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**VITAMIN A
FOR CHILD SURVIVAL
Chikwawa District
Lower Shire Valley, Malawi**

First Annual Report

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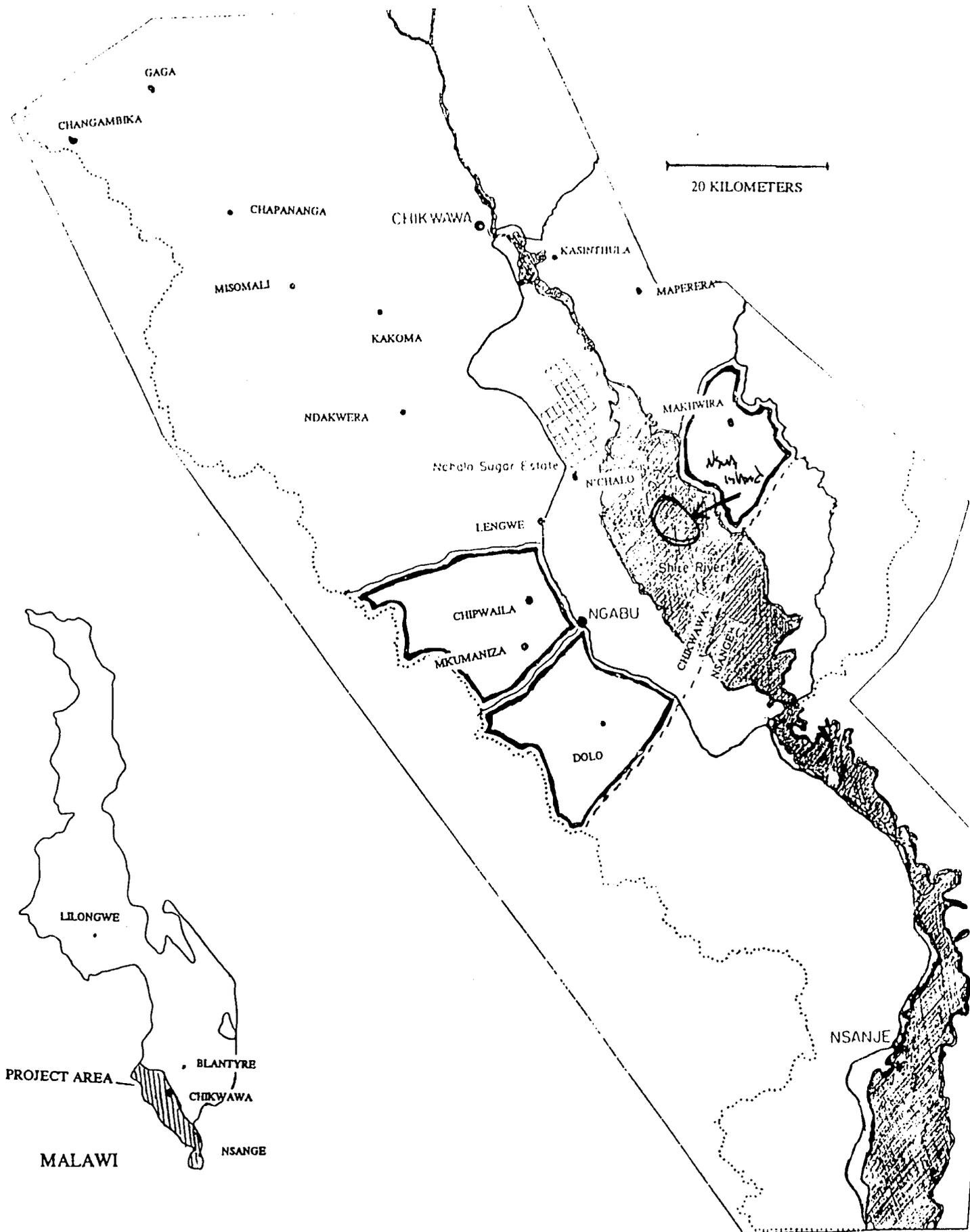
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○ ACRONYMS AND ABBREVIATIONS ○

ADD	Agriculture Development Division
ADRA	Adventist Development and Relief Agency
CDD	Diarrheal Disease Control
CSSP	Child Survival Support Program
CMS	Central Government Medical Stores
CONGOMA	Committee of NGOs in Malawi
DDC	District Development Committees
DHI	District Health Inspector
DHO	District Health Officer
DPHN	District Public Health Nurse
DRCU	Drought Relief Coordinating Unit
FASEB	Federation of American Societies of Experimental Biology
FHA/PVC	Food and Humanitarian Assistance/Private and Voluntary Cooperation
HSA	Health Surveillance Assistant
IEC	Information, Education and Communication
IEF	International Eye Foundation
INNE	International Nutrition Network Exchange
IVACG	International Vitamin A Consultative Group
LQAS	Lot Quality Assessment Survey
LSV	Lower Shire Valley
MCS	Ministry of Community Services
MAM	Medical Association of Malawi
MSF	Medecins Sans Frontieres
MOH	Ministry of Health
NAP	Nutritional Assessment Program
OFDA	Office of Foreign Disaster Assistance
PAC	Program Advisory Committee
PCV	Peace Corps Volunteer
PHAM	Private Hospital Association of Malawi
PHC	Primary Health Care
QECH	Queen Elizabeth Central Hospital
SCF	Save the Children
SSS	Sodium Salt Solution
SUCOMA	Sugar Company of Malawi
TA	Traditional Authority
TSC	Training and Supervision Coordinator
TTV	Tetanus Toxoid Vaccination
UNDP	United Nations Development Program
UNICEF	United Nations Children Fund
VAC	Vitamin A Capsule
VHC	Village Health Committee
VHV	Village Health Volunteer
VITAP	Vitamin A Technical Assistance Project

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CHIKWAWA AND NSANGE DISTRICTS



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1. Results In Year One

1.1 Major Results

Established New Office

A new office was established due to limitations of the previous office lease (at the Ngabu Agriculture Development Division compound). The new office, formally a bakery and store, is located in Nchalo Trading Center, the most central part of Chikwawa district and will house all staff including those working in drought relief.

Hiring, Training and Placement of Staff

Staff hired during the year include nine Health Surveillance Assistants (7 men and 2 women). HSA candidates were identified directly from the areas where they are currently assigned work, i.e., the Traditional Authorities (TA) Dolo, Chipwaila, and Makhwira. (See map attached). Each HSA underwent initial orientation and training by the Training and Supervision Coordinator (TSC); and all HSAs were involved in the execution of the baseline survey, the training of their own village health committees and village health volunteers.

Baseline Survey

A baseline survey was conducted between March and April, 1992 in coordination with Ministry of Health staff from Traditional Authority (TA) Gaga, Makhwira, Chikwawa, Ngabu, and Nchalo. A total of 2,173 mothers of children under 6 years of age were interviewed in 68 villages.

Establishment of Program Advisory Committee

A Program Advisory Committee was established in conjunction with the MOH health officials. Included in membership is the District Health Officer (DHO), the District Health Inspector (DHI), other district government staff, a representative of the Montfort Hospital of the Private Hospital Association of Malawi (PHAM), and IEF staff. The purpose of the PAC is to develop and coordinate project activities with district officials.

Village Based Distribution System

- ◆ In preparation for implementation of service delivery 111 village health committees have been reactivated or formed and 777 committee members have received basic orientation to the project and training in basic health care activities. VHCs selected 155 village health volunteers who were in turn provided task oriented training. All training was performed by the HSAs in conjunction with MOH staff in their own areas. A final phase of training for 79 new VHVs will be completed in December. Including VHVs from the previous project and the retraining of MOH VHVs a total of 250 VHVs will be in place by December 1992.

AREAS	Completed	Aug. 31st	Completed	Oct. 23rd
	*Training VHC	Training VHV	*Training VHC	Training VHV
Dolo	17/119	26	20/140	26
Chipwaila	21/147	23	18/126	18
Makhwira	14/98	27	21/147	35
Totals	52/364	76	59/413	79

* Number of villages & Number of members trained

◆ Two separate training activities in home vegetable gardening were conducted in early 1992. The training was conducted for VHCs and for HSAs from the previous project.

◆ The Health Information System was established with each phase of VHV training. Use of the family roster system is part of the training of the VHCs. Upon return to their homes each VHV is responsible for enrolling approximately 50 households of mothers with children (<6 years) and or pregnant women.

Emergency Drought Activities

◆ The project has played a major organizing role in the formation of the Drought Relief Coordinating Unit (DRCU) from concept, to proposal writing, to organizing meetings, to implementation. The DRCU is now fully operational with a full-time Director. Funding for the DRCU is through UNICEF and UNDP sources and is based in Lilongwe. See Appendix A, DRCU Newsletters.

◆ The project has been involved in the establishment of a Nutritional Assessment Program (NAP) in Chikwawa District in conjunction with Medecins Sans Frontieres (MSF) Netherlands and Save the Children UK (SCF). A pilot rapid-assessment anthropometric survey was conducted in August of 914 children. See section 4.2.3 below and Appendix B, Nutritional Assessment Program.

◆ The project has provided relief and emergency vitamin A technical assistance and supplies to Queen Elizabeth Central Hospital (QECH), Montfort Hospital, Trinity Hospital, and Chikwawa District Hospital. The project also coordinated a visit of a VITAP consultant to Malawi, Ms. Susan Eastman, to assist the DRCU in the development of an emergency vitamin A strategy. See Appendix C, Report by S. Eastman.

1.2 Change in Approach to Individuals at High Risk

The project has not made any changes in the way it identifies and provides services to individuals at higher risk.

1.3 Staffing

The organizational chart remains the same with the exception that a Drought Relief Coordinator is being recruited (under separate funds) and will become a part of the IEF-Malawi program. See organizational chart on following page.

1.4 Continuing Education

- ◆ All staff attended a week-long course on "Appropriate Methods for Working with Villagers and Encouraging Community Participation", sponsored by the Ministry of Community Services (MCS).

- ◆ Staff participated in a one-day workshop on "Sustaining Village Health Volunteers: Options", sponsored and organized jointly by IEF and SCF-UK in May.

- ◆ Mr. Jon Mauszycki, Peace Corps Volunteer, taught nutrition monitoring in an NGO workshop in conjunction with IEF, MSF, and SCF-UK.

- ◆ Mr. M'Manga will be presenting baseline survey results "Child Spacing in Chikwawa District" to the Medical Association of Malawi (MAM) annual meeting in November.

- ◆ Mr. Henderson Chikhosi, Project Director and Mr. Richard M'Manga, Training and Supervision Coordinator attend regularly the Chikwawa District Primary Health Care Technical Sub-committee, and CONGOMA meetings.

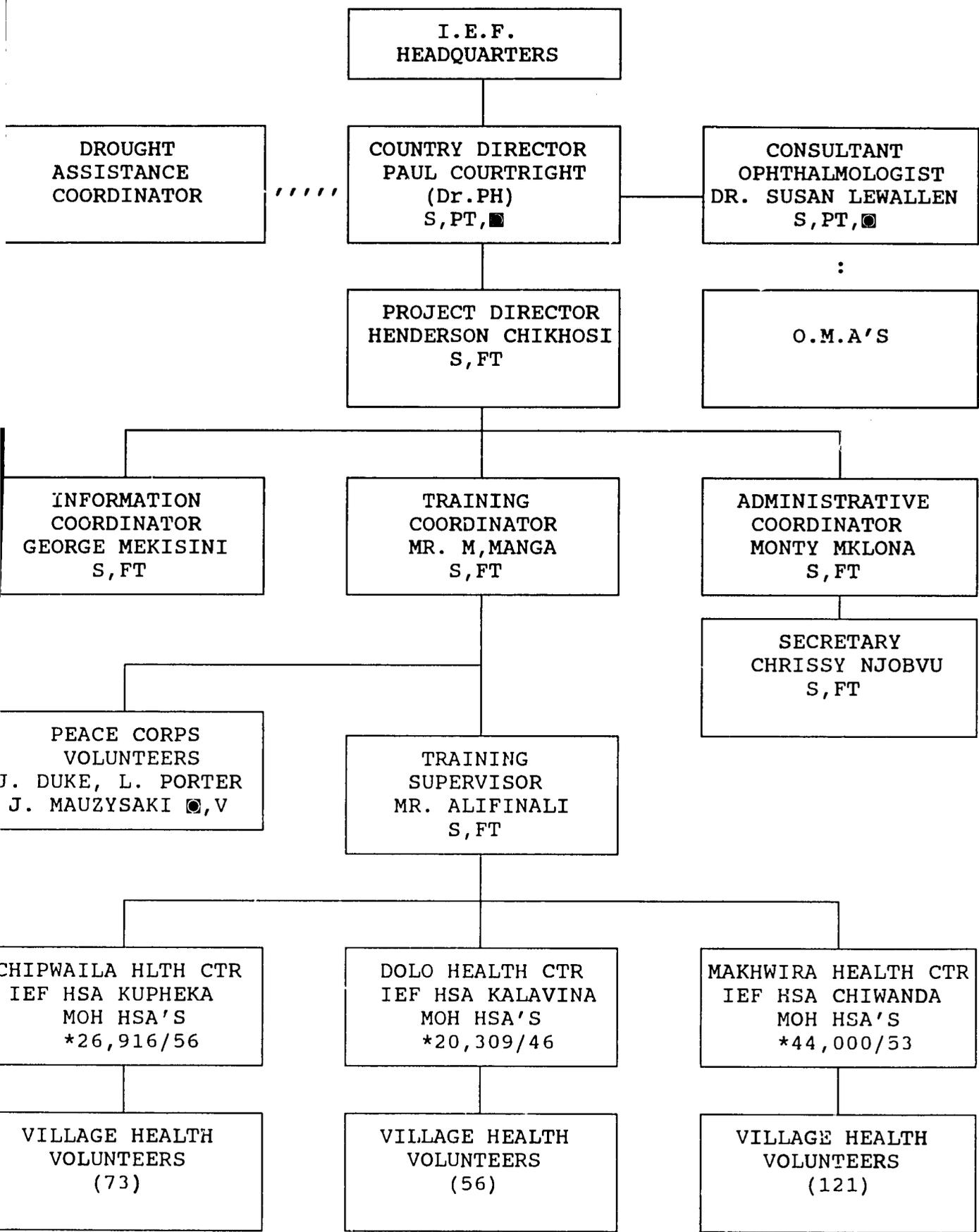
- ◆ Dr. Paul Courtright and Dr. Susan Lewallen present short lectures regularly at the QECH "Lunch Lectures" series.

1.5 Technical Support

- ◆ Mr. John Barrows, Child Survival/Vitamin A Coordinator, IEF-Headquarters, visited the project for 2 weeks in May. The purpose of the trip was to assist in development of the DIP.

- ◆ Sarah Elizabeth Castle, PhD, is currently visiting the project for 4 weeks to assist staff in ethnographic research on exclusive breastfeeding behaviors. This activity is in conjunction with WELLSTART and will likely include a second phase for development of an IEC strategy. See Appendix D, Scope of Work: WELLSTART.

LAWI ORGANIZATIONAL CHART



KEY

- | | | | |
|----|--------------------|---|-------------------------|
| ● | Expatriot | V | Volunteer |
| PT | Part Time Employee | S | Salaried Employee |
| FT | Full Time Employee | * | Pop. / # of Communities |

^

◆ Mr. John Barrows has also attended the 3-day Federation of American Societies for Experimental Biology (FASEB) annual conference in April; the International Nutrition Network Exchange (INNE) workshop sponsored by USAID Office of Nutrition in May; a 2-day workshop "Round Table on Vitamin A Assessment" sponsored by HKI/VITAP; a 3-day conference "Making it Work" sponsored by Johns Hopkins University Child Survival Support Program (CSSP) in August; and a 2-day workshop "PVO Week" sponsored by USAID FHA/PVC in September.

1.6 Community Participation

One hundred and eleven VHCs have been activated during the last 3 months (July, August, September). All have met at least once in the past 90 days to select VHVs for training and organize their communities for service delivery. These VHCs are also under demand by other government ministries to help organize drought activities.

1.7 Linkages to Other Health and Development Activities

◆ IEF has a formal agreement with the Adventist Development and Relief Agency (ARDA) child survival project in the neighboring district of Nsanje for training and VAC supplies for their project.

◆ IEF, ADRA, SCF-UK coordinating an operational research study on "Village Health Volunteers: Investigation of Key Issues". See Appendix E, Operational Research: Volunteers.

◆ IEF is working with Montfort Hospital to expand their own VHV program by providing training, support of minor expenses, and supply of VACs.

◆ IEF is providing emergency supplies of VACs to the MOH, PHAM, and PVOs in the region with assistance from Task Force "Sight and Life" of Hoffmann-LaRoche, Ltd. Sight and Life has provided 140,000 vitamin A capsules during the year.

◆ IEF organized a VITAP consultant, Ms. Susan Eastman, visit to develop an emergency vitamin A strategy in conjunction with the MOH, DRCU, and other PVOs.

◆ IEF is sponsoring a WELLSTART consultant to help develop a breastfeeding and nutrition strategy in conjunction with the MOH.

◆ IEF played a major role (and participates regularly) in the development of the DRCU.¹

¹ IEF was involved in the hiring of the DRCU Director and providing initial start-up costs for the unit, including transport of the Director and family, office procurement, and shipping.

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- ◆ IEF worker directly with MSF and SCF-UK in establishing the Nutrition Assessment Program in Malawi, as well as the standardizing of reporting, surveying, etc, among all NGOs.

- ◆ The project coordinates activities through the District PHC Sub-committee; Program Advisory Committee; NGO Collaborative Group (informal group to discuss child survival projects), and the Drought Relief Coordinating Unit.

2. Constraints, Unexpected Benefits, and Lessons Learned

2.1 Constraints

- ◆ **Drought:** The effects of the 1991/1992 drought are having a major impact on the current project. VHVs have less time to spend on child survival activities because they are having to spend time foraging for food, water, and firewood. A strategy to overcome this problem is to distribute maize once every two months to the VHVs through next year. The problem encountered with this proposal is the additional costs and the requirement that all VHVs in the district, not limited to IEF's project alone, would also have to be provided with maize. The project is working to get a "reasonable" list of VHVs from the MOH/Chikwawa, but this has been problematic. The MOH has trained "growth monitoring" volunteers who receive minimal supervision and whom the MOH has little knowledge concerning their activities. The project does not think it can justify providing maize to 5 MOH volunteers per village. One of the project's sustainability goals is to work with villages to identify how they can provide some support for VHVs. However, the drought is currently making this difficult.

- ◆ The project has written several proposals for drought relief activities to be "piggy-backed" onto the existing project. Essentially IEF, and other PVOs, argue that their existing project infrastructure can be an effective vehicle for food distribution and monitoring. The proposal submitted to OFDA was not funded and alternate funding is being investigated from the DRCU and other European sources.

- ◆ The deteriorating economic situation in Malawi and the departure of the DHO, an expatriate from Holland, has led to inefficiencies of the MOH in Chikwawa. A new DHO is not expected until early 1993. The other responsible district staff relied upon by the project staff (DHI, DPHN) have either been away on extended training programs or have been transferred from the district. Stocks of key supplies, e.g., 1 liter ORS containers, are now no longer in supply. The project ordered VAC supplies through the Central Government Medical Stores (CGMS) which currently have no funds, in part due to restrictions placed by major donors for improved human rights; a consequences of the May riots. The project's attempts to integrate these activities will be difficult in the current climate.

.a'

2.2 Unexpected Benefits

◆ Due to organizing in response to the drought there has been excellent cooperation among NGOs; between NGOs and government; and between NGOs, government, and donor agencies (USAID, UNICEF, UNDP, international governments and agencies).

2.3 Institutionalization of Lessons Learned

◆ As mentioned in 2.1 above, in time of drought, many sustainability objectives are either delayed or not within reach. Drought also quickly influences nutrition behaviors, e.g., women feel that they have less breastmilk due to the drought and consequently should supplement their children's diet with foods other than breastmilk. Simultaneous drought relief activities are a necessity.

◆ The coverage rates for vitamin A supplementation are highest among children less than 2 months of age who have attended EPI activities at Under-Five clinics. UNICEF is encouraging the integration of vitamin A supplementation through the EPI network. Project experience indicates that most of the children 3-5 years of age will be missed if this strategy is not supported by alternative delivery mechanisms, e.g., use of family registers for tracking, use of volunteers for distribution, and mini-campaigns. A paper addressing this will be presented at the IVACG meeting to be held in Tanzania, March 1993.

3. Changes Made in Project Design

3.1 Change in Perceived Health Needs

◆ The lack of food is the primary concern faced by villagers and something the project can do little about. The project has proposed to use its community-based infrastructure to assist in distribution, however, the major problem encountered is insufficient quantities of food supplies in the country.² The project does have the capacity to determine which areas are at greatest need. The nutrition assessment survey tool is increasingly being viewed by donors and government as an important measure to determine where scarce food supplies can be best distributed.

◆ The lack of water is a secondary problem faced by villagers and something the project can do little about. The project does have the capacity to identify areas at greatest need. Project HSAs are compiling this information which will be used by Project Concern and other PVOs for drilling wells.

² The Lower Shire Valley experienced a complete harvest loss in 1992 placing the entire population at risk. (MOH/UNICEF/UNDP, March, 1992).

- ◆ Although not a new situation, measles immunization coverage has been low and the drought may discourage mothers from taking their children for immunization due to other constraints on their time (food and water collection; food distribution is not attached to any health activities, etc.).

3.2 Change in Project Objectives

The project has not changed any objectives since the DIP. Comments and suggestions from the DIP review are presently being considered. Because the review was only recently received, reviewer's comments have not been fully considered by IEF headquarters and project staff. However, the project is considering:

Vitamin A supplementation:

- ◆ 70% of children 6 months to 6 years of age will receive vitamin A supplementation, by project area, every six months.
- ◆ 70% of women will receive vitamin A supplementation, by project area, between birth and 2 months of delivery.

Nutrition:³

Intermediate - Attitude

- ◆ By the end of the project (and by area), 0% of women will report that weaning foods should be introduced in the first month of life, and 20% before the third month of life.
- ◆ By the end of the project (and by area), 50% of women report that breastfeeding should be discontinued with the pregnancy of another child.

Long - Practice

- ◆ By the end of the project (and by area), 40% of lactating women will exclusively breastfeed their infants less than 3 months of age.

³ New objectives will be developed after planning research is completed in conjunction with WELLSTART.

AIDS⁴

Intermediate - Knowledge

- ◆ By the end of the project (and by area), 80% of women can correctly identify 3 major transmission pathways for AIDS.

Long - Practice

- ◆ By the end of the project (and by area), 20% of women report that their husbands had used a condom in the past year.

3.3 Change in Planned Interventions

There have been no changes in the type and scope of interventions. However, due to the drought, the project has included other drought related activities. These activities are those related to the development and support of the DRCU, emergency vitamin A technical assistance, and the rapid-assessment anthropometric surveys in conjunction with MSF.

3.4 Change in Potential and Priority Beneficiaries

There have been no changes in the location, number, or prioritization of services to potential beneficiaries of project services since the DIP. In the first three health center priority catchment areas of Dolo, Chipwaila, and Makhwira, the estimated total population is 91,225 (19,002 <6 years and 35,647 15-44 years) living in 155 villages. See following page, Potential Beneficiary Population. An expansion to the next three health center catchment areas is planned in January and the final three in September 1993. In response to the drought a small population situated on Nsua island in the "Elephant Marsh" will be included in the project. This island is geographically part of TA Makhwira but has been without services for 10 years. The project will extend project activities to the island by hiring an HSA from the island.

4. Progress in Health Information Data Collection

4.1 Characteristics of the Health Information System

4.1.1

The HIS at the community level is a family roster of families with children under six years and pregnant women specified in the DIP. There have been no changes since the DIP.

⁴ The project is looking for assistance from Family Health International.

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REF-MALAWI: Health Center Catchment Areas Dolo, Chipwalla, Makhwira

A. SIZE OF THE POTENTIAL BENEFICIARY POPULATION AND INTERVENTIONS

Note: POTENTIAL BENEFICIARIES is defined as the total population in the project area who are eligible to receive services for a given not the percent you expect to provide services to - which may be smaller than the eligible population.

1. AGE GROUP	2. POPULATION OF PROJECT AREA			3. POTENTIAL BENEFICIARIES* (if different from POPULATION, explain in (f))			4. INTERVENTIONS (age groups covered) (h) Code** for which interventions apply
	(a) Total	(b) Female	(c) Male	(d) Total	(e) Female	(f) Male	
0-11 months	3,492	1,755	1,737	3,492	1,755	1,737	O,I,NB,NW,NV
12-23 months	3,095	1,555	1,540	3,095	1,555	1,540	O,I,NV
24-59 months	9,286	4,667	4,619	9,286	4,667	4,619	O,NV
60-71 months	3,129	1,573	1,556	3,129	1,573	1,556	NV
6-9 years	12,516	6,290	6,226				
10-14 years	11,233	5,645	5,588				
15-19 years	9,221	4,634	4,587	4,634			I,NV,AC
20-24 years	6,944	3,490	3,454	3,490			I,NV,AC
25-29 years	6,415	3,224	3,191	3,224			I,NV,AC
30-34 years	4,966	2,496	2,470	2,496			I,NV,AC
35-39 years	4,855	2,440	2,415	2,440			I,NV,AC
40-44 years	3,246	1,631	1,615	1,631			I,NV,AC
45 and older	12,856	6,461	6,395				
TOTAL	91,254	45,862	45,392	36,917	9,550	9,452	

Note: Women and men (Ages 15 and up) should only be included as potential beneficiaries where they are direct beneficiaries of ser (Family Planning services), and not for educational interventions (i.e. education on proper preparation and use of ORT). For project vitamin A components, use children 0-71 months (a+b+c+d) as potential beneficiaries, if appropriate.

CODES FOR INTERVENTIONS

INTERVENTION	CODE
ORT	O
Immunization	I
Nutrition	
a. Breastfeeding	NB
b. Weaning Process	NW
c. Maternal Nutrition	NM
d. Vitamin A	NV
ALRI	A
Family Planning	FP
High Risk Birth	HR
Malaria Control	MC
Other AIDS	AC
Other EYE CARE	EC

NUMBER OF POTENTIAL BENEFICIARIES BY INTERVENTION

INTERVENTION	BENEFICIARIES
1. ORT	15,873
2. Immunization	24,502
3. Nutrition	
a. Breastfeeding	3,492
b. Weaning Process	3,492
c. Maternal Nutrition	0
d. Vitamin A	36,917
4. ALRI	0
5. Family Planning	0
6. High Risk Birth	0
7. Malaria Control	0
8. Other AIDS	17,915
9. Other	0

B. CALCULATION OF A.I.D. \$ per BENEFICIARY per YEAR: (\$000)

Place dollar amount (in thousands) only in shaded cell

1. Total A.I.D. Contribution to Country Project (refer to TABLE A - Page 3)	800,000
2. Total Potential Beneficiaries (sum of column d from table above)	36,917
3. A.I.D. Funding per Beneficiary for Project (line 1 divided by line 2)	21.67
4. A.I.D. Funding per Beneficiary per year (line 3 divided by 3 years)	7.22

Note: The letters "ERR" will appear until data has been inputted onto the worksheet above.

NAMES OF VILLAGES IN THE CATCHMENT AREAS-DOLO, CHIPWAIRA, MAKHWIRA.

DOLO

- | | | |
|----------------|---------------|----------------|
| 1. Lazo | 16. Nsangwe | 31. Tsidigo |
| 2. Kajuni | 17. Mwamtoma | 32. Chingodo |
| 3. Phalafinu | 18. Khoko | 33. Jackson |
| 4. Chokwe | 19. Namkumba | 34. Tabwa |
| 5. Nyadeka | 20. Ngombe | 35. Jeke |
| 6. Ladina | 21. Thayo | 36. John |
| 7. Thenesi | 22. Theta | 37. Ndampanga |
| 8. Gogo | 23. Thulasida | 38. Mtuwa |
| 9. Mpovu | 24. Nyambiro | 39. Lole |
| 10. Ntayamanja | 25. Masache | 40. Vega |
| 11. Bilisimu | 26. Thendo | 41. Chideu |
| 12. Mailosi | 27. Rabu | 42. Nyakabobo |
| 13. Mandele | 28. Thudzu | 43. Konzele |
| 14. Machado | 29. Nyaseta | 44. Kamchewere |
| 15. Lombe | 30. Mphonde | 45. Mtopola |
| | | 46. James |

The total population for the area: 20,309

CHIPWAIRA

- | | | |
|---------------|------------------|------------------|
| 1. Paiva | 20. Gonyo | 39. Sauti |
| 2. Chiutale | 21. Chabisala | 40. Chang'ambika |
| 3. Mthumbi | 22. Galanza | 41. Kutama |
| 4. Milisi | 23. Khisimisi | 42. Kudzanji |
| 5. Khundu | 24. Chionanjiwa | 43. Demanyundo |
| 6. Mtembeta | 25. Mgopanji | 44. Utumbe |
| 7. Santu | 26. Njiza | 45. Moses |
| 8. Kalu | 27. Kadulifa | 46. Trapence |
| 9. Kalulu | 28. Jojo | 47. Chamanga |
| 10. Nyangu | 29. Kachipapa | 48. Butiza |
| 11. Chidama | 30. Fuleti | 49. Binya |
| 12. Kafukiza | 31. Andiseni | 50. Jimu |
| 13. Saindi | 32. Thauzeni | 51. Dzosuma |
| 14. Ngalu | 33. Kusala | 52. Jeliati |
| 15. Therere | 34. Chokankunene | 53. Bapton |
| 16. Katomba | 35. Mbwanda | 54. Robert |
| 17. Chipwaira | 36. Mpakula | 55. Chaluma |
| 18. James | 37. Njomvuyalema | 56. Mailosi |
| 19. Mphungu | 38. Zyogi | |

There is a total population of 26,916

MAKHWIRA

- | | | |
|-------------------|-----------------|-----------------|
| 1. Mmodzi | 19. Nyaulombo | 37. Nyangu |
| 2. Kalaundi | 20. Gangu | 38. Chikuse |
| 3. Chikadza | 21. Nchacha | 39. Willison |
| 4. Kubalalika | 22. Chibadwa | 40. Gusu |
| 5. Mwinza | 23. Nantusi | 41. Kasambwe |
| 6. Mchipeta | 24. Singano | 42. Zing'ando |
| 7. Dwanya | 25. Machokola | 43. Mandele |
| 8. Mitengo | 26. Sabvala | 44. Mafunga |
| 9. Mwanayaya | 27. Makwiza | 45. Kanyimbili |
| 10. Chisanu | 28. Mitani | 46. Jimung'anga |
| 11. Malata | 29. Thedzi | 47. Kusakala |
| 12. Mtambo | 30. Mpama | 48. Mpwaila |
| 13. Jana | 31. Nkadyamwano | 49. Kalaundi |
| 14. Mpangowalimba | 32. Thopoloni | 50. Leza |
| 15. Makhula | 33. Matimati | 51. Nyambalo |
| 16. Bodza | 34. Nthenda | 52. Kabvalo |
| 17. Mfunde | 35. Kamoto | 53. Thawani. |
| 18. Mpingasa | 36. Ndombo | |

The population of the area: 44,000

Total Population :	20,309
	26,916
	+ 44,000
	<hr/>
	91,225

Total number of villages:

46
56
+ 53

155

SVH/DIP TABLE A: COUNTRY PROJECT SUMMARY (Rev. December 1, 2015) DPA-1 WK1

EF-MALAWI: Total Estimated Project Population Chikwawa District

- Revised W DIP

A. SIZE OF THE POTENTIAL BENEFICIARY POPULATION AND INTERVENTIONS

Note: POTENTIAL BENEFICIARIES is defined as the total population in the project area who are eligible to receive services for a given age group, not the percent you expect to provide services to - which may be smaller than the eligible population.

1. AGE GROUP	2. POPULATION OF PROJECT AREA			3. POTENTIAL BENEFICIARIES* (if different from POPULATION, explain in narrative)			4. INTERVENTIONS (age groups covered)
	(a) Total	(b) Female	(c) Male	(d) Total	(e) Female	(f) Male	(h) Code** for which Interventions apply
a) 0-11 months	14,188	7,132	7,056	14,188	7,132	7,056	O,I,NB,NW,NV
b) 12-23 months	12,577	6,322	6,255	12,577	6,322	6,255	O,I,NV
c) 24-59 months	37,732	18,968	18,764	37,732	18,968	18,764	O,NV
d) 60-71 months	12,713	6,391	6,322	12,713	6,391	6,322	NV
e) 6-9 years	50,854	25,564	25,290				
f) 10-14 years	45,643	22,945	22,698				
g) 15-19 years	37,467	18,835	18,632	18,835			I,NV,AC
h) 20-24 years	28,214	14,183	14,031	14,183			I,NV,AC
i) 25-29 years	28,067	13,104	12,963	13,104			I,NV,AC
j) 30-34 years	20,179	10,144	10,035	10,144			I,NV,AC
k) 35-39 years	19,729	9,918	9,811	9,918			I,NV,AC
l) 40-44 years	13,190	6,631	6,559	6,631			I,NV,AC
m) 45 and older	52,237	26,260	25,977				
TOTAL	370,790	186,396	184,394	150,024	38,813	38,397	

Note: Women and men (Ages 15 and up) should only be included as potential beneficiaries where they are direct beneficiaries of services (i.e. TT, Family Planning services), and not for educational interventions (i.e. education on proper preparation and use of ORT). For projects with vitamin A components, use children 0-71 months (a+b+c+d) as potential beneficiaries, if appropriate.

*** CODES FOR INTERVENTIONS**

INTERVENTION	CODE
1. ORT	O
2. Immunization	I
3. Nutrition	
a. Breastfeeding	NB
b. Weaning Process	NW
c. Maternal Nutrition	NM
d. Vitamin A	NV
4. ALRI	A
5. Family Planning	FP
6. High Risk Birth	HR
7. Malaria Control	MC
8. Other AIDS	AC
9. Other EYE CARE	EC

NUMBER OF POTENTIAL BENEFICIARIES BY INTERVENTION

INTERVENTION	BENEFICIARIES
1. ORT	64,497
2. Immunization	99,579
3. Nutrition	
a. Breastfeeding	14,188
b. Weaning Process	14,188
c. Maternal Nutrition	0
d. Vitamin A	150,024
4. ALRI	0
5. Family Planning	0
6. High Risk Birth	0
7. Malaria Control	0
8. Other AIDS	72,814
9. Other EYE CARE	0

B. CALCULATION OF A.I.D. \$ per BENEFICIARY per YEAR: (\$000)

Place dollar amount (in thousands) only in shaded cell

1. Total A.I.D. Contribution to Country Project (refer to TABLE A - Page 3)	800,000
2. Total Potential Beneficiaries (sum of column d from table above)	150,024
3. A.I.D. Funding per Beneficiary for Project (line 1 divided by line 2)	5.33
4. A.I.D. Funding per Beneficiary per year (line 3 divided by 3 years)	1.78

Note: The letters "ERR" will appear until data has been inputted onto the worksheet above.

4.1.2

In the previous project the roster system was useful in identifying and directing services to women and children, primarily in vitamin A. The current system has included additional interventions (ORT, EPI, TTV coverage). Because the training of VHVs and family enrollment was only recently completed the usefulness of these changes have not been fully assessed.

4.1.3

The project does not report on clinic activity. However, since these activities are part of the MOH system, this information is compiled monthly at the district hospital.

4.1.4

The system for reporting activities of HSAs is a monthly report based on the family rosters. Each month the HSA supervisor visits each VHV to review and update the roster and abstract information for his report. The HIS is now being implemented in the first three health center catchment areas (155 villages) with registration of families. The monthly supervisor's report is being used to ensure complete registration of villages by VHV and baseline coverage for vitamin A, EPI, and TTV. This report has been under some refinement in the past year. See following pages, HIS Formats.

4.2 Special Capacities of the Health Information System

4.2.1

The project does not monitor other service standards such as clinic sessions held. However, this information is monitored by the MOH.

4.2.2

The project monitors the numbers of trained VHVs still active as a sustainability indicator. However, this indicator has limited value by itself without information on *why* VHVs are active or not. The project conducted two workshops on VHVs and developed an operational research proposal to help answer some questions concerning VHV participation. This operational research is currently being carried out by IEF, ADRA, and SCF-UK. See section 1.7 above and Appendix E, Operational Research: Volunteers.

ROSTER OF FAMILIES WITH PREGNANT WOMEN AND CHILDREN UNDER 6

NAME	BIRTH DAY	E P I	TTV	YEAR ONE				YEAR TWO			
				VIT A	ORS	VIT A	ORS	VIT A	ORS	VIT A	ORS
FATHER _____	<u> / / </u>			o	oooooo	o	oooooo	o	oooooo	o	oooooo
MOTHER _____	<u> / / </u>	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD _____	<u> / / </u>	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD _____	<u> / / </u>	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD _____	<u> / / </u>	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD _____	<u> / / </u>	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo

NAME	BIRTH DAY	E P I	TTV	YEAR ONE				YEAR TWO			
				VIT A	ORS	VIT A	ORS	VIT A	ORS	VIT A	ORS
FATHER _____	<u> / / </u>			o	oooooo	o	oooooo	o	oooooo	o	oooooo
MOTHER _____	<u> / / </u>	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD _____	<u> / / </u>	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD _____	<u> / / </u>	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD _____	<u> / / </u>	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD _____	<u> / / </u>	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo

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CHIWERENGERO CHA MABANJA A AMAYI A PAKILI NDI AYA OCHEPERA ZAKA 6

DZINA	Tsiku lobadwa	E P I	I CHAKA CHOYAMBA			I CHAKA CHACHIWIRI					
			TTV	VIT A	ORS	VIT A	ORS	VIT A	ORS	VIT A	ORS
BAYBO	/ /				00000		00000		00000		00000
MAYI	/ /	0	00000	0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000
DZINA	Tsiku lobadwa	E P I	I CHAKA CHOYAMEA			I CHAKA CHACHIWIRI					
			TTV	VIT A	ORS	VIT A	ORS	VIT A	ORS	VIT A	ORS
BAMBO	/ /				00000		00000		00000		00000
MAYI	/ /	0	00000	0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000
MWANA	/ /	0		0	00000	0	00000	0	00000	0	00000

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HSA MONTHLY REPORT

HSA: _____ MONTH/YEAR: _____

NAME OF VHP						
DATE OF VISIT:						
# OF HOUSEHOLDS WITH -CHILDREN <6 -PREGNANT WOMEN:						
TOTAL # CHILDREN <6:						
# CHILDREN <6 WITH CARD AT LAST SESSION:						
# CHILDREN <u>6 MONTHS - 6</u> <u>YRS RECEIVED VIT A</u> CAPSULE:						
TOTAL # MOTHERS WITH INFANTS <2 MONTHS:						
# MOTHERS (WITH INFANTS <2 MONTHS) GIVEN CAPSULE BY <u>VHV</u> :						
# MOTHERS (WITH INFANTS <2 MONTHS) GIVEN CAPSULE BY <u>OTHER</u> SOURCE:						
# OF CHILDREN WITH COMPLETE EPI:						
# MOTHERS COMPLETED 3T TTV:						
# ORS PACKETS DISTRIBUTED:						
# CAPSULES GIVEN TO SUPPLY VHV:						
# ORS PACKETS GIVEN TO SUPPLY VHV:						
OBSERVATIONS:						

4.2.3

The project does not carry out case-finding for acute paralysis. In response to the drought the project has begun nutritional surveillance activities in the district. See section 1.1 above and Appendix B, Nutritional Assessment Project. The first pilot rapid-assessment anthropometric survey was conducted in August of 914 children. The results showed that the total number of children who were moderately (2.1% <2.00 WH) or severely malnourished (.2% <3.00 WH) including kwashiorkor was 3.9%.⁵ This level is considered "normal" because there is a basic level of malnutrition in Malawi that is chronic (3%). However, these levels are expected to rise as the dry season advances. A second survey was conducted in October. The survey is designed to be conducted every 6-8 weeks at a very low cost. Chikwawa district is divided in half with MSF working in the northern half and IEF working in the southern half.

4.2.4

The project monitors the number of hours of training for pre-service, in-service training of VHVs and VHCs as part of the routine reports prepared by the Training and Supervision Coordinator.

4.2.5

The family roster system and HSA monthly supervisory report formats have been designed to be as simple as possible to minimize reporting burdens. However, the HIS still requires a high level of supervision. The VHVs require frequent visits to help them maintain and update their rosters. In the previous project the HSAs were also experiencing some difficulties in preparing accurate monthly reports. The project plans to implement death registers in villages in 1993 and expects that establishing and maintaining accurate registers will be difficult.

4.3 Management of the Health Information System

4.3.1

Because the HIS was already in existence, the proportion of expenditures (field) since October 1991 spent on the HIS has been very low -- <1% of the A.I.D. country budget or \$5,858. These costs are primarily the baseline survey (training, extra vehicle rental and driver, fuel, MOH per diems, printing, communication, etc.). The project is considering technical assistance for the HIS later in 1993.

⁵ The deterioration of nutritional status are late indicators of the negative impacts of drought on a population. Relief efforts need to be underway before prevalence of malnutrition increases.

4.3.2

The project reviewed its indicators based on the baseline survey results and DIP reviewer's comments. Some of the indicator targets will be adjusted as a result (vitamin A supplementation, etc.). The HIS has not been fully operational for a sufficiently long period of time and has not yet been used to monitor progress towards set benchmarks. The first review of the HIS will be in November.

4.3.3

A workshop was held in June with MOH HSAs who participated in the baseline survey after which they reported back to the surveyed villages. Project information is reviewed at least quarterly during district Program Advisory Committee meetings. The next time information will be reviewed will be at the QECH clinical sessions on 13th October where regional health officials will be present.

4.3.4

The persons responsible for collecting, compiling, analyzing, and monitoring data are those specified in the DIP. The VHV maintains the family rosters; the HSA visits the VHVs monthly and abstract data for their monthly reports; reports are summarized by the Information Coordinator with assistance from the Project Manager and Country Director. Peace Corps Volunteers (PCVs) play intermediate roles as auxiliary supervisors and monitoring data quality.

4.3.5

The Information Coordinator, PCVs, and Chikwawa district MOH officials received training in the use of EPIINFO during the baseline and other survey activities. On October 8th IEF sponsored a short training for interested NGOs and MOH on the use of EPIINFO.

5. Sustainability

5.1 Recurrent Costs

5.1.1 - 5.1.2

The recurrent costs that are expected to continue after A.I.D. Child Survival funding ends; the dollar amount for each category; and the costs that are likely and unlikely to be paid by the community and MOH are as follows:

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What: Recurrent Costs	Est. \$	*Community	*MOH
1. Procurement			
. motorcycle (1)	2,700 yr	+++++	++++
. office supplies	1,800 yr	+++++	+
. vitamin A capsules (dist.)	3,100 yr	+++++	+++
2. Surveys (baseline)	5,800	+++++	++
3. Other Program Costs			
. personnel (1-HSA)	2,000 yr	+++++	+
. local travel	5,000 yr	+++++	++
. training sessions	17,400 yr	+++++	++
. vehicle operation	18,000 yr	+++++	+++
. office operation	1,200 yr	+++++	+
. incentives VHV's	?	+++	++

* = Ability to pay: + = likely; +++++ = unlikely

The costs that the MOH would have the most difficulty absorbing are 1) vehicles, 2) vehicle operation, 3) medical supplies, and 4) training costs. The MOH relies almost entirely on international donations for key equipment and supplies. The MOH can absorb personnel costs, e.g., HSAs. Because survey costs are mostly staff time the MOH could absorb costs for surveys. Training costs could be reduced significantly if the MOH implemented a more realistic policy for per diem rates. The MOH currently has a policy that PVOs not provide material incentives to VHV's. The costs that the community might bear are restricted to only those that might support VHV's. The estimated total amount need to cover IEF field recurrent costs is \$8,010 per month. These costs exclude expatriate staff and headquarters costs.

5.2 Strategies for Increasing Post-project Sustainability

5.2.1

A strong component of the village health committee training is generating interest to support VHV's. The project does not provide monetary incentives or other forms of incentives (uniforms, soap, etc.) other training and supervisory support to conform to local MOH policies. In the absence of visible incentives VHCs are strongly encouraged to provide some form of support. It should be recognized that, for the time of the drought, little monetary/in-kind support can be expected from the village. IEF anticipates that, by the end of the project, all villages will not yet be in a position to supervise, supply, or pay VHV's. Between the drought and the weakening MOH structure, the capacity for assuming these activities will take longer than originally planned. Experience with community supervision of VHV's elsewhere in Malawi is similar.

5.2.2

To reduce recurrent costs in the past year all training of VHVs is conducted in their own catchment areas; and transport costs have been restricted by elimination of mobile mass campaigns and supporting existing health center clinic activities conducted by foot, bicycle, or motorcycle travel.

5.3 Cost Recovery

5.3.1 - 5.3.2

The project is not involved in cost recovery activities.

5.3.3

The project has not undertaken any training to increase staff awareness of cost recovery and price setting.

6. **Project Expenditures and Justification for Budget Changes**

6.1 Pipeline Analysis

The Pipeline analysis is found attached as found on the following pages.

6.2 Justification of Budget Changes

There were no significant budget revisions during the fiscal year. There will be some budget revisions made for the second fiscal year and can be found in Section 7 below. Revisions include additional vehicle costs (motorcycles and vehicle), a computer, and travel and support costs for a consultant.

7. **1992/1993 Work Schedule and Budget**

The project's workplan and budget for fiscal year 1992/1993 is found on the following pages.

MALAWI VITAMIN A: PDC-0284-A-00-1123-00

9/23/91 - 9/30/92

	AID BUDGET	IEF BUDGET	Total BUDGET	AID ACTUALS	IEF ACTUALS	Total ACTUALS	AID BALANCE	IEF BALANCE	Total BALANCE
FORMAT G: ESTIMATED COUNTRY PROJECT BUDG									
I. PROCUREMENT									
A. EQUIPMENT	10,450	13,000	23,450	0	35,643	35,643	10,450	(22,643)	(12,193)
B. SUPPLIES	38,975	18,875	57,850	6,498	2,256	8,754	32,477	16,619	49,096
C. SERVICES	6,800	0	6,800	5,858	0	5,858	942	0	942
SUBTOTAL I	56,225	31,875	88,100	12,356	37,899	50,255	43,869	(6,024)	37,845
II. EVALUATIONS									
	11,000	11,000	22,000	0	0	0	11,000	11,000	22,000
III. INDIRECT COSTS									
	135,407	25,261	160,668	15,411	3,070	18,481	119,996	22,191	142,187
IV. OTHER PROGRAM COSTS									
A. PERSONNEL - Salary	107,250	34,250	141,500	27,893	8,321	36,214	79,357	25,929	105,286
(CD & OC) - Benefits	32,813	10,413	43,226	7,230	2,521	9,751	25,583	7,892	33,475
A. PERSONNEL - Salary	96,150	0	96,150	15,962	467	16,429	80,188	(467)	79,721
(Mal,FS) - Benefits	49,810	0	49,810	7,141	0	7,141	42,669	0	42,669
B. TRAVEL AND PER DI	109,850	26,950	136,800	3,903	390	4,293	105,947	26,560	132,507
C. Other Direct Costs	91,621	2,000	93,621	35,770	1,722	37,492	55,851	278	56,129
SUBTOTAL IV	487,494	73,613	561,107	97,899	13,421	111,320	389,595	60,192	449,787
TOTAL COUNTRY	690,126	141,749	831,875	125,666	54,390	180,056	564,460	87,359	651,819
TOTAL COSTS	800,000	267,307	1,067,307	139,086	69,371	208,457	660,914	197,936	858,850

	AID	IEF	Total	AID	IEF	Total	AID	IEF	Total
	BUDGET	BUDGET	BUDGET	ACTUALS	ACTUALS	ACTUALS	BALANCE	BALANCE	BALANCE
IEF:HQ									
I. PROCUREMENT									
SUPPLIES	0	3,900	3,900		727	727	0	3,173	3,173
EQUIPMENT	0	1,200	1,200	500		500	(500)	1,200	700
SERVICES/CONSULT	0	400	400	0	0	0	0	400	400
SUBTOTAL (PROC.)	0	5,500	5,500	500	727	1,227	(500)	4,773	4,273
II. EVALUATION	0	2,250	2,250	0	0	0	0	2,250	2,250
III. INDIRECT COSTS	21,558	24,635	46,193	2,058	2,606	4,664	19,500	22,029	41,529
IV. OTHER PROGRAM COSTS									
A. PERSONNEL - Salary	54,955	37,620	92,575	7,350	7,251	14,601	47,605	30,369	77,974
- Benefits	13,261	8,753	22,014	1,764	1,740	3,504	11,497	7,013	18,510
Public Health Program Co.									
Salary	36,250	18,915	55,165	4,536	4,536	9,072	31,714	14,379	46,093
Fringe	9,426	4,918	14,344	1,089	1,089	2,177	8,337	3,829	12,167
Medical Director									
Salary	3,950	3,950	7,900	0	0	0	3,950	3,950	7,900
Director of Programs (8%)									
Salary	6,430	6,430	12,860	1,554	1,467	3,021	4,876	4,963	9,839
Fringe	1,671	1,671	3,342	373	352	725	1,298	1,319	2,617
Program Assistant (8%)									
Salary	3,280	3,280	6,560	786	810	1,596	2,494	2,470	4,964
Fringe	852	852	1,704	189	194	383	663	658	1,321
Administrative Officer (8%)									
Salary	5,045	5,045	10,090	474	438	912	4,571	4,607	9,178
Fringe	1,312	1,312	2,624	114	105	219	1,198	1,207	2,405
B. TRAVEL COSTS	20,100	32,000	52,100	1,169	1,736	2,905	18,931	30,264	49,195
C. OTHER DIRECT COSTS									
Telephone	0	6,000	6,000		632	632	0	5,368	5,368
Postage	0	3,600	3,600	579	289	868	(579)	3,311	2,732
A-110 Audit Fees	0	4,800	4,800			0	0	4,800	4,800
Equip. Main.	0	400	400			0	0	400	400
SUBTOTAL (IV)	88,316	93,173	181,489	10,862	11,648	22,510	77,454	81,525	158,979
TOTAL HQ COSTS	109,874	125,558	235,432	13,420	14,981	28,401	96,454	110,577	207,031

	Oct '92	Nov '92	Dec '92	Jan '93	Feb '93	Mar '93	Apr '93	May '93	Jun '93	Jul '93	Aug '93	Sep '93	Oct '93	Nov '93	Dec '93
1. Personnel in Position															
a. Administrative Assistant		•Hir•													
b. HSAs		•Hir•													
- Nsua Island (1)															
- 3 new HCC Areas															
- 3 new HCC Areas			•Hire new •												
												•Hire New •			
2. Health Information System															
a. Review HIS		•Rev•													
b. Quarterly Reports				•Q•			•Q•							•Q•	
c. 2nd 3 HCCAs					•Impleme•	•Continue monitoring									
d. 3rd 3 HCCAs															
e. Implement Death Registers					•Impleme•					•Impleme•			•Impleme•	•Continue ▶	
3. Training															
a. 1st 3 HCCAs															
- HSA Nsua Island		•Train HSA for▶													
- compl. VHVs & VHCs		•Training for Re▶													
- AIDS and Eye Care										•AIDS Tr▶					
b. 2nd 3 HCCAs															
- HSAs				•Tra▶											
- VHVs & VHCs				•Training ▶											
- AIDS and Eye Care										•AIDS Tr▶					
c. 3rd 3 HCCAs															
- HSAs															
- VHVs & VHCs														•Tra▶	
- AIDS and Eye Care														•Training VHVs &▶	
4. Service Delivery (ORT, EPI, VA,)															
a. 1st 3 HCCAs															
b. 2nd 3 HCCAs															
c. 3rd 3 HCCAs															
d. Drought Relief															
- NAP surveys		•2nd▶		•3rd▶		•4th▶		•5th▶							
- Vitamin A training				•Vitamin A TA Training▶											
															•Servi▶
5. Technical Assistance															
a. Wellstart															
- planning research															
- strategy devel.															
- implementation															
b. HIS															
c. Headquarters				•Hea•											
															•2nd•
6. Progress Reports															
a. Quarterly				•Q•			•Q•				•Q•			•Q•	
b. Mid-term evaluation											•Mid-ter•				

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EF-MALAWI: CSVII WORKPLAN 1992/1993

<u>Hire AA</u>	11-02-92 to 11-16-92	[14 days]
Hire new Administrative Assistant.		
<u>Hire HSA</u>	10-12-92 to 10-26-92	[14 days]
Hire New HSA for Nsua Island.		
<u>Hire new HSAs</u>	12-07-92 to 01-11-93	[35 days]
Hire 6-8 new HSAs for next 3 new Health Center Catchment Areas.		
<u>Hire New HSAs</u>	09-06-93 to 10-11-93	[35 days]
Hire 6-8 new HSAs for 3 new Health Center Catchment Areas.		
<u>Review HIS</u>	11-16-92 to 11-30-92	[14 days]
Review the results of the HIS to assess effectiveness and efficiency; make revisions if necessary; plan for any TA.		
<u>Quarterly report</u>	01-11-93 to 01-18-93	[7 days]
1st quarterly report on progress made towards objectives.		
<u>Quarterly report</u>	04-12-93 to 04-19-93	[7 days]
2nd quarterly report on progress made towards objectives.		
<u>Quarterly report</u>	07-12-93 to 07-19-93	[7 days]
3rd quarterly report on progress made towards objectives.		
<u>Quarterly report</u>	10-11-93 to 10-18-93	[7 days]
4th quarterly report on progress made towards objectives.		
<u>Implement HIS in 2nd 3 new HCCAs</u>	02-01-93 to 03-01-93	[28 days]
Begin implementation of HIS (registration and monitoring) in 2nd HCCAs.		
<u>Continue monitoring</u>	03-08-93 to 12-20-93	[287 days]
Continue monitoring HIS.		
<u>Implement HIS in 3rd 3 new HCCAs</u>	10-11-93 to 11-08-93	[28 days]
Begin implementation of HIS (registration and monitoring) in 3rd HCCAs.		
<u>Continue monitoring</u>	11-15-93 to 12-20-93	[35 days]
Continue monitoring HIS.		
<u>Implement Death Registers</u>	03-01-93 to 03-29-93	[28 days]
Implement pilot death registers in 1st 3 HCCAs.		
<u>Implement Death Registers</u>	08-02-93 to 08-30-93	[28 days]
Implement pilot death registers		

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in 1st 3 HCCAs.

Train HSA for Nsua Island	10-26-92 to 12-14-92	[49 days]
Train HSA for Nsua Island.		
Training for Remaining VHV & VHCs	10-19-92 to 12-14-92	[56 days]
Complete training for the remaining VHV & VHCs in the 1st HCCAs.		
AIDS Training	05-03-93 to 05-31-93	[28 days]
Training for 1st 3 HCCAs in AIDS prevention.		
Training HSAs 2nd HCCAs	01-11-93 to 01-25-93	[14 days]
Training of 6-8 new HSAs in 2nd HCCAs.		
Training VHV & VHCs in 2nd HCCAs	01-25-93 to 03-01-93	[35 days]
Training of VHV & VHCs in 2nd HCCAs by HSAs.		
AIDS Training	05-03-93 to 05-31-93	[28 days]
Training for 1st 3 HCCAs in AIDS prevention.		
Training HSAs 3rd HCCAs	10-11-93 to 10-25-93	[14 days]
Training of 6-8 new HSAs in 3rd HCCAs.		
Training VHV & VHCs in 3rd HCCAs	10-25-93 to 12-20-93	[56 days]
Training of VHV & VHCs in 3rd HCCAs by HSAs.		
Service delivery in 1st HCCAs	09-28-92 to 12-20-93	[448 days]
Service delivery for EPI, TTV, ORT, VA continues in 155 villages (36,917 children and women).		
Service delivery in 2nd HCCAs	03-01-93 to 12-20-93	[294 days]
Services implemented for EPI, TTV, ORT, VA in 2nd HCCAs (approximately 150 villages).		
Service delivery in 3rd HCCAs	11-29-93 to 12-20-93	[21 days]
Services implemented for EPI, TTV, ORT, VA in 3rd HCCAs (approximately 150 villages).		
2nd Nutrition Assessment Survey	11-16-92 to 11-30-92	[14 days]
2nd Nutritional Assessment Survey (NAP) completed.		
3rd Nutrition Assessment Survey	01-18-93 to 02-01-93	[14 days]
3rd Nutritional Assessment Survey (NAP) completed.		
4th Nutrition Assessment Survey	03-22-93 to 04-05-93	[14 days]
4th Nutritional Assessment Survey (NAP) completed.		
5th Nutrition Assessment Survey	05-24-93 to 06-07-93	[14 days]
5th Nutritional Assessment Survey (NAP) completed.		

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<u>Vitamin A TA Training</u>	01-04-93 to 03-29-93	[84 days]
Technical assistance provided to PVOs in vitamin A.		
<u>Breastfeeding Planning Research</u>	10-05-92 to 11-09-92	[35 days]
Wellstart consultant completes planning research on breastfeeding behavior and practices.		
<u>EC Breastfeeding Strategy</u>	01-04-93 to 01-25-93	[21 days]
Analysis of planning research findings and development of an Information, Education, and Communication strategy.		
<u>Implement IEC Strategy</u>	01-25-93 to 12-20-93	[329 days]
Implement IEC strategy by re-training staff, MOH personnel, HSAs, and VHVs.		
<u>HIS Technical Assistance</u>	03-01-93 to 03-22-93	[21 days]
Optional - Technical assistance for further development of the HIS including analysis of data gathered (quality), completeness, training needs, computer needs.		
<u>Headquarters Visit</u>	01-11-93 to 01-25-93	[14 days]
Visit by headquarters technical staff and administrator to review project activities, expenditure and budget.		
<u>2nd Headquarters Visit</u>	05-31-93 to 06-14-93	[14 days]
Follow-up headquarters visit to review project activities.		
<u>Quarterly Report</u>	01-11-93 to 01-18-93	[7 days]
Quarterly report to MOH and headquarters.		
<u>Quarterly Report</u>	04-12-93 to 04-19-93	[7 days]
Quarterly report to MOH and headquarters.		
<u>Quarterly Report</u>	07-12-93 to 07-19-93	[7 days]
Quarterly report to MOH and headquarters.		
<u>Quarterly Report</u>	10-11-93 to 10-18-93	[7 days]
Quarterly report to MOH and headquarters.		
<u>Mid-term Evaluation</u>	08-02-93 to 08-30-93	[28 days]
Mid-term Evaluation completed.		

MALAWI VITAMIN A FOR CHILD SURVIVAL PROJECT
 BUDGET FOR THE PERIOD
 10/92 - 9/93

16-Oct-92

	AID ---	IEF ---	Total -----
IEF:HQ			
I. PROCUREMENT			
SUPPLIES			
Computer	0	300	300
General office	0	250	250
Prof./technical	0	250	250
EQUIPMENT			
Computer/Upgrade	0	1,500	1,500
Printer:VA Coord.	0	700	700
SERVICES/CONSULT			
DIP Admin Support	0	0	0
SUBTOTAL (PROC.)	0	3,000	3,000
II. EVALUATION			
Admin/Report Costs	0	500	500
SUBTOTAL (EVAL.)	0	500	500
III. INDIRECT COSTS			
IV. OTHER PROGRAM COSTS			
A. PERSONNEL			
TECHNICAL			
Public Health Program			
Coordinator (50%)			
Salary (\$35,000)	12,075	6,300	18,375
Fringe (26%)	3,140	1,638	4,778
PROGRAM SUPPORT STAFF			
Director of Programs (8%)			
Salary (\$51,000)	2,140	2,140	4,280
Fringe (26%)	556	556	1,112
Program Assistant (8%)			
Salary (\$26,000)	1,090	1,090	2,180
Fringe (26%)	283	283	566
Administrative Officer (8%)			
Salary (\$40,000)	2,500	2,500	5,000
Fringe (26%)	650	650	1,300
SUBTOTAL (PERS.)	22,434	15,157	37,591

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MALAWI VITAMIN A FOR CHILD SURVIVAL PROJECT
 BUDGET FOR THE PERIOD
 10/92 - 9/93

16-Oct-92

	AID ---	IEF ---	Total -----
B. TRAVEL COSTS			
SHORT-TERM			
Public Health Program Coordinator			
2 RT airefare	3,300	3,300	6,600
50 days per diem	2,200	2,500	4,700
Professional Meetings (AID wkshops, etc.)			
1 RT airfare & 6 days per diem	1,200	0	1,200
Program Mgt. Travel			
1 RT airfare	0	3,300	3,300
15 days per diem	0	1,550	1,550
<hr/>			
SUBTOTAL (Trav.)	6,700	10,650	17,350
C. OTHER DIRECT COSTS			
Office Operations			
Telephone	0	2,000	2,000
Postage	0	1,000	1,000
A-110 Audit Fees	0	1,500	1,500
Equip. Main.	0	200	200
<hr/>			
Subtotal (Other)	0	4,700	4,700
<hr/>			
SUBTOTAL (IV)	29,134	30,507	59,641
<hr/>			
SUBTOTAL I, II, IV	29,134	34,007	63,141
G&A Costs 15.%	4,370	5,101	9,471
<hr/>			
TOTAL HQ. COSTS	33,504	39,108	72,612

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MALAWI VITAMIN A FOR CHILD SURVIVAL PROJECT
 BUDGET FOR THE PERIOD
 10/92 - 9/93

16-Oct-92

	AID ---	IEF ---	Total -----
FORMAT G: ESTIMATED COUNTRY PROJECT BUDGET			
I. PROCUREMENT			
A. EQUIPMENT and SUPPLIES			
OFFICE EQUIPMENT			
1. Computer	0	2,000	2,000
2. Printer	250	0	250
3. Volt. Reg./UPS	335	0	335
4. Typewriter(3)	250	8	258
5. Office/House Fur.	3,000	0	3,000
6. FAX	0	800	800
7. Main./Ins.	500	0	500
SUPPLIES			
1. General Office	1,600	0	1,600
2. Paper/Printing	750	0	750
3. Comp. Software	0	0	0
4. Vitamin A	1,500	1,500	3,000
5. Teaching Aids	1,500	0	1,500
6. Roster Books/Bags	2,000	0	2,000
B. SERVICES			
1. Tr. Consultant (80 days @ \$50)	2,000	0	2,000
<hr/>			
SUBTOTAL I.	2,000	0	2,000
II. EVALUATIONS			
Midterm/Final Evl (Airfare, consult fees, per diem)	7,500	2,500	10,000
<hr/>			
SUBTOTAL II.	7,500	2,500	10,000
III. INDIRECT COSTS (See G & A line item)			
IV. OTHER PROGRAM COSTS			
A. PERSONNEL			
1. Country Director			
Salary (\$50,000)	20,000	6,000	26,000
Fringe (35%)	7,000	2,100	9,100
2. Ophthal. Consul.			
Salary (\$50,000)	15,750	5,250	21,000
Fringe (25%)	3,938	1,313	5,251

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MALAWI VITAMIN A FOR CHILD SURVIVAL PROJECT
 BUDGET FOR THE PERIOD
 10/92 - 9/93

16-Oct-92

	AID ---	IEF ---	Total -----
3. Project Director			
Salary (\$8,000)	8,400	0	8,400
Housing (200/mo.)	2,500	0	2,500
4. Admin. Coordinator			
Salary (\$4,000)	4,200	0	4,200
Housing (150/mo.)	1,900	0	1,900
5. Training Coordinator			
Salary (\$5,000)	5,250	0	5,250
Housing (150/mo.)	1,900	0	1,900
6. Trainers (3)			
Salary (\$3,000)	9,500	0	9,500
Housing (100/mo.)	3,700	0	3,700
7. Admin. Assistant			
Salary (\$2,500)	2,100	0	2,100
Housing (50/mo.)	630	0	630
8. Drivers(2)			
Salary (\$1,250)	2,600	0	2,600
Housing (40/mo.)	1,000	0	1,000
9. Peace Corps (3)			
Housing	5,000	0	5,000
<hr/>			
SUBTOTAL IV. A.	95,368	14,663	110,031

B. TRAVEL AND PER DIEM

1. Short-term

a. Training Consultant (30 days pa @\$50)	2,000	0	2,000
b. Local Staff Trav.	4,200	0	4,200
c. Int. Prof. Meet. (1 RT Airfare)	2,500	0	2,500
(pd @10 days pa)	1,300	0	1,300
d. Training Sessions (VHP, TBA & HSA)			
Travel	2,500	0	2,500
Per Diems	15,000	0	15,000

MALAWI VITAMIN A FOR CHILD SURVIVAL PROJECT
BUDGET FOR THE PERIOD
10/92 - 9/93

16-Oct-92

	AID ---	IEF ---	Total -----
2. LONG TERM			
a. Country Director			
Relocate (rt air)	1,500	1,500	3,000
Housing by GOM	0	0	0
Security	2,500	0	2,500
Shipping	2,500	0	2,500
Home Leave	2,000	0	2,000
b. Ophthal. Consul.			
Relocate (rt air)	0	3,000	3,000
Housing by GOM	0	0	0
Security	0	0	0
Shipping	0	2,500	2,500
Home Leave	0	1,500	1,500
<hr/>			
Subtotal IV. B.	36,000	8,500	44,500
C. Other Direct Costs			
1. Vehicle Operat.			
Fuel & Oils	12,750	0	12,750
Maint./Spares	5,000	0	5,000
Ins/Lic/Reg	4,000	0	4,000
2. Office Operations			
a. Blantyre			
Telephone	1,000	0	1,000
Postage/Courier	300	0	300
Freight	500	0	500
b. Ngabu			
Rent	5,000	0	5,000
Telephone	600	0	600
Postage	220	0	220
Security	300	0	300
3. Training Sessions			
Supplies	1,750	0	1,750
Facilities	800	0	800
<hr/>			
Subtotal IV. C.	32,220	0	32,220
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SUBTOTAL IV. A.B.C.	163,588	23,163	186,751
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SUBTOTAL	173,088	25,663	198,751
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G & A 15.%	25,963	3,549	29,512
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TOTAL COUNTRY	199,051	29,212	228,263

TOTAL COSTS	222,555	68,320	300,875

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8. Appendices

- A. DRCU Newsletters
- B. Nutritional Assessment Program
- C. Report, S. Eastman
- D. Scope of Work, WELLSTART
- E. Operational Research: Volunteers

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NEWSLETTER to NGOs — Malawi

Drought Relief Coordination Unit/CONGOMA

Issue #: 2

September 9, 1992

ZATSOPANO: DRCU SET-UP !!!

We welcome our new staff members aboard:
 Amella Muyco, Accounting/Admn. Officer
 Eluphy Banda, Executive Secretary
 Gervasio Kametela, Office Assistant

Our telephones and FAX are now operational:

TEL: 780-865
 FAX: 780-763

CONGOMA: The Standing Committee on Disaster and the DRCU are continuing to review their roles and responsibilities. The discussions have included the DRCU's special needs in order to operate responsively to the drought crises and the need for adequate accountability to donors and membership. There will be another Standing Committee on Disaster meeting the week of September 15th. Minutes of the August 17th Standing Committee Meeting are attached.

DRCU TRIP REPORT: The DRCU Coordinator recently completed a trip which took in parts of Ntcheu, Machinga, Zomba and Mwanza Districts. Accompanied by the new USAID/OFDA contractor, Monty Crisp, we met with NGOs and local government officials, visited warehouses and observed maize distribution. The most common problem reported was with transportation—delays in loading trucks at EDPs, slow "turn-around" time for trucks, unpredictability of maize deliveries by OPC from the EDP to the District, delays in amassing of enough maize to distribute to a centre, not enough trucks for maize and cars for distribution team personnel. Registration and re-registration is also a big problem—new forms not yet available, but DCs trying to collect new expanded data using the old forms, updating of the ration card system and finding enough hands to do the job(s). Maize allocation at levels insufficient to meet the current needs has led some DCs to re-allocate the scarce maize at less than the 9 kg/person/month.

Feedback and observations of NGOs and local government workers show that effective food distribution and other activities in the Districts share the same characteristics

- close working relations with the DC, staff, other NGOs and other local ministry officials in the

District—MOH, MoAg, Water Dept, Community Services;

- a "working" District-level drought committee where all the agency colleagues meet regularly on the operational issues—may be the DDC or a special District Drought Coordinating Committee;

- Integrated collaborative operations—NGO and District personnel cooperate on a daily basis assisting on the registration, planning distribution and reportage for the entire district, (rather than the NGO having its own distribution points and the District Commissioner staff having theirs);

- assist local gov't. employees (CDAs, HSAs, Extension Agents, etc.) in drought-related data collections and support operations;

- use local traditional leaders and village level volunteers to assist in operations.

Ntcheu District: IRC has recently set up operations in food distribution, health and water in Ntcheu District. The first cycle of food distribution has just been completed to all centers. For the first distribution cycle the old registration and distribution forms were used and at times the supply of maize to the district by OPC was so limited that the recommended 9 kg per capita per month ration was cut in half for a time. They are currently using 9 kg standard, but are considering using the 50 kg bag/family/month standard.

Under its USAID/OFDA grant IRC has funded a Sr. Clerk position in the DC's office to assist the DC in registration of beneficiaries and collection and reportage of food distribution data. IRC is also providing five trucks for transportation of food.

The registration clerks at each distribution point are paid employees. The handlers and distributors are volunteers and receive no payment.

Machinga District: ADRA has been operating in Machinga since early August, primarily in food distribution. They have contracted for the truck transportation for the entire district and thus far have been transporting and distributing maize in the western part of the district. August numbers show 582.6 mt distributed to 77,397 beneficiaries at 7 centers.

Because of insufficient supplies of maize, the DC has mandated a temporary upper limit on maize distribution of 36 kg per family, regardless of size.

NEWSLETTER to **NGOs** — Malawi p. 2

Drought Relief Coordination Unit/CONGOMA

Issue #: 2

September 9, 1992

TRIP (cont'd.) Zomba District: Emmanuel International and the Baptist Mission has been working closely with the DHO and the DC to facilitate food distribution, health surveillance, nutritional monitoring and water monitoring. They are supporting Health Surveillance Assistants as data collectors and report good local collaboration and cooperation.

Mwanza District: The Blantyre Synod (CCAP) is helping with food distribution in Mwanza Districts 16 food distribution centers. They have been collaborating closely with the District level officials and are interested in helping with other local needs, including supplementary feeding and nutritional monitoring. The first cycle of distribution to all points was nearly complete.

Dedza District: We stopped briefly to visit the DC. No NGO is currently assisting Dedza in drought-related problems. The DC reported that food distribution is being planned at 11 centers in the Ntakataka area. Other areas of Dedza District are not as badly impacted as those (based on crop estimates). The DC asked for assistance in food transportation and distribution in those areas and also for an additional 5-6 centers in the Nkhoma area of the District, which anticipate food shortages soon.

DUTCH GOVERNMENT FUNDING for nutritional monitoring to accompany other interventions—see Paul Courtright's memo (attached.)

USAID/OFDA Funding Tips

Monty Crisp shared some insight about the criteria which AID/Washington's Office of Foreign Disaster Assistance uses in looking at proposals for funding:

- short-term activities directly related to an acute emergency situation,
- clear and finite time frame for proposed activities—since the drought crisis is recognized to extend until the end of March 1993, proposed activities should not extend further,
- expected immediate effects of the proposed intervention and the numbers of beneficiaries,
- since the focus is on immediate mitigation of the emergency situation, avoid mention of ongoing needs, rehabilitation or training needs, chronic problems and post emergency follow-up;
- OFDA funds are not intended for development purposes,
- modest overhead costs can be approved,

- the proposing organization must be registered with AID/Washington as an approved NGO;
- the higher the number of beneficiaries for the dollar, the better.

UNICEF has ordered some US\$377,000 worth of drugs for the MOH. The first shipments are expected as early as next week. These supplies will be distributed through the MOH Central Stores. NGOs with Health projects can assist DHOs in putting together drug requisitions to help meet the drought-related needs in their districts. UNICEF has circulated the **United Nations Monthly Drought Report - August**. (attached).

FOOD ASSESSMENT & MONITORING: A meeting of the Sub-Committee on Food Assessment and Monitoring was held at the MoAg on Sept. 4th (see notes on proceedings, attached). The principal accomplishment was to underline the expectation that there will be a shortfall in maize for free distribution, aggravated by already short supplies of commercial maize. An appeal to OPC for leadership in re-allocation of the maize and delegation of authority to DCs—to target maize at the district level—was agreed to. We have also attached alternative food production figures which were circulated at the meeting.

HEALTH: VITAP REDUX—International Eye Foundation (IEF) and Helen Keller International (HKI) sponsored Vitamin A consultant Susan Eastman to talk with NGOs interested and involved in health interventions. Seven NGOs responded with interest. She shared her information and advice at the Nutritional Monitoring Workshop and the Southern Region Health Task Force on the Drought. The information and insights she provided should help all to have a better appreciation and understanding of the complex nutritional problems related to the drought. We have attached a SUMMARY of her report for your information.

MAIN DONOR, NGO AND GOVERNMENT MEETING: Lilongwe, August 25th - An appeal by the Ministry of Health for drugs was made to donors (copy attached). The meeting was apparently frustrating for all—little new emerged. Many participants felt that consensus was not achieved and necessary action was not agreed on. Minutes of the meeting are attached.

NEWSLETTER to NGOs — Malawi p. 3

Drought Relief Coordination Unit/CONGOMA

Issue #: 2

September 9, 1992

HEALTH: Nutritional Monitoring Workshop: IEF and MSF(Holland), in collaboration with SCF(UK) consultant Jane MacAskill, sponsored a Nutrition Monitoring Workshop, in Blantyre on Aug. 31 & Sept. 1st. It was well attended and well received. a summary is attached and the handout **How to Conduct and Analyze Nutritional Status Surveys** is available on request from the DRCU.

The latest Regional Health meeting was held September 3rd at the RHO in Blantyre. Susan Eastman, a Vitamin A Technical Assistance Program consultant with Helen Keller International, presented and discussed vitamin A deficiency and malnutrition. She recommended several options for appropriate intervention to supplement current local programs and encouraged NGOs to expand their health activities to include distribution of vitamin A supplements (see attached SUMMARY of her recommendations, with a short summary of the proceedings of the meeting.)

Mr. Kos of WFP discussed the supplies needed for supplementary/complementary rations (attached.)

WATER: A few NGOs have included collection of data on water sources in their drought-related surveys. This data can be very useful in identifying hard-hit areas in the district and assisting the DC and the Water Department in establishing priorities.

We have heard nothing new on the overall water situation since Craig Sanders' update to the NGO Water Services database. Several districts are beginning to collect information on water availability and adequacy of existing sources. This data should be shared with the local District Drought Committee. NGOs interested in rehabilitating boreholes which already exist in their areas should discuss their ideas and plans with the local Water Coordinator and the local Water Department officer. Both new wells and rehabilitated wells should be developed to Water Department standards.

The recommendations from the Water Task Force are still in effect. the Water Coordinator for each district is responsible for meeting with and coordinating the efforts of the appropriate members of the District Development Council, or the District Drought Coordinating Committee (if you have one). It is the Task Force's responsibility to allocate scarce resources (trained local personnel and locally

available special equipment/supplies) for districts and projects. There is no update on the use or availability of the German Gov't. funding mentioned in the last NEWSLETTER.

AGRICULTURE: REHABILITATION—SEEDS: ActionAid and the Min. of Agriculture are continuing their close collaboration on this Project. ODA has now committed to fund the entire project for all of the severely drought-impacted districts. Attached is the August 25th Status Report and an Open Letter to NGOs asking for assistance in seed distribution.

HELP!! To make this newsletter more useful and informative to all NGOs, we need your input—send us your perspective on issues, updates on what you're involved in, needs, frustrations and solutions you have come up with—to share with other NGOs. Please also advise us of your new or changed telephone and FAX numbers. We are looking forward to your input for the NEWSLETTER.

READING & REFERENCE: The DRCU has received a copy of SADCC's Drought Emergency in Southern Africa, Situation Report, August 1992. If you would like a copy, let us know. We also have copy of the UNHCR Programme for Mozambican Refugees (June 1992) for those interested.

DRCU/CONGOMA

P.O. Box 30743

Lilongwe

tel: 780-865/FAX: 780-763

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Asst. Coordinator: Mike Kandulu

Accounting/Administrative Officer: Amy Muyco

Executive Secretary: Eluphy Banda

Production Asst.: Gervaso Kamelela

NEWSLETTER:

to **NGOs** - Malawi

Drought Relief Coordination Unit/CONGOMA

Issue #:3 October 5, 1992

MAIZE SEED DISTRIBUTION: The DRCU and ActionAid co-sponsored a workshop for the five Districts in Blantyre ADD--Mwanza, Blantyre, Thyolo, Chiradzulu and Mulanje. It was held for ADD, District and NGO personnel and addressed the logistics of seed distribution specific to each District. The idea was to get district-level people together to discuss and come up with a plan of action for the districts where maize seed is needed first.

ActionAid report that seed is being bagged at 10 kg./family and is currently being shipped out to ADMARC Markets in each district. (see list, attached) It is up to the DCs, NGOs and local Ministry of Agriculture people to work out viable distribution plans that will probably include direct distribution at the ADMARC Markets, some distribution along with food maize at distribution points and some creative village-level distribution schemes.

Common problems emerged from the discussions: lack of appropriate-size vehicles for local hauling; lack of funds for transport of personnel and seed; synchronization of seed and food deliveries would be logistically difficult, if not impossible; and, of course, not enough time.

Since the workshop, ActionAid has clarified several issues:

1) time is terribly short -- seed must be in people's hands in the Blantyre ADD and other districts by October 20th;

2) ActionAid can reimburse for actual transport costs (for personnel and seed);

3) District personnel need to use the ADMARC Markets, where the seed is now being stored to distribute seed, as well as additional distribution points and strategies, depending on local conditions: farmers within 5 km. of an ADMARC Market can get the seed there, more distant villages will require different strategies, to be worked out by the DC and NGOs;

4) local officials and traditional leaders must get the word out to the farmers that the maize seed is now available;

5) DCs and NGOs will need to work out a mechanism where the ration cards are marked when a seed pack is distributed.

For further clarification call ActionAid 781-268 or the DRCU 780-865. Remember, late planting means a poor crop, even with good rainfall.

DROUGHT RELIEF TOUR: The Main Task Force Committee undertook field visits to observe food distribution and drought effects. One group visited Karonga, Rumphi and Nkhata Bay on 10 and 11 September 1992 and another group visited Nkhotakota, Salima, Dedza and Ntcheu on the same dates.

Findings included: Cooperation by all parties involved in relief operations-- party leaders, traditional leaders, government officials and NGOs;

Delays in deliveries of maize from EDP to districts and from districts to distribution centres; the delays caused frustrations to relief workers and beneficiaries; occurrence of water-related diseases is skyrocketing and severe

lack of essential drugs in district hospitals and health centres was obvious; Water table levels are further receding, resulting in the drying up of rivers, streams, shallow wells and boreholes; some wild animals were leaving their natural habitats and encroaching on communities; some areas in Rumphu and Nkhata Bay can only be reached by lake transport, which is sorely lacking.

In some districts, mitigation projects are being implemented. In Karonga, at Wovwe, villagers are growing winter rice and the scheme has a potato plot with harvest and cuttings for distribution to the beneficiaries through health centres. At Limphasa rice scheme in Nkhata Bay people were advised to grow maize in rice plots but met resistance due to diseases that attack maize. The growing of winter rice seems more acceptable.

There is need for continuous verification and re-registration of beneficiaries. In one district 11,000 were de-registered.

MAIN TASK FORCE MEETING: The GOM, donors and NGOs met at their bi-weekly meetings on September 15th and on the 29th. Minutes of the September 15th meeting are available at the DRCU. The highlights of the meeting on Sept. 29th follow.

Three UN Volunteers have arrived to assist the Emergency Management Unit at OPC and the Transportation and Logistics Unit. It was noted that congestion is occurring in the ports in RSA and in Beira. Urgent requests have been made to drought-affected countries and donors to advise their shippers to use the less-impacted ports, such as Dar-es Salaam. Congestion in ports is delaying unloading of ships by as much as 10 days. USAID reported that it is proposing funding for the improvement of communication

linkages among the ports, dispatch centers and destination countries.

A representative of the Associated Chambers of Commerce, Malawi, stated their interest in supporting drought-related activities. Stagecoach is offering buses with seats removed to haul maize, if required. DRCU is following-up on local donor interest and the potential for facilitation by NGOs. The issue of how much and what kinds of food is being donated to NGOs for distribution and supplemental feeding purposes was raised. The DRCU is following-up to update the supplementary feeding data and Jim Lawrence, Transp. & Logistics Unit will update the list of food donated to NGOs for free distribution and complementary rations.

The lack of drug availability in the country was discussed and concerns about the low level in MOH central stores were raised. No one from MOH was present to respond. SCF(UK) is bringing in supplies to diagnose and treat the epidemic of bloody diarrhea afflicting people in the Central Region.

The DRCU Coordinator updated the meeting on the districts covered by NGOs in food distribution -- Karonga, Mchinji, Lilongwe, Salima, Ntcheu, Machinga, Mangochi, Zomba, Mwanza, Chiradzulu, Thyolo, Chikwawa and Nsanje. Rumphu District will be added and interest has been expressed by NGOs to help in Nkhata Bay, Dedza and Nkotakota. These areas are among the hardest hit and, along with Mulanje, really need NGO help. NGOs approached have all expressed interest but are afraid of becoming over-extended and would need significant additional funding immediately in order to respond.

The unforeseen influx of over 50,000 refugees in the last three months was raised as a concern.

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Attached are tables of statistics released by the OPC/EMU for June, July and August.

MEETING ON WATER COORDINATION UNIT:

The Deputy Minister of Works addressed the Thursday, 17 September 1992 meeting called for donors and NGOs on the formation of a water coordination unit. NGOs and donors were requested to fund the running costs of the unit. Unfortunately, the only donor present was UNICEF. NGOs indicated that the request was directed to the wrong group, it should have been directed to the donor community that finances such activities. NGOs are implementors and not source of funds.

OFDA/USAID FUNDING:

Africare has received \$350,000 from OFDA for water projects - rehabilitation of shallow wells and boreholes in Chiradzulu, Thyolo and Machinga.

OTHER SOURCE OF FUNDING

Dutch Government is a possible source of funding. For contact address and conditions see attached letter from Paul Courtright, IEF.

*** ALERT ***

NGOs are badly needed to help in food distribution in Mulanje, Dedza, Salima, Nkotakota and Nkhata Bay Districts. Funds can be available through the NGO Strengthening Fund to help you to expand your efforts to one of these districts. Read the Fund Guidelines (attached) and get in touch with the DRCU if you need further information.

NGO STRENGTHENING FUND:

There was a low response to needs assessment questionnaires. Over fifty questionnaires were mailed to NGOs with only fourteen responding. A summary of responses made and

discussed at the Standing Committee on Disaster meeting held on 22 September 1992 is attached.

The Committee decided that there should be no restrictions on access to the Fund for NGOs--any NGO could apply and need not be a member of CONGOMA. Proposals may request up to MK200,000 and there should be no restriction on the use of funds. Proposals will be reviewed for technical, administrative, relief and operational viability. Approval/disapproval will be decided by the Review Committee, made up of at least three members of the Standing Committee on Disaster.

The DRCU Coordinator had a subsequent meeting with UNDP to review the Fund guidelines. UNDP changed only two items: 1) only CONGOMA member NGOs may be funded; and 2) community-based development projects cannot be funded, as the purpose of the Fund is NGO capacity building. The final Guidelines have been sent to the Ministry of Women and Children Affairs and Community Services for approval and will be implemented immediately on approval. (see copy, attached)

COMPLEMENTARY FOOD DISTRIBUTION

A meeting on Complementary Food Rations, was convened by the Commissioner on Disaster on September 14th. The meeting was intended to develop plans to begin distribution of additional food rations (3 kg./mo. of Likuni Phala); to target the most vulnerable group(s) in the hardest hit districts, beginning in October. Nsanje and Chikwawa Districts have been allocated the complementary rations for children under five (U-5s) for October. Other hard-hit districts will be added later. The complementary ration will be distributed along with the standard ration and logged in the new registration forms.

Since the old forms did not identify the U-5 population, the Commissioner strongly recommended that registration using the new forms should proceed as quickly as possible-to facilitate the allocation of the additional rations. He encouraged District Government and NGOs to work closely together in this process, and stated that in districts where NGOs were already working with the DCs the progress was well advanced. WFP said they hope to have the new registration log books and other forms printed and available to the districts by the end of September. (see Proceedings of Meeting September 14, 1992, attached).

THYOLO UPDATE:

There was a meeting on food distribution in Thyolo on September 16, 1992. Mr Mambelera was chosen as District Drought Relief Coordinator. The meeting also discussed water problems in some parts of the district (See minutes of the meeting, attached).

Northern Region: ELCM/LWS and the Christian Council of Malawi have agreed to assist the DC in Rumphu District with food distribution and reportage in the lakeshore areas. In Karonga District, where they have been assisting the DC with transportation and distribution, they are trying to institute direct delivery of maize from Mzuzu Extended Delivery Point (EDP) to distribution points. Until now, maize has been transported to Karonga by OPC transporters and then to distribution points by the NGOs. This arrangement has created high costs for the NGOs and delays. They are hopeful that a better operational plan can be worked out.

HEALTH/NUTRITION MONITORING

UNICEF has supplied the Regional Health Offices with Mid-Upper Arm Circumference (MUAC) Tapes - North: 400; Central: 1,350; South: 2,700. The tapes are to be made available

for both Government and NGO Nutritional Surveillance activities. Additional tapes will be ordered in anticipation of expanded surveillance activities. Contact your RHO for these needed supplies: Dr. Khosa, RHO (North); Dr. Bekedam, RHO (Central); Dr. D Jacka, RHO (South).

The RHO (South), Dr. David Jacka, has arranged for Ms Yoko Saeki, a JOCV Nutritionist, to be available to receive data and enter it on interpretive database for nutritional and health surveillance data being reported from the Districts in the Southern Region. She will be using EPI INFO and EPI NUT, public domain software developed by the Centres for Disease Control, USA.

The DRCU has loaned a computer to facilitate data processing, analysis and reporting.

ZOMBA DISTRICT REPORT: Since the Nutritional Monitoring Workshop in Blantyre in August, Zomba District has implemented an ongoing survey conducted by Health Surveillance Assistants under the DHO and the Superintendent of the Zomba General Hospital and supported by the Baptist Food Aid and Emmanuel International.

The Questionnaire they used covers broad subject areas including: household composition, water source status and food security. Measurements taken include MUAC, height/age, weight/age and weight/height. Enumerators are HSAs based at the twenty Health Centres in the District. Each week the HSAs visit a village within a five km. radius of each Health Centre, where they interview 12 households selected randomly. Each HSA has attended two seminars on conducting surveys. Completed surveys are returned to the DHO where the information is analysed using a computer.

After six weeks of operation, 894 forms have been completed from over 70 villages. The techniques and methodology is being reviewed and revised as the surveying progresses.

Interested NGOs are encouraged to contact Ann Robins, Nut. Surveillance Coordinator, Baptist Food Aid, P/Bag 12, Zomba, tel: 522 029.

Vitamin A from UNICEF:

UNICEF has announced that the second supply of vitamin A capsules (1,399,999 caps.) will soon be delivered to regional vaccine stores. RHOs, DHOs and MOH Nutritional Units have been advised. Attached is a copy of the distribution to be made to all 24 districts.

FOOD TRANSPORTATION:

The government ban on use of the Northern Corridor was lifted in late August. Attached are the government's Phytosanitary Guidelines for Imported Food Grains.

At a recent transport meeting between South African port officials and GOM officials, the former warned that they expected congestion at their ports in the coming months. GOM was advised to use other corridors to lessen the expected congestion of ports and roads. Malawi should project expected monthly tonnage through South Africa to enable re-scheduling of facilities.

REFUGEES: The number of refugees in Malawi has been increasing rapidly in the last few months. In July, August and September of this year over 50,000 new Mozambican refugees were registered. This escalating number is creating problems of crowding and allocation of housing areas in the camps. In addition, the 20,000mt of maize "loaned" by UNHCR to OPC for free distribution to Malawians will need to be replaced by donors sooner than

expected.

LATE BREAKING NEWS: The District Commissioners are now receiving FAX machines donated by the British High Commission. Nkotakota DC has advised us of his new FAX#:292-348.

WATER: The Water Department has just released Development of Comprehensive Water Department and Water Well Development and Rehabilitation Standards (copy attached). This guideline has been long-awaited and provides NGOs with the standards required by the Water Department for wells which they will be expected to maintain or consult on in the future. They have requested all donors and NGOs to adhere to these standards and guidelines.

SCF(UK) WATER PROJECT: SCF(UK) reports the progress on its USAID grant (\$1.1 million) to drill 80 new boreholes and to rehabilitate 50 boreholes. The activities take in Machinga, Mwanza, Mulanje, Chikwawa and Mangochi Districts and include collaboration with the Water Department and the American Refugee Committee (ARC).

FOOTNOTE: For NGOs working in community health, the Rockefeller Foundation has distributed guidelines for its new HIV/AIDS NGO Support program. If you are interested, please contact the DRCU for a copy of the Programme Brochure.

DRCU/CONGOMA

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Report on the Baseline Nutrition Assessment conducted in Chikwawa district, 3 - 8 August, by IEF, MSF-Holland, SCF-UK

Summary

A nutrition status survey was conducted in Chikwawa District from the 3 - 8 August, 1992 by MSF-H, IEF in collaboration with SCF-UK. 3.8% of the children were moderately or severely malnourished.

Although the nutrition status data results do not show any significant deterioration in nutritional status in Chikwawa District at present when compared with previous surveys conducted in Malawi in which weight for height data was collected. (The last NSSA survey conducted in 1981/2 found 1.6% of the children moderately and severely malnourished, this figure does not include kwashiorkor children.) The observations and additional information collected during the survey suggest that the situation in Chikwawa district can be expected to deteriorate dramatically over the next few months unless appropriate interventions are implemented in the near future.

Many of the villages visited had a total crop failure and no stocks of food in the village. In some areas all the livestock had been sold and access to income generating activities was extremely limited. Water supplies in those villages dependant on neighbouring rivers or shallow wells reported a continued deterioration in both the quantity and quality of water. Diarrhoea was reported in many of the villages visited.

Although free food distributions had started in Chikwawa district in May this year, most of the villages visited had received 1 ration of 50kg per family in a three month period (ie 350 kilocalories/person/day in families with 5 people). This is one third of the GOM/WFP recommended quantity of 9kg/person/month (1000 kilocalories/person/day) and one sixth of the recommended UN/WHO daily energy requirements of 2000 kilocalories/person/day.

There is an urgent need to improve the general ration distribution and to establish an on-going system of monitoring the nutritional status of the population in Chikwawa district. The monitoring of nutritional status done at the sub-district level should also be used to assist in targeting limited resources eg; food (general, supplementary, complementary rations), water improvement programmes, and health activities to the worst affected areas within the district.

Introduction

Malawi is currently experiencing the worst drought in many years. Chikwawa district in Southern Region is one of the six districts identified by the government as most affected by the drought. The UNICEF/CSR emergency assessment conducted in March/April reported almost total crop failure in the district and the District Commissioner has registered 98% of the population for free food distributions.

In July, the Regional Health Office established, in collaboration with NGOs working in the field of health, a regional health committee which meets fortnightly to discuss health and nutrition

issues arising from the on-going drought in Malawi.

At one of these meetings it was agreed that there was a need to conduct regular nutrition assessments in the region in order to:-

- monitor the nutrition status of the population during the drought.
- assist in prioritising areas for targeted interventions.
- assess the effectiveness of the general food distribution

Following this meeting some of the NGOs (Project Hope, MSF-F, IEF and SCF-UK) drew up guidelines for conducting nutrition assessment surveys and IEF, MSF-H in collaboration with SCF-UK decided to conduct a pilot survey in Chikwawa district.

The pilot survey was conducted in Chikwawa district from the 3 - 8 August, 1992.

Aims and Objectives

The aim of this survey was to:-

- form the basis for setting up nutrition monitoring in the district in order to support the Ministry of Health and other government bodies minimise the impact of the drought on the health status of the Malawian population and particularly of the under five child population.
- provide baseline information on nutrition status in Chikwawa district. Surveys done within the district at the TA level in the coming months could be compared to the baseline survey results and surveys conducted in other districts could be compared with Chikwawa district.
- provide other agencies with an outline of the costs, time and staffing needed to conduct similar nutrition surveys in their district.
- improve the survey guidelines drawn up by the NGOs based on lessons learnt during the survey.
- train survey teams who will conduct surveys in the districts at regular intervals as part of an on-going drought monitoring programme.

Survey methodology

30 clusters of 30 children were randomly selected in the district using probability proportional to size sampling. (For full details of the survey methodology refer to the draft guidelines for nutrition status surveys compiled by the NGOs)

Weight and height data was collected as this is an accurate measure of thinness/wasting (acute malnutrition). All children under 110cm and greater than 6 months of age were weighed to the nearest 0.1kg. Children less than 85cm were measured lying down and children greater than 85cm were measured standing up. Length was measured to the nearest 0.5cm.

Information was also collected, through discussions with the village elders in each village visited, on water supply, last food distribution, disease outbreaks, movement of people into and out of the village and general impressions of conditions in the village.

Survey Results

The results have been presented in terms of z-scores and mean weight for height/proportion less than 80%WFH to allow comparisons to be made with other agencies in the future. (For full details of the survey methodology and analysis refer to the draft guidelines for nutrition status surveys compiled by the NGOs)

Results:- Z-scores

The total number of children surveyed was 914. The mean z-score was -0.23 (95% Confidence Limits = -0.15 to -0.31). 2.1% of the children had z-scores 2.00 - 2.99 (ie were moderately malnourished) and 0.2% of the children had z-scores \leq 3.00 (ie were severely malnourished). An additional 1.6% of the children surveyed had kwashiorkor (ie were also severely malnourished).

The total number of the children who were moderately or severely malnourished including kwashiorkor children was 3.9%

Results:- WFH%

The mean weight for height was 98.4 (95% CL 97.6 - 99.2%) and the percentage of children between 70-79.9% WFH (ie moderately malnourished) was 1.5%. The percentage of children less than 70%WFH (ie severely malnourished) was 0.1%. An additional 1.6% of the children surveyed had kwashiorkor (ie were severely malnourished).

The total number of the children who were moderately or severely malnourished including kwashiorkor children was 3.2%

Table 1:- Summary of the results

Z-scores					total
Mean	95% CI	- 2 to 2.99	- 3 and greater	kwash	moderately & severely malnourished
-0.23	-0.15 to -0.31	2.1	0.2	1.6%	3.9%
WFH%					
Mean WFH	95% CI	70-79%	< 70%	kwash	
98.4	97.6-99.2	1.5	0.1	1.6%	3.2%

When the data was broken down by %WFH, it can be seen that most of the kwashiorkor cases fell in the 30-41 months age group category, whereas children who were moderately malnourished tended to fall in the lower age groups 6-29 months. This would suggest that the younger children tend to be more to become marasmic whereas the children aged 30-41 months tend to get kwashiorkor. It would be interesting to see if a similar trend is found in future surveys.

Table 2:- Weight/Height: Distribution by age. (WFH%)

Age	<70% %	>=70&<80% %	>80% %	Oedema %
06-17	0.0	3.5	95.3	1.2
18-29	0.0	1.5	97.0	1.5
30-41	0.5	0.5	95.1	3.9
42-53	0.0	1.3	97.4	1.3
54-59	0.0	0.0	100.0	0.0

TOTAL	0.1	1.5	96.8	1.6

Discussion of survey results and other information collected

The nutrition status data results do not show any significant deterioration in nutritional status in Chikwawa district at present when compared with previous surveys conducted in Malawi in which weight for height data was collected. (The last NSSA survey conducted in 1981/2 found 1.6% of the children moderately and severely malnourished, this figure does not include kwashiorkor children.) The observations and additional information collected during the survey suggest that the situation in Chikwawa district can be expected to deteriorate dramatically over the next few months unless appropriate interventions are implemented in the near future.

Most of the villages visited had absolutely no harvest this year, and thus no food stores. The next major harvest is not until April 1993. A few people living along the marshes are now harvesting a small quantity of maize and other foods but in many of the villages further away from the marshes conditions appeared to be very bad.

Many people appeared to be surviving through selling firewood which they collect and sell or trade for flour in towns up to 20km distance from the village. Many families are only eating one meal a day and people have resorted to eating foods they can find, such as *miseau*, a type of fruit found on trees during the months of June - August, or are eating the roots of a local trees (*kanyienani/menyanya*).

In 'normal' non-drought years people do sell some of their livestock to buy food; this year in some villages, particularly in the hilly areas, all the cattle, goats, and chickens had been sold by May and there were absolutely no animals in those village.

Some villages are close to the two refugee camps in the district and can sell firewood and purchase flour at cheaper prices than is available in the towns. The majority of the villages are quite far away, making it more difficult for the people to exchange items with the camps except through more expensive middle men.

Water quality and quantity

Most urban/road-side villages most places visited had boreholes or piped water. In three villages people reported having to pay for their water. (There is normal monthly charge of 2K/household for

the maintenance of equipment.) Some of the villages with boreholes reported a decrease in water pressure.

In the hilly areas most villages got their water from nearby rivers; water levels in the rivers were reported to be extremely low. One village commented that the water in the river was even lower than in 1949. These water sources are now drying up. In the lowland areas away from the marshes, the rivers have dried up and people are now having to dig deep holes in the river beds. Likewise the quality of water in the shallow wells is deteriorating as the level of the water decreases.

Some villages visited along the edge of the marshes had boreholes and the rest depended on the river or unprotected shallow wells for water.

Population Movements

In a few villages, where water was a more serious problem, some of the men had travelled to cultivate along the marshes and were expected to return when the crop was harvested. In one of the villages surveyed in which the river was at an even lower level than in 1949, whole families were reported to have moved to cultivate in the marshes.

Food distributions

27 of the 30 villages visited had only received one free food distribution of 50kg per family irrespective of family size (14 of these received their ration in May and 11 in June). 1 village reported not having received a ration at all and 2 villages had received a second ration.

50kg of food per family of 5 people over a 3 month period provides approximately 350 kilocalories/person/day, ie one third of the WFP/GOM recommended general ration distribution or one sixth of the WHO/UN recommended daily energy requirement of 2000 kilocalories/person/day. Larger families have received considerably less than this.

Health status

Diarrhoeal disease was reported in most villages visited and several villages had cases of eye infection. In some areas bilharzia was reported as being common, but treatment was unavailable in the local health centres or district hospital.

Conclusion

As can be seen from the above discussion some villages are more affected by the drought than others. Those villages that are worst affected appear to be those in which:-

food stores are totally depleted and people do not have gardens in the marshes,
water supplies are deteriorating rapidly,

- all the livestock have been sold,
- people have limited sources of incomes,
- basic health services and marketing facilities (eg trading centres, & refugee camps) are a long distance from the village.

This suggests that there is an increased need to monitor the situation within Chikwawa district preferably at a sub-district level, so that scarce resources can be targeted to those areas that are worst affected. It is also important to monitor the situation so that any deterioration in nutrition status can be identified early and quickly.

Recommendations

- The general food distribution should be strengthened to ensure that those registered receive the GOM/WFP recommended ration of 9kg/person/month (1000 kilocalories/person/day).
- Consideration should be given to increasing the general ration or providing a complementary ration to those villages that are particularly badly affected by the drought.
- It is important that regular nutrition status surveys are conducted to monitor the situation within Chikwawa district.
- Nutrition status surveys conducted at the sub district level would be important for identifying worst affected villages so that limited resources can be targeted effectively.
- Nutrition status surveys should also aim to monitor the general food distribution: frequency of distribution and quantity received.
- There is a need for coordination and collaboration at the district level of all bodies collecting information on agricultural indices, water availability, health status/surveillance information and nutrition data so that action can be targeted quickly and productively.
- There is an urgent need for a water surveillance system to be established in the district, particularly in those areas where the rivers are drying up.

Villages randomly selected for sampling.

TA/Village	EA	Population estimate
TA Chapanga		
Akunseu	35	500
Belton	28	350
Changoima	17	600
Kuwani	7	1250
Mandalika	58	350
Mangulenje	52	650
Zuze	18	1800
TA Katunga		
Khumbulani	1	1050
TA Makhira		
Kamisale	50	450
Masache	27	850
Masache	29	2400
Mfunde	20	1200
Nthinda	47	1300
TA Kasisi		
Kavalo	7	250
Njereza	9	950
TA Lundu		
Chipakuza	801	1750
Mangulenje 1(suc)	10	1500
Sekani 1	804	1100
Sekani 2	805	550
Thomu 1	11	450
TA Maseya		
Muyaya	16	1100
TA Ngabu		
Chambuluka	44	800
Chipwaila	37	350
Density Homes	801/2	1500
Malikopo 1	21	750
Makande	803/4	1200
Mponya	71	550
Ng'ombe 2	87	600
Nyakabobo	102	200
Ziloso	30	350

IMPLEMENTATION OF SURVEY

* TRAINING

Training was given at the Chikwawa District Hospital on Friday 31/7 and Saturday 01/8. The teammembers were collected by MSF/IEF on Thursday 30/7 from their villages and provided accommodation in Chikwawa till start of survey on Monday (so Sunday as well to be sure all teammembers are present).

* SURVEY

The teams started in the following villages on Monday morning 07.30 hrs:

team I&II : Chikwawa
team III&IV: Ngabu

The planning of the survey was as such that the first day was near Chikwawa or Ngabu, in case the teams would face problems and needed back-up.

The teams found lodging in the vicinity of the survey-villages. Lodges had been informed in advance.

The survey was planned in such a way that all four teams would finish their surveys around Nchalo on Friday, the last day of the survey. There had to be done 5 clusters around Nchalo. In case one team had completed its survey it could assist another team.

Each team consisted of 5 members:

- 1 teamleader (HSA or Expats)
- 3 team asst. (HSA or Volunteers)
- 1 driver

* MISCELLANEOUS

- The team was supplied with the survey-material.
- Each participant took care of its own personal gear.
- The coordinator supervised the survey in his/her own vehicle to support and assist the teams whenever necessary.
- In case of emergency one person was appointed central point of contact and telephone numbers were known to the teams.
- The survey was concluded with an evaluation of the teams.
- Compilation and analyzes of data according to EPINUT.

* MISCELLANEOUS

- The team was supplied with the survey-material.
- Each participant took care of its own personal gear.
- The coordinator supervised the survey in his/her own vehicle to support and assist the teams whenever necessary.
- In case of emergency one person was appointed central point of contact and telephone numbers were known to the teams.
- The survey was concluded with an evaluation of the teams.
- Compilation and analyzes of data according to EPINUT from 8-12 August.

* BUDGET

Listed below are the expenses in Kwacha made during 8 days of survey including two days of training and one day rest (Sunday). Not included are salaries expat staff and computer equipment.

* STAFF	
- salaries/allowances:	
5x driver (allowance+overtime)	1,500
16x teammember	1,900
- HSAs in catchment area participating in survey	350
- accommodation for 23 persons	
- food and drinks	1,200
	3,100
* TRANSPORTATION	
- 4 vehicles were available from own resources	
- 1 vehicle rented	
- petrol 5 vehicles	1,850
	900
* SURVEY EQUIPMENT	
- 4x salter scales	
- 4x measuring board	1,800
(both can also borrowed from UNICBF or MoH)	400
- miscellaneous equipment	
- copies (forms, teaching material)	650
	200
TOTAL	13,850
	+ \$ 3,551

Please note that these expenses have been made to conduct this survey rapidly in a large district. Also borrowing equipment and use of own transport will reduce the costs considerably.

Programme for training workshop

Day 1

- 8.00 - 9.15 Why measure children?
Why use Weight For Length rather than WFA, MUAC?
Which children should be weighed and measured:
How to check the equipment.
- 9.15 - 10.00 How to measure children
How to weigh children
- 10.00 - 10.15 Kwashiorkor children
- 10.15 - 10.30 The recording format for use in the field
- 12.00 - 1.30 Lunch
- 1.30 - 2.30 Weigh and measure 10 children. Each team should weigh and measure the same 10 children and then calculate the WFL. Using the recording format.
- 2.30 - 3.30 Compare the results from all 4 teams and discuss any problems.
- 3.30 - 4.30 What other information is useful and why? Introduction. Then group discussion to identify people they could talk to who could provide this information and identify questions that could be used to find out this information.

Day 2

- 8.00 - 9.30 Review of previous day. Group discussion and presentation on the following topics.
Group 1:- How to check the equipment
Group 2:- How to weigh a child
Group 3:- How to measure a child
Group 4:- Describe other information necessary to interpret the results
- 9.30 - 10.00 How to select the households and children who should be surveyed.
- 10.00 - 11.00 The groups are each given four villages on paper to sample and identify households for survey. During which they should identify key problems with surveying each village.
- 11.00 - 12.00 Discussion of potential problems and potential solutions.

Times are not accurate in fact this programme finished at about 4.00pm on the second day.

Summary of the workshop held on 31/7 - 1/8/92 for IEF and MSF(Ho1) nutrition surveillance staff.

The affects of drought

The results of drought can be any of the following if appropriate action is not taken soon enough.

No crops:- therefore reduced food availability and loss of earnings
Deterioration in quality and quantity of water
Movement of people in search of food
Increase in burglary and robbery
Increase in diseases:-
 skin/scabies
 diarrhoea
 measles
 pneumonia
Malnutrition
Death

Some reasons for the increase in diseases during drought:-

- malnourished children are more susceptible to infection
- if large numbers of people crowd in to one area in search of food and water, this will increase the spread of infectious diseases.
- a deterioration in the quantity and quality of water will lead to an increase in diarrhoeal and skin diseases

Nutrition monitoring of the drought

The purpose of monitoring the drought is to

- identify worst affected areas so that resources can be targeted to those areas.
Resources:- free food, money and equipment to improve water supplies, increased medical supplies are often in short supply
- Nutrition monitoring provides numbers (quantitative data) with which one can argue for assistance.
- If one asks households what food they have or how much money they have it is difficult to get a good answer.

Why measure children?

- Children are more vulnerable than adults
- They need food for growth and everyday living.
- International standards are available for children.
- Nutritional data quantifies the situation in a community, and can be used to cross check other information or indicate a lack of other information.

Types of nutrition data. Why is Weight and Length measured in community surveys.

- Weight for age
WFA data is collected in the nutrition centres in the growth monitoring programme. Weight for Age data does not distinguish between chronic/long-term food shortages and acute/immediate food shortages.

A child who is chronically malnourished may be stunted (short for his age) but have the right weight for his present height. Stunting is not

life threatening.

- **Mid Upper Arm Circumference (MUAC)**

MUAC is good for screening and identifying individual malnourished children for a specific intervention eg supplementary food.

MUAC is not recommended for assessing the nutritional status of a community. This is because there are no international standards for MUAC and it is difficult to get an accurate result using MUAC (between observer variation is high)

- **Weight for Height**

WFH data takes time to collect but is an accurate measure of thinness (acute malnutrition). This is because:

- body weight is extremely sensitive to acute shortages in food intake, while height remains relatively constant.
- in children prior to puberty, the relationship between body mass and height is nearly constant regardless of sex, race or age. Surveys done in rich Malawian children have found that they grow in the same way as children from the USA.
- morbidity and mortality have been shown to occur with at least twice the frequency in children who are of low weight for height as compared with normal children.

It is recommended as the best measure to use in surveys to: assess community nutritional status

Which children should be measured

In Malawi, the Ministry of Agriculture nutrition surveys and the MSF surveys weigh and measure children from 6 months to 60 months (5 years). Age can be determined using the MOH under 5 cards (Road to Health/Growth monitoring cards).

If a child has no under 5 card, it is recommended that a 110cm is used to identify children less than 5 years.

Measuring equipment

If the length boards or the weighing scales are inaccurate then all the results collected will be useless.

CHECK THE EQUIPMENT BEFORE EACH WEIGHING SESSION.

Weighing scales

- check glass and needle are not damaged
- zero the scales
- put a known weight into the pans eg a 10 or 15kg weight,
- check that the reading on the scales corresponds to the known weight, if the weight does not correspond to your known weight then get some new scales from your team leader.

If you do not have a 10 or 15kg weight, then weigh a heavy stone on two scales. If the weight of the stone is the same on both scales then both scales are working properly. The weight can then be written on the stone and the stone used to check the scales before each measuring session.

Length board

The tape measures should be checked before each session. Are the tape

measures easy to read? Have they been fixed firmly to the length board?
Are they accurate? Are they in the right place?

Points to remember when weighing children

- make sure that the scales are secure and hung with a strong rope.
- make sure the scales hang clear of any obstacles, and that the ground below the scales is clear of stones and other nasty objects in case the child falls,
- make sure the sling/sack/pants used for measuring the children is strong,
- the scales should be hung at eye level,
- the scales with the pants should be set to zero before each measurement is taken,
- remove heavy clothing, shoes and jewellery before weighing a child,
- do not hold the scale hook when reading the weight. You can hold the sides of the face.
- do not touch the child or let the mother touch the child when you are weighing the child.
- make sure that the feet do not touch the ground.
- when reading the scales stand straight in front of the scales.
- weight should be measured to the nearest 0.1kg
- with screaming/wriggling children be extremely patient, try and calm the child down, get the mother to help calm the child.
- be careful not to poke a child's eye out with the hook on the scales,
- let the child see the mother at all times.

Even children who are very active, which causes the needle to move greatly will become still long enough for one or two seconds, to take a reading. WAIT FOR THE NEEDLE TO STOP MOVING.

Points to remember when measuring the length of a child

- HSF measure all children less than 85cm lying down and all children taller than 85cm standing up.
- shoes should be removed,
- heels and feet should be firmly against the foot board,
- the shoulders, buttocks, thighs, and knees should be touching the length board,
- the head should be in such a position that
 - when the child is lying down:- the eyes are pointing directly upwards
 - when the child is standing:- the eyes are pointing straight forwards.
- height should be measured to the nearest 0.5cm
- use a 110cm stick to check that a child is not greater than 60 months

Kwashiorkor - Mwana Wotupilana(Tsempho)

Kwashiorkor is a clinical feature of malnutrition. The signs of this condition are:-

- swollen arms and legs, and sometimes face, due to the retention of fluids in the child's body.
- sometimes light hair
- apathetic, miserable, quiet
- loss of appetite
- flaky/peeling skin

To check for kwashiorkor: apply firm pressure to the top of the foot with your thumb for 3-5 seconds (count 'one thousand and one, one thousand and two, one thousand and three'). If an indentation remains for 1 second or more after you remove your thumb, this indicates oedema/kwashiorkor.

Weight is not a reliable measure in children with oedema, because the body is swollen

Children with kwashiorkor are severely malnourished and should be reported on the recording format in a survey. **THEY SHOULD NOT BE WEIGHED AND MEASURED.**

The reporting format

Below is an example of how to fill in the form.

Village _____ TA _____ EA _____ District _____
 Date _____ Team Leader _____

Number	Oedema	Sex M/F	Age months	Weight kg	Height cm	%WFH	Comments
1		F	48m	16.8	107.5		scabies
2	kwash	M	24m				
3		M	36m	12.9	99.5		diarrhoea

On the back of the reporting format are questions to guide discussions with people in the village. The local health worker may also be able to give you a lot of this information. The aim of these questions are to help get information on some of the factors that cause malnutrition. The nutrition data (the weight and height information that is collected) may tell us that there is malnutrition, but on its own it will not explain what the main causes of malnutrition are.

The causes of malnutrition

- Lack of food
- Limited variety in the diet
- Diseases
- Lack of knowledge

Poor water and sanitation can cause malnutrition for the following reasons:-

- If the local borehole or protected shallow well has either broken or dried up, then people in a village will have to collect dirty water from the river. This can lead to an increase in diseases such as diarrhoea, cholera, dysentery which can cause malnutrition.
- If there is not enough water in a village this will lead to an increase in skin diseases.
- If the local water supply has dried up and mothers have to go a long distance to search for water then the mothers will be more tired and may not have time or energy to prepare food for their children.
- If a lot of people move to one place in search of water, then the increased number of people gathering in one place will lead to a deterioration in sanitation and an increased risk of disease.

Many factors can cause malnutrition. It is important to try and identify the major contributor to malnutrition in an area so that limited resources can be targeted more affectively.

Sampling

When we do a nutrition survey we are trying to find out about the nutrition status of the community (in the first survey - Chikwawa district).

It is recommended that a sample of children are selected when collection nutrition status data.

To survey all the children in a district takes a lot of time and energy.

- Reduces the time that can be spent on relief or development work which may benefit the population.
- A well selected sample with adequate analysis can provide a good estimate of the nutritional status in the area.

In each of the randomly selected villages, the sample of children is approximately 30 children.

The exact number of children will depend on the number of children in the last house. It is important to finish a house. So the exact number of children measured in each village (cluster) will be 30, 31, 32 or 33.

How to identify which houses to visit in a village.

- go to the centre of the village
- randomly select the direction in which you will move. Do this by spinning a pen on even ground. Wherever the pen points when it stops is the direction in which you will move.
- count all the houses in that direction moving in a straight line from the centre of the village to the edge of the village. Try and move in this direction even if the path is very small and you have to zig-zag a little.
- randomly select a number between 1 and the total number of houses along the directional line selected. You can do this by asking somebody to give you a number. This will identify the number of the first house to be visited.
- go back to the centre of the village and then count the houses until you reach the number that was given to you.
- weigh and measure all the children 6 - 59 months in that household.
- in small villages:- the second household you visit will be the one closest to the household you've visited when moving in a spiral clockwise direction.
- in large villages (1000-2000 people) visit every third household moving in spiral clockwise direction.
- in the last household you visit, measure all the children 6 - 59 months even if this means that you have 31 or 32 children in the cluster.

NOTE 1. Kwashiorkor children selected in the survey should be recorded on the reporting form as oedema, but their weight and height should not be measured.

NOTE 2. Malnourished children who were not randomly selected in the survey but are brought to you to look at, should not be included in the survey. Measure those children in the houses that you selected. You can advise the mother to visit the health centre/hospital.

NOTE 3. If the mother is away there is usually a guardian with the children and it should be possible to weigh and measure the children.

NOTE 4. Introduce yourselves to the village chief before starting the survey in a village and explain what you are doing.

NOTE 5. If a mother asks you "what problem you have found with the child?" then do the following:-

- If the child is healthy then explain that there is not problem and the child is healthy.
If the child is malnourished or sick then recommend that the mother takes the child to the health/nutrition clinic.
- If the child is severely malnourished and is marasmic or has kwashiorkor then recommend that the mother takes the child to the hospital. If you do not think that the mother will go to the hospital because it is a long way to travel then encourage her to at least visit the health centre

NOTE 6. In very small villages it may not be possible to find 30 children. If this happens go to the nearest village and using the same method to select the houses finish the survey there. On your recording form write down the names of both villages and indicate which children come from the neighbouring village.

NOTE 7. If children are absent from the house, but near by ask the mother to call the children. If the children are absent from the house and are a long distance away, then go the next door house.

NOTE 8. Measure all children who live/sleep inside one compound (fence)

NOTE 9. Do not measure day visitors to the house.

NOTE 10. If people ask what you are doing, explain that you are doing a nutrition status survey which will be used to assist in monitoring the drought. The houses that you are visiting have been selected using statistics. An appropriate sampling methodology has been drawn up and ICF/MSF (Holland) can provide full details on request. Their offices are in Dintyre.

The purpose of the survey is to alert government and donors of the situation in Chikwawa.

HAVE A GOOD WEEK. REMEMBER TO CHECK THE EQUIPMENT. ACCURACY IS VERY IMPORTANT.

ACTIVITIES:

- **Data collection**
 - total population of Chikwawa, listed per village, including urban centers and Sucoma estate.
 - Maps of the district (per TA)
- **transportation**
 - 2x vehicle IBF, 2x vehicle MSF-H, 1x vehicle SCF,
 - petrol: fill the tanks
 - first aid kits
- **human resources**
 - 1 x coordinator/nutritionist
 - 1 x nurse
 - 5 x driver
 - 4 x survey team: 4 of which one team leader
- **support of HSAs of the district of Chikwawa**
 - HSAs involved who are stationed in catchment area.
- **Acquisition of survey team equipment**
 - 4x salter scales (25kg) + spare(MSF-F)
 - 4x length boards (120cm)+ spare(MSF-F)
 - 110cm stick to identify children <110cm
 - 4x stones of 10/15kg for checking the scales
 - rope to hang the scale (3-5m)
 - 4x weighing pants/sack +spare(MSF-F)
 - stationary: record sheets, clip boards, pens+pencils
 - 4x calculators
 - recording forms (form to contain info of 30 children)
 - 4x baskets to carry the equipment
 - copies of NCHS tables in plastic covers
 - steel tapemeasures for checking the length board.
 - spare tapemeasures for length boards
 - food and drinks, coolboxes
 - teaching material (flip-over chart, etc)
 - computer, printer, copier
- **lodging BLT and in the field:**
 - Chikwawa, Gaga, Ngabu, Livundo, Nchalo
 - planning of daily contact

PLANNING OF SURVEY (Mo 3/8 - Sa 8/8)

TEAM I

Mo 3/8 Kavalo (Mr.Kapanda)
Njereza
lodge: CHIKWAWA

Tu 4/8 Changoima (Mr.Butao)
Zuze
lodge: GAGA

We 5/8 Kuwani (Mr.Butao)
Belton (Mr.Banda)
lodge: GAGA

Th 6/8 Akuncheu (Mr.Banda)
lodge: CHIKWAWA

Fr 7/8 Mandalino (Mr.Phiri)
Mangulenje
lodge: NCHALO

TEAM II

Mo 3/8 Khumbulani
Muyaya (Mr.Msaka)
lodge: LIVUNDO

Tu 4/8 Kamisale
Nthenda (Chiwanda)
lodge: LIVUNDO

We 5/8 MEUNDE (team)
lodge: NCHALO

Th 6/8 Chipakuza (Syampani)
Mangulenje
lodge: NCHALO

Fr 7/8 Sekani1 (Nyamizinga)
Sekani2
lodge: NCHALO

TEAM III

Mo 3/8 Ziloso (Mr.Kupeka)
lodge: NGABU

Tu 4/8 Chambuluka (Mr.Kupeka)
lodge: NGABU

We 5/8 Chipwaila (Mr.Bodza)
(Thomu)
lodge: NCHALO

Th 6/8 Masache 1 (Nyamizinga)
Masache 2
lodge: NCHALO

Fr 7/8 Masache ?
Thomu? (Nyamizinga)
lodge: NCHALO

TEAM IV

Mo 3/8 Makande (JoeFilisi)
Density Homes
lodge: NGABU

Tu 4/8 Nyakabobo
lodge: NGABU (JoeFilisi)

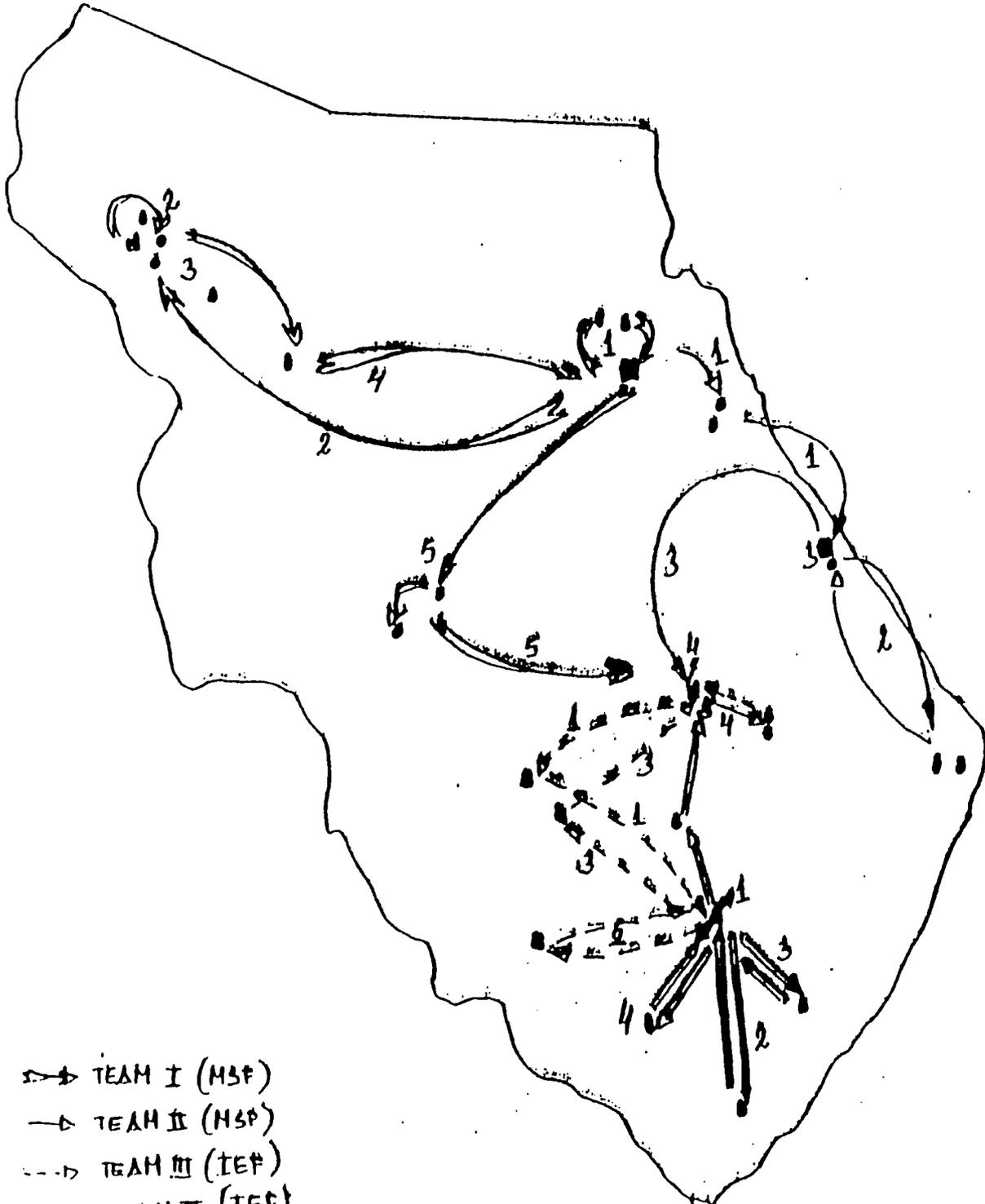
We 5/8 Ngombe
lodge: NGABU (Mr.J.Phiri)

Th 6/8 Nponya (Mr.Makassa)
lodge: NGABU

Fr 7/8 Malikopo (JoeFilisi)
lodge: NCHALO

** Names between brackets are USA's of the different areas.

PLANNING OF SURVEY CHIKWAWA DISTRICT 03-08 AUGUST



- ⇔ TEAM I (MSF)
- TEAM II (MSF)
- - - - - TEAM III (IEF)
- ⇔ TEAM IV (IEF)

1,2,3,4,5 DAYS

September 5, 1992
Susan Eastman

ISSUES PAPER
VITAMIN A, MALAWI, AND THE DROUGHT

The consultant was asked to examine the vitamin A activities in Malawi in relationship to the drought and the role of NGOs. This was at the invitation of the International Eye Foundation and the Drought Relief Coordination Unit, sponsored by Helen Keller International. The paper is submitted separately.

In assessing vitamin A intervention and the drought in Malawi, a number of issues arose. These will need to be resolved in order to achieve adequate implementation of the MOH's new protocol of vitamin A semi-annual supplementation throughout the country. The issues are not unique to drought conditions; the drought underscores the urgency of their resolution.

Finally, there is impressive support among key international, bilateral, governmental and non-governmental organizations to implement the policy. There is an awareness, however, that key decisions need to be made to finalize strategic intervention.

It is suggested that a meeting be convened (i.e., by UNICEF), with representatives from the Secretary for Health, UNDP, concerned bilaterals (i.e., USAID, CIDA), DRCU, 3 RHOs, and the International Eye Foundation to respond to the concerns which follow.

1. Rally points or Case management

The consultant recommends semi-annual distribution of the WHO-recommended capsule (200,000 IU) in campaign style, designating two months of the year when vitamin A supplementation will be highlighted. This recommendation is based on experience elsewhere, which showed that with community participation and targeted months, coverage could reach over 70%. In Malawi, the IEF demonstration project also demonstrated that rally points could result in 60% coverage (before follow-up, which eventually could result in 65-98% coverage). This involved using the HSAs and community volunteers.

Individual case management depends on the health provider determining whether or not to supplement on a case-to-case basis. This is appropriate in treatment (i.e., for measles, acute diarrhea, or xerophthalmia), but inefficient in a mass distribution program.

Since the rainy period is a special risk period for vitamin A deficiency, measles and diarrhea, it is suggested that the first campaign be targeted for October-November.

2. Vitamin A Supply

a) Quantity: UNICEF has recently ordered 1.5 million capsules; in addition to a July MOH regional/district distribution of 875,000. There are also reported pledges from AID and CIDA.

Recent calculations, based on the MOH memo from 29 June, allow for 823,500 capsules to be distributed throughout the country, excluding a central buffer stock of 51,500. The criteria for distribution appeared to be population size (citizens and refugees) per district. Hence if the district has 5% of the total population, it receives approximately 5% of the total available capsules to be distributed. (See attached 29 June 1992 memo).

This distribution took place before the official circular from the Secretary for Health (July 22, 1992) indicating vitamin A supplementation semi-annually throughout the country.

If the total citizen and refugee population is as calculated in the 29 June memo, at 10.74 million, an estimated 20% or approximately 2.15 million are under-five years of age. Reported pledges would cover at least one nationwide campaign, once the capsules are made available at the district level. (Note: This does not include the second targeted population, lactating women within two months of delivery, which could be an additional 8-10% of the population.)

b) Cost of Capsule: It is assumed that the capsule as part of the EPI/Vaccine Central Stores pipeline will be made available free to the general population. This issue has been brought up, with apparent regard to the mission hospitals and possible charges for medicines.

c) NGO access: The non-governmental organizations have access to vaccines, when supporting the national immunization program. It is assumed that they will also have access to the MOH vitamin A capsules at the district level. It has been suggested that they can individually procure supplies to serve as a buffer at the district level.

d) Prioritizing: If there are insufficient capsules or resources to implement a nationwide campaign, it is evident that the most seriously affected area is the Southern Region. This should be the first target.

3. Training

The WHO-recommended vitamin A capsule is safe. However, it is not to be confused with a regular or daily vitamin. Hence, some minimal training or orientation needs to be

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provided to the HSAs and volunteers. Equally, the MOH has directed that the vitamin A should be recorded on the Child Health Card, the mother's TTV card, and totaled on the MCH report forms along with vaccines.

Existing educational material in English includes:

--Government of Malawi, NUTRITION FACTS FOR MALAWIAN FAMILIES/1990. The vitamin A section is useful as a general reference. It does not include the latest directive on vitamin A supplementation.

--Government of Malawi, MOH/Nutrition Unit. EPI Feedback Newsletter: Special Edition. Vitamin A Deficiency: Highlights. (Just released). This is a very good explanation of vitamin A and the new protocol.

The International Eye Foundation includes vitamin A training material. Helen Keller International, WHO and Johns Hopkins University produced a colorful brochure in Chichewa (Find, Treat, Prevent or Mupeze, Muchiritse, Muteteze). These can be ordered through Helen Keller International, Attn: Ms. Anne Ralte, 15 West 16 Street, New York NY 10011, USA, Fax: 212/463-9341.

4. Refugee Population

In emergency relief conditions, the vitamin A supplementation protocol is modified for distribution more frequently: every three months. The vast majority of refugees have been settled in Malawi for a number of years. Their condition is thought not to be worse than the general population.

There are mixed reports on the health status of new refugee arrivals. At major reception centers, the vitamin A capsule is administered on arrival. This is recommended. Unless the situation deteriorates, it is recommended that the refugee population be on the same protocol as the general population. It should be noted that UNHCR in Zimbabwe has recommended dosing the new arrivals every three months up to at least age 12 years, following reports of significant measles mortality in the adolescent population.

If the condition of the refugee or the general population deteriorates dramatically, the MOH will need to consider altering its protocol to an emergency level, with distribution quarterly (or every three months).

5. Coordination

Many of the NGO representatives have expressed interest in supporting the vitamin A initiative. They will need to work

with the district health office to assure complementary outreach throughout the districts.

The DRCU has just released its first newsletter, which is most informative. Some NGO members report not receiving it yet. The distribution list should be comprehensive (including both Lilongwe and field NGO representatives), as well as the Regional Health Officers and District Health Officers.

6. NGO Funding

Significant funds are apparently available through the DRCU, with UNDP monies. There are complaints by the NGOs that the criteria and process have not been finalized. Proposals have been developed and are ready for submission (including vitamin A activities). There is also the issue of whether or not non-indigenous NGOs are eligible for support. It is recommended that criteria be immediately established, all registered NGOs be eligible for support, and the process be as simple and timely as possible.

7. Technical Assistance

A logical technical vitamin A resource is the International Eye Foundation, who oversaw a demonstration project in the Lower Shire Valley, and is currently assisting the government in its expansion. To take on additional responsibilities (such as providing necessary support for the NGOs), additional resources will be required: at minimum, one staff member, travel assistance, training materials. Suggestions include seeking authorization to modify their current program and budget; seeking subcontractual responsibility for Malawi from Helen Keller International pending its success in securing TA funds for the region; or submitting a separate proposal. Helen Keller International's Vitamin A Technical Assistance Program (VITAP) has provided consultants in the past to work with NGOs in developing vitamin A projects. VITAP is seeking additional funds from Washington to expand its mandate in view of the drought and emergency conditions in East and Southern Africa. At minimum, VITAP should be able to serve as the source for training materials.

SCOPE OF WORK

This consultancy will provide technical assistance in initiating a social marketing project to promote optimal breastfeeding and weaning practices in Malawi. In the interest of food security, improved infant nutrition and health, and child spacing benefits, the promotion of exclusive breastfeeding for six months will be a primary target of this effort. The purpose of this initial consultancy is to document current infant breastfeeding practices and related weaning practices, and to investigate the beliefs and attitudes surrounding those practices in order to provide information necessary to develop an effective communication strategy. Relevant information pertaining to potential target groups in addition to mothers -- husbands/partners, mothers and mothers-in-law, village leaders, etc. -- will also be gathered, as well as information on communication factors such as interpersonal networks, sources of influence, pictorial literacy, etc. Duration of the consultancy is 4-5 weeks.

Specifically, the consultancy will involve the following tasks:

- Review existing documentation on breastfeeding in Malawi
- Interview local experts who have familiarity with breastfeeding
- Select a sample of villages in which to work and population segments to target
- Determine appropriate methodology and construct associated instruments
- Conduct data collection, which includes, but is not limited to, the following topics:

BREASTFEEDING PRACTICES

Initiation: timing, use of colostrum, use of pre-lacteal feeds
Exclusivity: giving of water, ritual liquids or foods, age when foods and liquids introduced
Techniques: frequency of feeds (day and night), cues for initiating feeding, length of feeds, cues for terminating feeding, positioning, problems
Duration: weeks/months of breastfeeding, reason for termination, especially looking at effect of subsequent pregnancy

BREASTFEEDING KNOWLEDGE, ATTITUDES AND BELIEFS

--Knowledge of correct BF practice
--Knowledge about and attitudes toward colostrum
--Knowledge of milk supply as function of demand
--Knowledge of contraceptive effects of BF, and attitude whether positive or negative
--Perceived benefits
--Perceived problems
--Men's and grandmothers' knowledge of BF and their influence on mothers decisions

COMMUNICATION

--(Illiteracy is assumed)
--Communication networks, opinion leaders, credible information sources, and specifically credibility of village volunteers
--Oral communication traditions, including song, drama, storytelling
--Pictorial literacy

- Write report containing the following information:
 - Summary of BF practices and influences on those practices.
 - Identification of behaviors needing changing, factors that predispose, enable or reinforce each change, as well as factors presenting barriers to making those changes.
 - Identification of potential avenues of communication.

Title: Operational Research on Village Health Volunteers
in Malawi: Investigations of Key Issues

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Study period: July 1, 1992 - July 31, 1995

1. BACKGROUND

Village health volunteers (VHVs) form an integral part of community-based health programs developed and implemented by a number of non-governmental organizations (NGOs) and the Ministry of Health (MoH) in Malawi. The use of volunteers is not a new strategy; publications on teaching community health volunteers are available from the MoH. (1-2) It is unfortunate that there is a paucity of information in the existing literature on the utilization of volunteers for health promotion; this lack of research serves to minimize its importance. It also correctly implies that the role of the village health volunteer is not well understood. This has led to considerable disparity among different agencies in recruitment, support and supervision, working conditions, and hours for village health volunteers.

There is a sound public health policy established in Malawi although there are not enough trained people (or other resources) to teach, counsel, treat, and motivate the community to good health. It has been shown elsewhere that some form of community-based health worker can make primary health care services more accessible to everyone (3-4) although large-scale programs have met with great difficulties in implementation. (5-6) Rigorous evaluations of village health volunteer programs are few worldwide and have not been conducted in Malawi. Defining who these village health volunteers are in Malawi will help us identify some of the problems inherent in using non-paid community health workers.

2. HYPOTHESIS

Factors related to volunteer attrition and low activity are associated with expectations of future employment, esteem derived from the job, and support from a health project and community.

3. SPECIFIC AIMS

The multiplicity of often conflicting programs and the lack of Ministry of Health (MoH) policy indicates that there is a lack of reliable information on village health volunteers in Malawi. To assist the MoH develop policy operational research is needed to answer the following questions:

1. What is the true attrition rate for VHVs in different programs in Malawi?
2. What factors are associated with attrition or low activity in VHVs in Malawi?
3. How does a VHV's expectations of future employment affect performance, attrition, and status in the community?
4. What are the true costs (non-recurrent and recurrent) of a program that relies on VHVs?

5. Can communities (through the village health committee) have input into which duties VHVs are trained to do?
6. What is the minimum technical supervision necessary for supporting VHVs?

Answers to these questions, and others, would assist agencies and villagers in designing, implementing, and sustaining primary health care programs at the community level.

4. STUDY DESIGN AND METHODOLOGY

Study Population

Village health volunteers enrolled as part of International Eye Foundation's, Adventist Development and Relief Agency's, and Save the Children-UK's child survival grants will be the study population.

Methods

There will be two different methods used to research the questions listed. The first method will be quasi-structured interviews (including focus groups) with existing village health volunteers, village health committees, villagers, and representatives of different governmental and non-governmental agencies in Malawi. These interviews will assist in the development of the primary method -- a prospective study.

Sample Size

We anticipate enrolling a proportion (about 50%) of new volunteers in the three projects over a six month period (July to December 1992). Based on project plans this should include 200-300 volunteers.

Pilot Test & Quality Control

The enrollment interview form will be constructed during the interview stage. Pilot testing will be done and corrections made according to results. To ensure adequate quality control the investigators and interviewer will meet after enrollment of the first 50 new volunteers. Miss Chikweza will supervise the interviewer during the first series of enrollment interviews as well as subsequent follow-up interviews. The follow-up interview forms will combine items on the enrollment form plus additional items to assess attrition and performance.

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Data Collection

Data collection will cover three basic areas:

▶ **Predisposing characteristics of the volunteer**

These characteristics include items such as: age, sex, marital status, number of children, death of any child in the family, under-5 cards available for all children, membership in local organizations, and self-assessment of health (past success at changing behavior).

▶ **Structural characteristics of the village**

These characteristics include: size of the village, distance to health center, degree of village support/sponsorship, appreciation by villagers, perception of the role of VHV by the community, method of selection by community, and degree and type of preparation prior to (and after) selection.

▶ **Performance measures of the volunteer**

These measures include: attitude to worthiness of project, personal interest/commitment, supervision provided, satisfaction level, use of skills learned, administrative abilities, political abilities, professional abilities, and link with local health center staff, and agency-sponsored reward system.

At various times in the prospective study a number of volunteer supervisors in the IEF, ADRA, and Save the Children-UK programs will be instructed to increase (or decrease) the level of supervision they provide. Responses to these changes will be recorded and interpreted.

Data Entry & Analysis

All data will be collected in a structured fashion to facilitate data entry using an ASCII format. Cross-tabulations will be constructed to describe each group of study subjects: 1) those who have left the volunteer program, and 2) those remaining in the volunteer program. Results will be analyzed using logistic regression to determine the independent contribution of each of these characteristics.

Management

Quarterly meetings of co-investigators will be the primary format whereby decisions regarding the progress of the study will be taken. Overall responsibility for training and supervision of the interviewer will be done by Dr. Courtright, Mrs. Biggs-

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Jarrell and Ms. Reid. Field-based evaluation of the interviews will be the responsibility of Miss Chikweza. Both Miss Chikweza and Dr. Cuppen will be involved in the planning, implementation, and analysis of this study. Mr. John Barrows will provide additional support from the IEF headquarters in Bethesda, Maryland.

5. ASSESSMENT OF THE IMPORTANCE EXPECTED TO RESULT

We will conduct a prospective study of volunteers in a number of NGO sponsored programs to follow the experience of volunteers over the span of the projects. Results would help agencies better define their recruitment criteria, establish appropriate incentives, and maintain sufficient supervision and support, and provide information necessary for the MoH to develop policies regarding the use of village health volunteers.

6. TIME SCHEDULE

All three agencies will be conducting recruitment of village health volunteers through 1993. Initial interviews will be conducted by the same interviewer in all three areas. The follow up period will be for two years, ending December 1994. Data analysis will be on-going throughout the study period. Final reporting will be completed by July 1, 1995.

7. BUDGET

Costs include salary for the interviewers, secretarial services, and a percentage of the investigators time; data analysis; transportation expenses including vehicle rental, petrol, and a driver; and in-country travel expenses for a total of \$47,375. Research funds will be channeled through IEF headquarters in Bethesda, Maryland to the appropriate Malawian organization. The budget reflects costs over the entire study period. The bulk of the expenses will occur in the first year.

8. CURRICULUM VITAE

The co-principal investigators for this project will be Dr. Paul Courtright, Mrs. Bee Biggs-Jarrell, and Ms. Morag Reid. The co-investigators are Dr. Peter Cuppen, and Miss. Grace Chikweza. Curriculum vitae for the co-principal investigators are given as an appendix.

9. APPENDIX

Curriculum Vitae
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