is required.

As volunteers, they do their volunteer work after their normal home and/or work duties are completed. They are regularly supervised by HSAs. In at least one village this supervision was said to be perfunctory, with the HSA visiting only to deliver and pick up the monthly report forms. Most of the volunteers look at what they do as something that is important for their community. Some appear to have hopes that this service could serve as a stepping stone for health sector employment.

Incentives that have been provided have included the provision of a uniform, a carrying bag and a name badge. (Some of these have yet to be provided.) They are also provided food while attending training sessions. These incentives differ from those provided by MOH to their volunteers. Government volunteers are not provided with either uniforms or name tags but are instead given a cash per diem during training. It will be important to develop a consistent approach to incentives for volunteers or there may be discontent because of perceived greater or lesser rewards in various volunteer services. This could discourage volunteers from continuing in service and make it harder to recruit volunteers in the future. A proposal to explore the volunteer phenomenon has been developed and funding is being sought. This proposal is a joint effort with IEF.

B. Coordination with Government

There has been coordination with the Ministry of Health at various levels. Government counterparts have been involved in the interviewing and selection of HSAs for their posts. Government officials were involved with ADRA in training of these HSA staff. The HSAs and volunteers are regularly involved in growth monitoring and immunization activities at government health clinics, both static and mobile. Because of the turnover of staff at government health facilities, there needs to be more attention to orienting new health care workers to the objectives of the project and the need for their cooperation in the delivery of services.

There has also been coordination with other government agencies such as Agriculture (ADD).

C. Coordination with Other NGOs

There appears to be good cooperation with the other NGOs providing health services coordinated by the Private Hospital Association of Malawi (PHAM) such as the International Eye Foundation (IEF). Project staff HSAs and volunteers provide services in other clinics just as they do in the MOH clinics. They also work in close collaboration with IEF on vitamin A capsule distribution and the growing vitamin A rich vegetables. IEF has provided some funds for an ADRA associated well/borehole program.

Trinity Hospital and IEF have had volunteers working in the project area in the past. Rather than duplicate efforts, there has been agreement that all volunteers in the project area will now be called "Child Survival Volunteers" and will be trained and supervised by the ADRA project staff. There is good expectation that some of these volunteers will revert to their prior organization at the close of the project.

D. Conclusions

The activities of the project are not new to the areas where they are being implemented, but the project appears to have brought them closer to the people. This is a welcome direction.

Coordination and communication at the health facility level needs further development. Regular "team meetings" of ADRA and the MOH and other NGO staff could help facilitate this. In addition, providing copies of ADRA reports to the relevant health facility staff could improve communication and foster cooperation for the benefit of the people of the area.

It will be very important to foster liaison among the various groups involved so that arrangements can be made for the absorption of project volunteers and HSAs at the end of the project period.

IX. Fiscal status of project

A. General Discussion

When the project began in October 1990, accounting services were provided by the Southeast Africa Union (SEAU) of Seventh-day Adventists in Blantyre. An account was opened for the project at the National Bank of Malawi. Unfortunately because of miscommunications, the first draft of funds was not received in that account until April 1991. During the interim period, operating funds were

advanced by SEAU. ADRA-Malawi employed a business manager in June 1991 and a new country director assumed his position in July 1991. Regular financial statements for the project were not produced by the new business manager and it became apparent to ADRA and project administration that accounting systems were not adequate; steps were taken to remedy that.

At the request of the ADRA/Malawi administration, the books of the project were audited. This was followed by a country visit by the Vice President for Operations of ADRA International. The ADRA/Malawi business manager resigned under pressure in February 1992. Since that time, the Treasurer of SEAU, together with a new accountant have been painstakingly re-posting all financial transactions into ADRA's new AAA accounting program. (The AAA accounting package is becoming the international standard for ADRA International.)

Financial policies of ADRA/Malawi have been tightened, including requirements for multiple signatures, a strict imprest system for petty cash, and purchase by check rather than by purchase order. In late April 1992, a representative of ADRA International will visit Malawi to give technical assistance with the new ADRA standardized accounting system. A full fiscal audit of the project is to be conducted by an auditor of the General Conference of Seventh-day Adventists in June 1992.

Data on the current financial status of the project versus budget to date were not available at the time of the evaluation, but are expected within the month and will be reported in the Annual Report.

B. Conclusions

Financial records for the project were incomplete at the time of the evaluation, but the team was assured that they will be available within the month and was reassured that ADRA/Malawi has taken strong measures to regularize business practices and accounting.

X. Sustainability

A. Communities

Well selected, well trained, actively involved Village Health Committees can be very important to the support and continuation of volunteer services within the communities. This function should be emphasized in the training of these Committees.

B. Government

Attention to sustainability has been emphasized since the initial planning of the project. Though in the early stages of the project planning verbal assurances were received from MOH Regional Health officials with regard to the future absorption of ADRA HSAs by the MOH, there are no definite or well defined agreements. Project management states it is working on these agreements.

ADRA has, however, taken steps to facilitate the future absorption of ADRA staff by MOH. The most important of these steps was to involve the central coordinator for HSA training of the MOH and MOH resource people at both the region and district level in planning and organizing the HSA training making certain the ADRA training closely followed the MOH guidelines. Care was also taken to keep the salary structure for ADRA employees in conformity with that of MOH for similar workers.

C. Other NGOs

Contacts were made at an early stage with other primary health care providers in the project area. Most of their volunteers were absorbed by ADRA in mutual agreement with these organizations. Trinity Hospital plans to absorb their former volunteers and continue project activities in its catchment areas after the ADRA project ceases. There will still be need for HSAs to provide immediate support, motivation, supervision and ongoing training of the volunteers.

D. Conclusions

A formal, written agreement with the MOH on future employment of ADRA project staff is very important.

Frequent communication in the field with other primary health care providers is essential to keeping them well informed about the ADRA project. As much as possible they should be involved in actual planning and implementation of project activities. This will foster mutual cooperation and keep others who might be involved in the continuation of activities when ADRA phases out conversant with what is going on within the project.

XI. Assessment of unanticipated problems

A. Computer Software

The project was designed to include a baseline survey and registration of the population of the area. Because of the size of the population involved,

approximately 100,000, it was felt necessary to computerize the records and use data processing for analysis. The first software selected was not suitable for data analysis needs. A U.S. based software consulting group, Hubert Allen Associates, had a consultant with health information system experience already in the area and was contracted to help sort out the problem. He recommended a different software package, EPI INFO. The project was able to locate a Malawian consultant able to continue to provide assistance with the system.

Unfortunately, to date, the system has been able to only produce data or analysis on the village level. With over 200 villages registered, this has not produced the information base needed to assist in managing interventions. Even if it is possible to get the needed information using this data base package, superficial analysis by the team indicated that quality control of the data is not adequate. It was not possible for the team to determine whether the quality control problem is at the data collection level or further downstream. As indicated in the section on Project Objectives, much of the required information can be obtained more easily through 30 cluster sampling surveys.

B. Accounting

Problems with accounting for the project and delayed availability of fiscal data are discussed in the Fiscal section of this report. The problem appears to have been too extensive trust in the ability and integrity of one person. We believe that ADRA International and ADRA/Malawi have taken the necessary steps to prevent a recurrence and that regular operating statements will be available before this report is finalized.

C. Early Departure of Project Manager

The Project Manager, with many years of experience in public health management in the U.S., came on a planned two year commitment. She developed a very extensive and complex systems for operating the project. It was planned that a Malawian counterpart would be selected and oriented by her to project operations before her departure. Unfortunately, for personal and health reasons, it has become necessary for she and her husband, who served as driver/mechanic for the project, to return to the U.S. after 18 months. A suitable counterpart or successor had not been located by the time of the team's visit. Thus the handover of the project is not likely to go as smoothly as could have been hoped. There is documentation of the systems, written policies, and the ADRA/Malawi Director has been involved in project operations enough so that if a replacement Manager can be named soon, disruption will be minimal.

D. Drought

Probably the most significant unanticipated problem is the developing drought in the project area as well as in other parts of Malawi and southern Africa. It was a sad paradox to see much of the project area superficially green but note the underlying indicators of what is to come. Although the field visit was at the end of the usual rainy season, the only sources of water in some of the villages visited were holes scooped out of already dry river beds. Shallow wells are already dry in places visited and boreholes were not producing because of broken pumps or other problems. The fields that should be tall with maize are empty. There is not even enough stalk for cattle fodder. We were told that people had planted up to four times, after isolated rains fell, only to see their seedlings wither and die from lack of continuing moisture. We were told that many people have planted the last of their seed grain stock, leaving a major problem for next year as well. The people of the villages visited are thin and we were told that some are already missing meals. The situation is likely to become desperate before rains come again. Food seems much more available for the Mozambiquans in the refugee camps than for the Malawians in the District.

The infrastructure the project has established down to the village level could be very important if food becomes available for distribution. If so, this must be considered to be the highest priority and the child survival project interventions will probably have to be scaled back. The drought will have major impact on the project. In the face of starvation, other objectives become secondary. Some volunteers are becoming less available because they must leave the area to try to find work to be able to buy food. The gardening objective of the project is unlikely to be met, nor is the hoped for decrease in malnutrition. Continuation of the project for a time after the drought ends could use the project infrastructure to speed recovery of the health of women and children of the area.

E. Conclusions

There appear to be ways to address the identified unanticipated problems with the exception of the drought situation. Project management is aware of the other problems and has responded appropriately to overcome them.

XII. Recommendations

- A. A replacement for the departing project Manager must be hired immediately if the success of the project is to be assured.
- B. Simple, readily ascertainable specific indicators must be developed and collected for each of the project objectives. Examples of the type envisaged can be found in the section on Program Objectives. Much of

the monitoring data can be collected by cluster sample surveys rather than requiring area-wide collection.

- C. "High Risk" should be redefined so that project interventions can be focused on those at highest risk rather than on all families that include a child under three years of age or a pregnant woman. Families in the general population can be visited less often and those at "high risk" can be visited more often.
- D. Data collection should be simplified and greatly decreased in volume and frequency. This will make it more likely that the volunteers collecting the data will find it a manageable task and will allow for Quality Control checking of the data by supervisors at each level.
- E. Structure should be designed to assure that supervisory visits are made at all levels of the project according to a designated schedule.
- F. Regular in-service education of project HSAs and volunteers on topics such as 1) reason for home visits and 2) appropriate ORT must continue.
- G. A schedule of needed technical assistance should be developed as soon as possible after the new Project Manager is in place.
- H. The health information system should be simplified to collect only those items needed for operating and monitoring the project.
- I. A birth/death register would provide much useful information for planning health programs. Project staff and Ministry of Health staff are interested in attempting a pilot of such a scheme in some part of the country. With the infrastructure in place in the project area, this could be the place to try it. A project proposal for this should be developed and funding to implement it should be sought.
- J. Training of Village Health Committees should be done as soon as possible to capitalize on the interest of members and establish a supportive group to work with and help guide volunteers. These Committees are most critical to sustainability.
- K. Focus on health promotion and disease prevention must not be lost in trying to meet the requests of villagers for the volunteers to have a wider range of basic medicines available.
- L. Provision of some basic medications through the volunteers with replenishment through a revolving drug fund (excluding the idea of

profit for the volunteer) should be tried where interest and readiness is apparent.

- M. An inventory and supply system should be built into supervision so that those basic medications that are to be available (such as ORS) are indeed available.
- N. Incentives for volunteers need to be carefully developed in consultation with the Ministry of Health officials and designed to encourage sustainability.
- O. Coordination between the project and other primary health care providers in the area should include orientation of newly assigned staff and a system of more formal introduction to this ADRA project and its interventions. Opportunities for collaboration should be developed.
- P. Linkages with workers in other sectors, e.g. home craft workers, should be strengthened. For example, villagers can be taught how to use vitamin A rich vegetables that can be grown in backyard gardens.
- Q. Reports developed by the project should be supplied to the relevant area primary health care providers as well as to the project management. These reports could form the basis for regular "team meetings" in the areas.
- R. In order to make sustainability more likely, well defined written agreements should be obtained regarding future employment of the HSAs who are a vital supervisory link with the volunteers.
- S. If dependence on computers for data analysis is to be a feature of this project, then some degree of in-house computer expertise is needed in addition to the services of the consultant.
- T. Coordination of project activities with drought relief must occur.

XIII. Project Extension

If the drought continues to develop as projected, an extension of the project to have the infrastructure in place during the drought recovery phase should be sought. This time could also be well used if a recommended pilot birth/death registry proposal is to be funded and implemented.

XIV. Sources of information

A. Evaluation Team

The evaluation team was made up of two members with extensive international health experience from outside of Malawi and six members with extensive experience in Malawi. The team was as follows:

- **Lester N. Wright, M.D., M.P.H.**
Chairman of the Department of Health Administration, School of Public Health, Loma Linda University, Loma Linda, California.
Chairman of the evaluation team.
- **Peter Cuppen, M.D., M.P.H.**
Medical Officer, Trinity Hospital (in the project area)
- **William Dysinger, M.D., M.P.H.**
Senior Health Advisor, ADRA International (April 2 to 8)
- **Gloria Gazanga, R.N.**
Chief Community Health Nurse, Nsanje District, Ministry of Health (April 6)
- **Paul Juluma**
Central Region Health Inspector, Ministry of Health
- **Gloria Khunga, R.N.**
Southern Region MCH Coordinator, Ministry of Health
- **Vincent Kunkeani**
Nsanje District Health Inspector, Ministry of Health (April 7 to 9)
- **Alfred Mwenifumbo, M.P.H.**
Assistant Program Officer, UNICEF/Malawi

B. Evaluation Process

Members of the evaluation team spent three days in active field observations. In order to maximize the time available, the team divided into two groups, one concentrating mostly on the east bank area and the other on the west bank. The field process included semi-random visits to ten villages where interviews were conducted with head men, health committee members, volunteers, HSAs, and residents. Gardening plots were also visited at several sites.

The team visited the primary health care delivery sites in the project area (health posts, health centers, and hospitals) and interviewed the officers in charge of them.

Senior District health officials were interviewed at Nsanje District Hospital. Representatives from the Agriculture Development Division, International Eye Foundation, and TALRES Leprosy project were interviewed.

The Director of ADRA-Malawi, the Treasurer of Southeast Africa Union of Seventh-day Adventists, project management staff including the project Manager, Health Inspectors, and many HSAs were interviewed. Project policies and records were reviewed at the field office as well as at the ADRA/Malawi office in Blantyre. The health information system was discussed with and demonstrated by Mr. Phiri, the in-country software consultant.

In order to achieve greater uniformity of data, observations were made according to a specific set of instructions emphasizing semi-structured interviews according to a draft outline for this report and interview forms designed to assure that important areas were not neglected. According to instructions, the interview forms were used only for guidance and data was transferred to them after the interviews and observations. After gathering its observations, the evaluation team worked together, each drafting segments of this report. These were integrated and discussed as a team. Recommendations were developed by team discussions after each field day and during the report drafting process.

The Chairman of the Evaluation Team wishes to express his appreciation to the members of the team for their diligent work and to the agencies that they represent for their time. In addition, the provision of a vehicle and driver by UNICEF was greatly appreciated.

APPENDIX A

Pipeline Analysis

Actual Expenditures to Date
 (09/01/90 to 09/30/92)

Projected Expenditures Against
 Remaining Obligated Funds
 (10/01/92 to 08/31/93)

Total Agreement Budget
 (Columns 1 & 2)
 (09/01/90 to 08/31/93)

COST ELEMENTS

I. PROCUREMENT

- A. Supplies
- B. Equipment
- *C. Services/Consultants
 - 1. Local
 - 2. Expatriate

SUB-TOTAL I

II. EVALUATION

SUB-TOTAL II

III. INDIRECT COSTS

HQ/HO Overhead 17 (%)

SUB-TOTAL III

IV. OTHER PROGRAM COSTS

A. Personnel (list each position & total person months separately)

- 1) Technical
- 2) Administrative
- 3) Support

B. Travel/Per Diem

- 1) In country
- 2) International

C. Other Direct Costs
 (utilities, printing
 rent, maintenance, etc)

SUB-TOTAL IV

TOTAL HEADQUARTERS

*Excludes Evaluation Costs

	A.I.D. 1	PVO 2	TOTAL 3	A.I.D. 4	PVO 5	TOTAL 6	A.I.D. 7	PVO 8	TOTAL 9
	67.50	22.50	90.00	932.50	4,830.50	5,763.00	1,000.00	4,853.00	5,853.00
				4,418.00		4,418.00	4,418.00		4,418.00
	6,600.00	2,200.00	8,800.00	19,333.00	(2,200.00)	17,133.00	25,933.00		25,933.00
	6,667.50	2,222.50	8,890.00	24,683.50	2,630.50	27,314.00	31,351.00	4,853.00	36,204.00
	5,358.99	2,045.16	7,404.15	(858.99)	9,733.84	8,874.85	4,500.00	11,779.00	16,279.00
	96,918.53	32,346.60	129,265.13	124,662.47	65,472.40	190,134.87	221,581.00	97,819.00	319,400.00
	11,267.21	3,744.00	15,011.21	(7,893.21)	20,039.00	12,145.79	3,374.00	23,783.00	27,157.00
	10,384.67	3,452.31	13,836.98	8,764.33	(3,452.31)	5,312.02	19,149.00		19,149.00
	23,265.93	7,755.30	31,021.23	54,662.07	15,484.70	70,146.77	77,928.00	23,240.00	101,168.00
	13,596.72	4,533.24	18,129.96	16,613.28	10,466.76	27,081.04	30,210.00	15,001.00	45,211.00
	58,514.53	19,484.85	77,999.38	72,146.47	42,538.15	114,685.62	130,661.00	62,023.00	192,684.00
	167,459.55	56,099.11	223,558.66	220,633.45	120,374.89	341,009.34	388,093.00	176,474.00	564,567.00

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Actual Expenditures to Date
09/01/90 to 08/31/92

Projected Expenditures Against
 Remaining Obligated Funds
09/01/92 to 08/31/93

Total Agreement Budget
 (Columns 1 & 2)
09/01/90 to 08/31/93

COST ELEMENTS	Actual Expenditures to Date			Projected Expenditures Against			Total Agreement Budget		
	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	30,636.00		30,636.00	(5,236.00)		(5,236.00)	25,400.00		25,400.00
B. Equipment	16,269.89	25,587.77	41,857.66	3,280.11	(5,587.77)	(2,307.66)	19,550.00	20,000.00	39,550.00
* C. Services/Consultants									
1. Local	561.85		561.85	15,688.15		15,688.15	16,250.00		16,250.00
2. Expatriate	9,661.24		9,661.24	11,114.76	4,000.00	15,114.76	20,776.00	4,000.00	24,776.00
SUB-TOTAL I	57,128.98	25,587.77	82,716.75	24,847.02	(1,587.77)	23,259.25	81,976.00	24,000.00	105,976.00
II. EVALUATION									
A. Consultant/Contract	404.44		404.44	8,945.56		8,945.56	9,350.00		9,350.00
B. Staff Support									
C. Other	1,459.90		1,459.90	(259.90)		(259.90)	1,200.00		1,200.00
SUB-TOTAL II	1,864.34	0	1,864.34	8,685.66	0	8,685.66	10,550.00	0	10,550.00
III. INDIRECT COSTS									
HQ/HO Overhead <u>0</u> (%)									
SUB-TOTAL III	0	0	0	0	0	0	0	0	0
IV. OTHER PROGRAM COSTS									
A. Personnel (list each position & total person months separately)									
1) Technical	25,698.15	1,800.18	27,498.33	8,101.85	5,008.82	13,110.67	33,800.00	6,809.00	40,609.00
2) Administrative	12,759.07	1,868.79	14,627.86	13,640.93	11,371.21	25,012.14	26,400.00	13,240.00	39,640.00
3) Support	6,263.44		6,263.44	16,694.56		16,694.56	22,958.00		22,958.00
B. Travel (Short Term)									
1) In country	32,892.63		32,892.63	30,781.37		30,781.37	63,674.00		63,674.00
2) International	11,753.89	11,911.89	23,665.78	3,246.11	23,088.11	26,334.22	15,000.00	35,000.00	50,000.00
C. Other Direct Costs (utilities, printing rent, maintenance, etc)	45,428.35	1,665.53	47,093.88	10,329.65	3,734.47	14,064.12	55,758.00	5,400.00	61,158.00
SUB-TOTAL III	134,795.53	17,246.39	152,041.92	82,794.47	43,202.61	125,997.08	217,590.00	60,449.00	278,039.00
TOTAL FIELD	193,788.85	42,834.16	236,623.01	116,327.15	41,614.84	157,941.99	310,116.00	84,449.00	394,565.00

* Excludes Evaluation Costs

TOTAL

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PVO/COUNTRY PROJECT Child Survival VI

Actual Expenditures to Date
~~(09/01/90 to 09/30/92)~~

Projected Expenditures Against
Remaining Obligated Funds
~~(10/01/92 to 08/31/93)~~

Total Agreement Budget
(Columns 1 & 2)
~~(09/01/90 to 08/31/93)~~

	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL	A.I.D.	PVO	TOTAL
TOTAL HEADQUARTERS	167459.55	56099.11	223558.66	220633.45	120374.89	341009.34	388093.00	176474.00	564567.00
TOTAL FIELD	390250.63	119263.06	509513.69	445856.37	249459.94	695316.31	836107.00	368723.00	1204830.00
TOTAL	557710.18	175362.17	733072.35	666489.82	369834.83	1036325.65	1219200.00	545197.00	1769397.00

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