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**SAVE THE CHILDREN  
MALAWI FIELD OFFICE  
CHILD SURVIVAL 5  
ANNUAL REPORT**

**Agency for International Development**

**Grant # AID-OTR-0500-A-9149**

**9/1/89-8/30/94**

**October 1992**

**Save the Children  
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Westport, Ct 06880**

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## TABLE OF CONTENTS

	<u>Page</u>
1. Results for the Year	1
2. Constraints, Unexpected Benefits and Lessons Learned	4
3. Changes Made in Project Design	6
4. Progress in Health Information Data Collection	7
5. Sustainability	9
6. Project Expenditures and Justification for Budget Changes	11

### APPENDICES

Appendix 1  
Child Survival Program Organogram

Appendix 2  
Job Descriptions

Appendix 3  
Summary of Health Coordinators Report

**VOLUNTEER VILLAGE HEALTH PROMOTERS & SUSTAINABILITY:  
MALAWI CHILD SURVIVAL 5 PROJECT  
1992 ANNUAL REPORT**

**1. RESULTS IN 1992**

**1.1. MAJOR RESULTS**

The project has intensified its training activities with the goal of handing over the project to the community. During the year, the program conducted refresher courses for volunteer Village Health Promoters (VHP) and Community Health Supervisors (CHSs) in both Impact Areas of Mkhota and Mbalachanda.

The project also undertook a training of Village Health Committee (VHC) members, government Community Development Assistants (CDAs) and Homecraft Leaders. Village Health Committees received training on sustaining health activities within the village including monitoring health needs of the community, disease surveillance, roles and responsibilities for community development and health. The training emphasized the role in sustaining Child Survival Program interventions.

Other major results include the increase of the number of new modern child spacing acceptors, which have been increased from 72 during the Mid-Term evaluation (August 1991) to 583 in September 1992. This has resulted because of intensified education and community motivation by our community based staff.

**1.2. CHANGE IN APPROACH TO INDIVIDUALS AT HIGHER RISK**

After the Mid-Term Evaluation findings and recommendations, the program intensified training families in nutrition and weaning, AIDS/STD education and Child Spacing. Pregnant women were encouraged to attend ante-natal clinics, nutrition education followed those children who were underweight or malnourished. Children with chronic diarrhoea were given ORS and their mothers trained in management and prevention of diarrhoea. Children with incomplete immunization coverage for age were followed up and encouraged to complete the immunization.

Specifically with HIV/AIDS education, an initiative to work with school-age children on the development of HIV/AIDS/STD drama groups has been started. These groups focus on peer education and awareness through traditional educational methods of drama and song. The

homecraft women's groups also teach others through drama and other non formal educational activities.

### **1.3. STAFFING**

Mrs. Ruth Manjolo joined the program in February 1992 as Health Project Supervisor in Mbalachanda and Mrs. Rose Kaulimbo was seconded from the Ministry of Health as Child Survival Coordinator in Mkhota.

\*Please see appendix 1 for Child Survival Organizational Chart and job descriptions.\*

### **1.4 CONTINUING EDUCATION**

Stanley Jere attended a Nutrition workshop in Embu, Kenya in November 1991, and also attended another one in Nairobi, Kenya - a Training for Facilitators course sponsored by AMREF (African Medical Research Foundation September - October 1992).

Stanley Jere attended a nutrition workshop in relation with the drought in Blantyre, Malawi. In addition, Mr. Jere attended a workshop on AIDS/HIV in Zomba, Malawi.

Mr. MacDonald Mtekama, the Health projects Supervisor for Mkhota Impact Area, attended another workshop in Blantyre, Malawi on nutritional monitoring and surveillance sponsored by Save the Children, UK.

### **1.5. TECHNICAL SUPPORT**

Dr. Loren Galvao, from Save the Children Headquarters Health Unit, visited the project in March 1992. During her visit she reviewed the status of CS 5 and provided recommendations. She also conducted a Lot Quality Assessment (LQA) survey in Mbalachanda Impact Area to verify the usefulness of the Health Information system records for the child survival program, and to determine whether sizable proportions of the population were enrolled. The study revealed that 12 out of 14 CHSs (Community Health Supervisors) met the goal of having 85% or more of the children U-5 with immunization cards, 13 out of 14 CHSs met the goal of having 85% or more of the immunizations updated on the rosters, that 7 out of 14 CHSs met the goal of having 85% or more of births, deaths, in-migration and out-migration updated on the rosters and that 5 out of 14 CHSs met the goal of 85% or more training in ORT. This information was used to conduct update training and to improve supervision of staff. As follow up on the LQA report, performance of individual CHSs was discussed with each of them and areas of major weakness were strengthened.

## **1.6. COMMUNITY PARTICIPATION**

There are 45 active Village Health Committees in the impact areas of Mbalachanda and Mkhota, (20 and 25 respectively). The Committees' role has been targeted at supporting volunteer Village Health Promoters in their tasks of family training. During the year, more than 70 committee members in Mkhota and 121 members in Mbalachanda have been trained in all child survival interventions including planning for future sustainability. The training of these Committees has taken place within the past 3 months and has served to re-activate Committees which before this time had no formal training. The training is part of the SCF effort to work towards greater sustainability at the village level. During refresher courses of village health promoters, Village Headmen/or Area Political leaders had in some cases been given the opportunity to open a workshop, as well as, attend.

Another large component of community participation has been the identification and training of Village Health Promoters, Community Leaders (including village headmen) and mothers. Currently, 342 Community Health Workers (including Community Health Supervisors and Village Health Promoters), 70 village leaders and 4,480 mothers have been trained in CS interventions with strong emphasis on AIDS/STD, Immunization, Child Spacing, Diarrhoea and Nutrition, weaning practices.

## **1.7. LINKAGES TO OTHER HEALTH AND DEVELOPMENT ACTIVITIES**

During the year, there has been an increased collaboration in all aspects of program interventions with government ministries such as the Ministry of Women and Children Affairs and Community Services. SC/US was the first NGO to have succeeded to receive a seconded nurse from the Ministry of Health. The link has moved the project initiatives towards more sustainability.

Project Coordinators attend quarterly meetings of American NGOs implementing health programs in the country. Such NGOs include: Project Hope, Adventist Development and Relief Agency (ADRA), International Eye Foundation and World Vision International (WVI). This forum is used as an exchange for program strategy successes and constraints.

As the seriousness of the drought began to be realized in late February, one of the first groups to act was the coordinating of AID CSP agencies. It was out of this group that the National Drought Relief Coordinating Unit (DRCU) for all NGOs in Malawi was

formed. SC/US played a key role in facilitating this process.

Given the severity of a national situation and donor limitations, SC/US accepted OFDA funding to work in the Mangochi District - one of the largest and hardest hit districts in the country, while not taking direct responsibility for the entire districts of Kasungu and Mzimba where current CS 5 activities are underway. Both GOM and Donors requested NGOs to take entire districts rather than pieces and SC accepted the worst hit of the 3 districts where it has programs. Systems and procedures developed in Mangochi are translated through CS 5 program personnel to those District Authorities and vice-versa.

SC/US continues to work with District Relief Committees in Kasungu and Mzimba. Current HIS monthly reports play an integral part in providing District Authorities with on the ground situation information to assist in strategic planning and personnel and resources are utilized to assist impact area with specific interventions. Most recently, with dramatic reduction in relief commodity in-flow to Malawi, National strategic planning has begun to flow more intensely on coordinated systems for the Drought & Impact monitoring and targeted assistance on the national level. SC/US is a major participant in planning and coordination. As this continues to develop, it is assumed that current Impact Area monitoring will be integrated into the National monitoring plan, strengthening both National strategy and current project sustainability.

There is a great opportunity for cross fertilization of approaches between Districts during this emergency; an obvious one would be to establish stronger links between the project and the District Health Office in Mangochi whom we are supporting in the set up of more effective health monitoring procedures.

## **2. CONSTRAINTS, UNEXPECTED BENEFITS AND LESSONS LEARNED**

### **2.1. CONSTRAINTS.**

The drought has been a major constraint in the country. Despite increased education motivation of families in proper nutrition, the number of malnutrition cases have continued to increase through the months. The same has been happening with diarrhoea, as safe sources of water have dried up and this has resulted in the community resorting to alternative or tradition sources of water.

The project tried to implement field cropping as a means of as an income generation activity to support

village health promoter incentive. Maize was planted in six villages and was looked after by the community. The harvest was very poor because of the drought. It is however looked at by the community as a good I.G.A. as it is a source of staple food, some of the 6 communities managed to get a reasonably good harvest in the circumstances.

In Mkhota impact area, CHSs and VHPs in the Malembo area will be involved in wet and dry supplementary feed distribution in collaboration with the MOH and Ministry of Women and Children Affairs and Community Services.

CHSs and VHPs will also help in targeting at risk groups in both impact areas.

CS 5 Program will circulate the community-based data and also the Health centers' data to the District Health Officers in relevant districts, the District Commissioner, and the District Drought Relief Committee. This data will help them in decision-making.

Coordination with other NGOs are already taking place and will continue in order to respond to the drought.

## **2.2. UNEXPECTED BENEFITS**

The secondment from the MOH of a nurse for our program lead to an increased collaboration with the MOH and a strengthening of our child spacing activities. There has been an increased dialogue with the MOH Center staff in the area by generating discussions on how they can improve participation in Child Survival activities, especially child spacing, AIDS education and nutrition/weaning procedures training. This collaboration estimated MOH officials' interest in the CS program and it can probably facilitate further secondment of MOH staff.

## **2.3. INSTITUTIONALIZATION OF LESSONS LEARNED**

The Drug Revolving Fund (DRF), which was instituted in Mbalachanda Impact area in 1989, has significantly increased the profile and acceptability of the our child survival project amongst families living in the rural areas. Villagers can be heard stating "the project (and availability of essential drugs) has made access to health care nearer to us". Save the Children is currently exploring how the DRF can best be sustained in the future. Community awareness of this potential has already begun through Village Health Committee training on how a village-based DRF can function. Discussions have already begun with the District Health Officer regarding the possible re-

stocking and monitoring of Village Health Promoters drugs supply by the District Health Officer.

From our Mid-term evaluation, it was found out that the project was weak in Child Spacing, AIDS and Weaning. During the year, there has been intensification of these by retraining the Village Health promoters and CHSS. Cooking demonstrations have also been used during training of nutrition and weaning. In collaboration with the MOH Nutrition Section, Office of the President Nutrition/Economic Planning Division Section we have been able to get Nutrition Facts Books which we use for retraining CHS/Promoters in Nutrition/Weaning.

### **3. CHANGES MADE IN PROJECT DESIGN.**

#### **3.1. CHANGE IN PERCEIVED HEALTH NEEDS.**

One of the major problems which has been identified in both project areas are the unprotected shallow wells. This has caused great concern among the rural population as water availability continues to be hindered because of the prolonged drought. This directly affects other interventions such as the reduction in cases and deaths due to diarrhoea. This was mainly noted through discussions with the community during the mid-term evaluation in September 1991.

Malnutrition cases have increased from 97 in July, 1992 to 205 in August, 1992 and 237 in September, 1992 (data from our HIS). In late May, 1992, by analyzing data from our HIS, a Measles outbreak was recognized in Khongoni area of Mkhota I.A. and Kamb'anga area of Mbalachanda I.A..

#### **3.2. CHANGE IN PROJECT OBJECTIVES**

There have not been changes in measurable objectives since the submission of the detailed implementation plan and the First Annual Report.

#### **3.3. CHANGE IN PLANNED INTERVENTIONS**

As the project is looking towards greater sustainability and future phase-over, Community Health Supervisors are slowly being phased-out and supervision of Village Health Promoters is now being turned over to the Communal Health Committees and the Government Community Development Assistants and Health Assistants. There has been a reduction in the number of growth monitoring stations as it was felt to be more effective and encouraging to mothers to have these sessions

combined with regular vaccination sessions. Mothers would therefore have all the service at once.

### **3.4. CHANGE IN POTENTIAL BENEFICIARIES.**

There has been a reduction in the population served in the Mkhota Impact Area, as has been recommended by the Mid-Term Evaluation. The original target population of 32,000 people was expanded to 110,000 at the beginning of the current grant. The Evaluation Team felt that a smaller target population would be much more conducive to achieving impact and working towards sustainability. The project is now working with a target population of approximately 80,000 individuals.

## **4. PROGRESS IN HEALTH INFORMATION DATA COLLECTION.**

### **4.1. CHARACTERISTICS OF THE HEALTH INFORMATION SYSTEM.**

4.1.1 Our health information system includes reports on health indicators from the village, and these include; deaths reports, pregnancy report, migration report (in and out), birth report and disease surveillance reports. The number of families trained and number of children immunized and growth monitored are registered on U-5 rosters maintained by Village Health Promoters. Pregnant women are follow-up through pregnancy and birth report.

4.1.2. The system is useful in directing services to pregnant women by encouraging them to attend ANC. The system allows for follow-up of children who do not receive immunization and for mothers of underweight children to be encouraged in appropriate nutrition and weaning practices.

The project has made changes in the health information system. This year to improve the quality of data and also the simplicity of data collection new forms are currently being field tested (see Appendix 3)

4.1.3. This project does not report on clinical activities.

4.1.4. The number of active village health promoters is monitored by monthly report submitted by Community Health Supervisors to the Impact Area Health Coordinators. Those who fail to submit project reports are followed up by Project Supervisor and Health Information Clerk.

### **4.2. Special Capacities of the Health Information System**

4.2.1 Health Information System is not currently developed to monitor scheduled clinic sessions.

- 4.2.2. The project monitors the number of active community health promoters through the monthly Community Health Supervisors reporting form. The form is currently in a new stage of re-structuring for more effective data collection.
- 4.2.3. The project promotes disease surveillance of leading communicable and preventable illness in the community through the activities of the Village Health Promoter and awareness of families. Community Health Promoters are encouraged to report outbreak/cases of preventable diseases to the nearest MOH Health authorities, as well as, SCF Health Supervisors.
- 4.2.4. The project monitors all training activities of Village Health Promoters through training reports submitted on all activities.
- 4.2.5. The most difficult data to collect has been the "in" and "out-migration". Although we emphasized training on this aspect of the HIS, the promoters find it difficult to define who is migrating and what is the importance of this type of data.

#### **MANAGEMENT OF THE HEALTH INFORMATION SYSTEM.**

- 4.3.1. The health information system has taken 5% of our program expenditures for the year, since October 1991. This has included procurement of stationery items such as pencils, pens and paper. Other costs incurred has been the cost of transport (fuel) to deliver and collect reports from the field workers; and also the costs incurred for Training workshops in HIS.
- 4.3.2. The project reviewed the Health information system in Sept 1991 during the mid-term evaluation and also in March 1992 during the Lot Quality Assessment. From the mid-term evaluation it was suggested that the target population for the Mkhota Impact area be reduced in order to work towards greater sustainability. From results gathered from families on knowledge and practice it was suggested that more focus be placed on training for proper weaning, child spacing and HIV/AIDS education. The project has in the past year focused on these interventions with training activities for families, Village Health Promoters, Community Health Supervisors and community leaders. As a result of the mid-term evaluation re-cycling training and planning steps have been initiated to move the project closer to a sustainable outcome. The Drug Revolving Fund progressive transfer to community leadership and the phase-out of Community Health Supervisors are examples of steps taken.

In March 1992, the project gained a greater appreciation for the strengths and accuracy of the Health Information System from the LQA. The project has been able to target those Village Health Promoters in need of follow-up training and closer supervision, as well as, encourage those Promoters who were effectively functioning. In addition, the project has continued to develop HIS forms for improved utilization.

- 4.3.3. Child Survival Coordinators meet on an ongoing base to provide feedback to Village Health Promoters. Community Health Supervisors meet on a quarterly basis to provide feedback to community leaders, village headmen and Village Health Committees. These meetings took place in July 1992 for both Mkhota and Mbalachanda Impact areas. Child Survival Coordinators are members of the District Technical PHC Subcommittee which meets with District Health and other sectoral Officials on a monthly basis and, at times, bi-monthly basis for discussing District PHC multisectoral strategies.

A preliminary workshop on sharing the HIS of the MOH and SC/US was conducted in June, 1991 where all data collection tools from SC/US and MOH was discussed and compared. This workshop brought MOH participants from District, Regional and National levels. A follow-up workshop is planned for November, 1992.

- 4.3.4. Volunteer Village Health Promoters collect village based health data. Community Health Supervisor, who looks after 6-8 VHPs consolidate the data from her/his VHPs, i.e for her area and send a report to the Impact area Coordinator. Reports from Coordinators from two impact areas are finally summarized by the Health Program Administrator and Health Projects Support Officer. On impact area level, the Health Information Clerk summarizes the data ready for community feedback.
- 4.3.5. In view of the new reporting forms, the program has already held one session and is planning to hold a follow up training session to all those who are involved in reporting in order to improve the quality of data collected.

## **5. SUSTAINABILITY**

### **5.1. RECURRENT COSTS**

- 5.1.1 The specific recurrent costs which will continue after AID Child Survival program funding end is the village drug revolving fund, volunteer Village Health Promoter incentive and supervision, and the Health

Information System. In order to get the above activities sufficiently operational after the end of the funding, an estimated amount of US \$2000 would be required annually due to rising costs and inflation.

- 5.1.2 It is felt that the need for accessible, essential drugs is substantial within the communities where SCF works. Through preliminary discussions with community members it appears that the community will be willing to pay for and support a village-based drug revolving fund. Preliminary discussions with the District Medical Officer indicate that the District may be able to provide the ongoing support for such a program. The cost of the Community Health Supervisors will unlikely be continued and the project is now phasing out this level of supervision by increasing village health committee responsibility.

The majority of HIS system costs will most likely not be supported by the MOH; they felt that the SC HIS has excessive data collection tools. On the other hand, the MOH staff suggested that some community-based data collection forms could be merged with SC's. Further discussions on the possibility that the MOH may pick some costs related to the HIS will take place in the MOH/SC HIS workshop in November, 1992. The project is also exploring which aspects may be sustained at the village level by profits from the Drug Revolving Fund and field cropping such as maize or beans.

## **5.2. STRATEGIES FOR INCREASING POST-PROJECT SUSTAINABILITY**

- 5.2.1 The project has made noteworthy steps towards a sustainable program. Sixty-eight Community Health Supervisors, which are project's employees at village level, were trained using Ministry of Health training syllabus for Health Surveillance Assistants, making them qualified to be employed by Ministry of health as similar positions become available or any other organization seeking the services of trained Surveillance Assistants.

The Drug Revolving Fund (DRF), which appears to be meeting a felt need in the villages, has made considerable profits which could be used to sustain volunteer village health promoter incentive. The VHPs are currently being given 4 tablets of soap per month. However, the MTE found out that the VHP appear to be more motivated by the opportunities to receive training, help the communities and be recognized by their communities than the soap incentive. This has been proved by the fact that the promoters have sometimes not received the soap for several months but they do not stop doing their work.

Health Information System: refer to 5.1.2.

5.2.2. The project has, during the year tried to reduce CHS-VHP supervision by not replacing CHS who dropped out, and also by increasing and intensifying VHP training in all Child Survival Interventions. There has also been intensification of training of Village Health Committee members, government Community development assistants and Home craft workers as these will play a major role in supporting VHP activity when the project ends.

### **5.3. COST RECOVERY**

5.3.1 The only cost recovery that the CS programme is engaged in is the Drug Revolving Fund (DRF) and maize growing. The cumulative amount was US \$4230. The money is being used to buy more essential drugs and fertilizer and seed for field crops. Only if there is a balance, it can be used to buy simple incentives for promoters.

5.3.2. The communities are very enthusiastic with such activities and ask for even more than what the project can offer within the limitations of the project objectives. As far as service delivery is concerned, villages which have not generated enough money due to either mismanagement or poor management, e.g Drug Revolving Fund, compete with other villages who manage theirs well. However, this does not create inequities in service delivery.

5.3.3 The project extended the training in management and accountability for essential drugs and income generation. This training included basic skills on bookkeeping/storekeeping and it was organized for senior members of the Village Health Committee such as the Chairman, Secretary and Treasurer in Mbalachanda.

## **6. PROJECT EXPENDITURES AND JUSTIFICATION FOR BUDGET CHANGES.**

6.1 Pipeline Analysis  
Attached.

6.2 Justification of Budget Changes  
The no-cost extension for Malawi CS 5 was approved by U.S.A.I.D. in April, 1992.

7. 1992/1993 Work Schedule and Budget  
The Work plan is attached. The fiscal year budget can be seen as the balance remaining in the pipeline analysis.

CHILD SURVIVAL V: MALAWI

BUDGET VS. ACTUALS FOR YEAR 3 AND TOTAL EXPENSES TO DATE VS. TOTAL GRANT

	YEAR 3: EXPENSES VS. PLANNED BUDGET *						PLANNED RUBET YEAR 4****	PLANNED RUBET YEAR 5	LIFE OF GRANT: CUMULATIVE EXPENSES VS. TOTAL GRANT *				
	EXPENSES YEAR 1	EXPENSES YEAR 2	EXPENSES 07/31/92	PLANNED RUBET **	BALANCE	% EXPENDED			CUMULATIVE ACTUALS	TOTAL PLANNED BUDGET****	% OF TOTAL GRANT SPENT		
												BALANCE	% OF TOTAL GRANT SPENT
<u>Procurement</u>													
Supplies***	17,158.84	31,700.86	19,410.32	28,886.39	9,476.07	67.21	10,600.00	0.00	68,270.02	88,346.09	20,076.07	77.31	
Assets***	0.00	23,723.85	603.83	0.00	(603.83)		0.00	0.00	24,327.68	23,723.85	(603.83)	102.51	
Consultants	1,473.54	595.07	(1,374.93)	5,730.00	7,104.93	-24.01	0.00	0.00	693.68	7,798.61	7,104.93	8.92	
Sub-Total:	18,632.38	56,019.78	18,639.22	34,616.39	15,977.17	53.81	10,600.00	0.00	93,291.38	119,868.55	26,577.17	77.81	
Evaluation	344.33	0.00	1,300.67	0.00	(1,300.67)		11,300.00	0.00	1,645.00	11,644.33	9,999.33	14.11	
<u>Other Program Costs</u>													
Personnel	34,098.63	50,211.97	41,987.17	61,397.00	19,409.83	68.41	46,066.00	0.00	126,297.77	191,773.60	65,475.83	65.91	
Travel	12,638.47	12,099.91	23,272.40	25,500.00	2,227.60	91.31	17,400.00	0.00	48,010.78	67,638.38	19,627.60	71.01	
Other	35,032.85	35,393.29	18,161.52	18,316.00	154.48	99.21	14,640.00	0.00	88,587.66	103,382.14	14,794.48	85.71	
Sub-Total:	81,769.95	97,705.17	83,421.09	105,213.00	21,791.91	79.31	78,106.00	0.00	262,896.21	362,794.12	99,897.91	72.51	
TOTAL	100,746.66	153,724.95	103,360.98	139,829.39	36,468.41	73.91	100,006.00	0.00	357,832.59	494,307.00	136,474.41	72.41	

\* Final Field Office, Home Office expenses, and Overhead through: 07/31/92  
 \*\* Year 3 has balances from Year 2. LDG Revised Budget approved 4/28/92.  
 \*\*\* Assets are individual items \$500 and over. Supplies are individually under \$500 per item.

Year 1 = Sept. 1, 1989 - Aug. 31, 1990  
 Year 2 = Sept. 1, 1990 - Aug. 31, 1991  
 Year 3 = Sept. 1, 1991 - Aug. 31, 1992  
 Year 4 = Sept. 1, 1992 - Aug. 31, 1993  
 Year 5 = Sept. 1, 1993 - Aug. 31, 1994

**MALAWI CS5 ANNUAL WORKPLAN FY 93**

<b>ACTIVITY</b>	<b>Nov.</b>	<b>Dec.</b>	<b>Jan.</b>	<b>Feb.</b>	<b>Mar.</b>	<b>Apr.</b>	<b>May</b>	<b>June</b>	<b>July</b>	<b>Aug.</b>
Develop tasks for Village Health Committees	X									
Joint SC/MOH HIS Workshop	X				X			X		
Develop Roles for CDA/HCW		X								
HIV/AIDS Workshop Primary School Teachers			X				X			
Refresher Course CHS/HSAs			X					X		
Extend Village Drama Groups		X		X		X		X		
Refresher Training VH Committee			X		X		X		X	
Refresher Training VH Promoters				X		X			X	
Refresher Training CDAs/HCW			X				X			
Training Needs Assessment		XXXX								
Field Supervision of CHS/VHPs		X X	XX	XX	XX	XX	XX	XX	X	
SCF/MOH/WC & MCS Meetings			X		X		X		X	
Phase-over refresher courses for Committee Leaders				X		X		X		
Final Program Evaluation									? X	X
Monthly/Bimonthly Program Reviews		X	X	X	X	X	X	X	X	

SAVE THE CHILDREN/USA MALAWI FIELD OFFICE.

CHILD SURVIVAL PROGRAM ORGANOGRAM

FOD (FIELD OFFICE DIRECTOR)

AFOD (ASSISTANT FIELD OFFICE DIRECTOR)

HPA (HEALTH PROGRAM ADMINISTRATOR)

HPSO (HEALTH PROGRAM SUPPORT OFFICER)

MBALACHANDA IMPACT AREA  
PROGRAM MANAGER

MKHOTA IMPACT AREA PROGRAM  
MANAGER

CHILD SURVIVAL COORDINATOR

CHILD SURVIVAL COORDINATOR

HPS (HEALTH PROJECT SUPERVISOR)

HPS (HEALTH PROJECT SUPERVISOR)

HIC  
(HEALTH INFORMATION CLERK)      SECRETARY      DRIVER

DRIVER      HIC      SECRETARY

CHS/HSAs

CHS/HSAs

AT VILLAGE LEVEL

NOT EMPLOYEES OF SCF

MBALACHANDA  
146 VVHPs- Volunteer Village Health Promoters  
VHC - Village Health Committee

MKHOTA  
154 VVHPs  
VHC

Current for 1992

14

SAVE THE CHILDREN (U.S.) MALAWI FIELD OFFICE  
JOB DESCRIPTION REFERENCE: JBD1204

**TITLE:** HEALTH PROJECTS ADMINISTATOR

**IMMEDIATE SUPERVISOR:** The Health Programme Administator reports directly to the Assistant Director for Program (ADP) or other designated head of program for the geographical area in which their projects operate.

**GENERAL DESCRIPTION:** The Health Programme Administrator is responsible for the over-all coordination and ultimate success of all Health projects under their supervision. This person will work in close coordination with the Program Managers who are responsible for the daily support and supervision of health programs within their geographical regions to ensure that they are able to maintain daily operations. General responsibilities include routine program planning and development, staff training, budget monitoring and over-site, and general supervision and maintenance of the quality of health program operations.

**CLASSIFICATION:** Grade 12

**ROUTINE RESPONSIBILITIES:**

1. **PROGRAM DEVELOPMENT AND PLANNING:** Coordinate timely preparation of all annual program and project implementation plans and budgets, including development of annual program planning and budgeting components routinely required by the agency, development and planning of new initiative, writing of proposals, and programme organizational development initiatives.
2. **MAINTENANCE OF POLICY:** Ensure maintenance of all established policy and procedure, both as pertaining to the agency in general and the field office programme specifically. Assist FOD or ADP in development of new policy as required and ensure all legal requirements per the Government of Malawi are met and followed.

**STAFF SUPERVISION:** Supervise and regularly coordinate activities of all personnel and operational units, including implementation of routine evaluations; ensure that personnel guidelines for conduct are maintained and that all personnel receive the full measure of their dues per policy and the legal requirements of the Government of Malawi.

4. **STAFF DEVELOPMENT:** Ensure that all personnel are able to meet the full measure of their specified responsibilities to the highest degree possible. Prepare regular annual staff development plans and implement training as needed in coordination with the FOD or ADP.

5. MAINTENANCE OF ASSETS AND PROPERTY: Ensure full accountability and protection of all assets within programs including funds, equipment, and property. Ensure that established standards of accounting and financial control are maintained at all levels of operation and that inventories are maintained in up-to-date and correct order at all times. Ensure that all program properties are kept organized, neat, and clean at all times, and that all equipment and assets are maintained to the highest order.
6. EXTERNAL LIAISON AND REPRESENTATION: Liaise regularly with local funders, government coordinating bodies, local agencies, and persons necessary for the support and development of program in coordination with FOD or ADP. Act as local representative for the Country Program and Agency where necessary.
7. MAINTENANCE OF QUALITY OF PROGRAMMING: Maintain all aspects of program to the highest levels of quality possible, both as dictated through established policy and to the ability of the agency and personnel.

REPORTING RESPONSIBILITIES:

1. PROJECT AND GRANT REPORTING: Coordinate, supervise, and ensure completion of all required project, program and fund reporting by required deadlines.
2. ROUTINE MONTHLY PROJECT REPORTING: Ensure the establishment and maintenance of routine monthly internal reporting systems. Ensure receipt by established deadlines, and provide training and development for improvement where necessary.
3. INTERNAL MONITORING: Establish and maintain all and any internal monitoring systems of projects and operations as required to ensure sustained performance and quality.
4. ROUTINE MONTHLY PROGRAM REPORTING: Prepare and coordinate completion of required monthly reports on all required aspects of program by established reporting dates. Prepare routine monthly reports for the Field Office Director on all aspects and issues under supervision.

I have read or had read to me all points noted above, I understand them, and considering myself qualified, agree to perform these tasks to the fullest measure of my ability.

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16

SAVE THE CHILDREN (U.S.) MALAWI FIELD OFFICE  
JOB DESCRIPTION REFERENCE: JED1103

- TITLE:** CHILD SURVIVAL PROJECTS SUPPORT OFFICER
- IMMEDIATE SUPERVISOR:** The Projects Support Officer reports to the Health Programme Administrator and in close coordination with the Assistant Director for Program.
- GENERAL DESCRIPTION:** The Health Projects Support Officer serves as the headquarters liaison person between the Child Survival program and its Administrator, and the other departments of the field office and local government. This person is additionally responsible, after consultation with the Programme Administrator, for preparation of regular reports and study papers, data compilation, proposal writing, and general backup support for all facets of Child survival program operations.
- CLASSIFICATION:** Grade 11
- ROUTINE RESPONSIBILITIES:**
1. **ACT AS LIAISON:** Represent the Health section in the absence of the administrator in all FO functions and meetings. As directed by the Programme Administrator, represent the agency and programme at governmental and inter-agency meetings.
  2. **PROVIDE COMMUNICATIONS SUPPORT:** Maintain appropriate and timely communications between the main office and the Administrator when that person is in the field. With prior consultation of Programme Administrator and in accordance with established protocol and procedures, relay and maintain communications between programme and agency Home Office Health department and funders on programme related matters.  
  
**PREPARE PROPOSALS:** Assist in research, preparation, and assembly of programme proposals and requests as directed by the Programme Administrator or AFOD. Maintain momentum through routine communications, as directed by and in coordination with the Programme Administrator, with prospective funders on progress and development of pending proposals.
  4. **PROVIDE MONITORING SUPPORT:** Maintain, and coordinate appropriate monitoring activities on all aspects of programme operations as directed by the Programme Administrator. Provide timely feedback on any perceived trends or patterns, and provide appropriate responses as the situation may demand.
  5. **PROVIDE OPERATIONAL BACKUP:** Provide support to Programme field activities as needed. Coordinate and relay requests between the various programme units, and provide timely feedback to administrator on issues of need as they arise.

11

6. PREPARE RESEARCH MATERIALS AND ARTICLE DEVELOPMENT: Prepare any research materials as directed by the Programme Administrator or AFOD. Develop articles for publication or reporting to donors as directed, and provide directed research as directed to assist in improvement of programme outputs
7. PROVIDE GENERAL SUPPORT AND ASSISTANCE: Provide general support and assistance as called upon to strengthen not only the health sector, but inter-sectoral cooperation. Provide backup to other sector units as requested by the AFOD or FOD when these do not interfere with the first priority of health programme assistance.

**REPORTING RESPONSIBILITIES:**

1. ASSIGNMENTS AND REPORTS: Ensure that assigned assignments are acted on promptly and deadlines met. Maintain up-to-date records on any assets assigned to Health Administrative unit and report any loss or damage immediately.
2. REPORTS ON WORKSHOPS/MEETINGS: Attend and maintain notes as directed on any meetings/workshops as directed by the Programme Administrator or when acting as representative. Prepare and submit reports on any meetings attended in the Administrator's absence.
3. PROJECT FIELD REPORTS: Receive from IA monthly reports, sort, organize, and prepare for submission to the Administrator, all IA monthly progress reports. Similarly, receive, sort and provide to Administrator any reports received from the MOH, Home Office, or related agencies and ensure timely response and action as necessary to meet requested deadlines.
1. DISTRIBUTION OF AGENCY MATERIALS: Ensure appropriate distribution both internally and externally of any written reports or other materials as related to the support and development of the Agency Health Programme. Likewise, ensure the appropriate filing, storage and confidentiality of any classified materials, and ensure that distribution of any materials outside the agency is done with the prior approval of the Programme Administrator, AFOD, or FOD as necessary.

I have read or had read to me all points noted above, I understand them, and considering myself qualified, agree to perform these tasks to the fullest measure of my ability.

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18

SAVE THE CHILDREN (U.S.) MALAWI FIELD OFFICE  
 JOB DESCRIPTION REFERENCE: JBD1102

**TITLE:** HEALTH PROGRAM COORDINATOR

**IMMEDIATE SUPERVISOR:** The Health Program Coordinator (HPC) reports to the Program Manager on general administrative and daily logistical coordination matters, but is professionally responsible to the Programme Administrator for the quality of Health Program activities in their respective area.

**GENERAL DESCRIPTION:** The HPC is responsible, in consultation with the Program Manager and professional guidance by the Programme Administrator, for implementation and supervision of all facets of Health Program activities within their given geographical area. This includes the routine planning and coordination of all Health Program activities, supervision and training of staff, liaison with community, MOH, and other NGOs, coordination and planning of community training activities, and maintenance and supervision of all data collection and reporting activities.

**CLASSIFICATION:** Grade 11

**ROUTINE RESPONSIBILITIES:**

1. **PLANNING AND COORDINATION OF HEALTH ACTIVITIES:** Take responsibility for planning and timing of all health activities in the Impact Area in coordination with the Programme Manager. Discuss and coordinate strategies with the Programme Administrator in order to follow MOH policies in health delivery. Ensure constant liaison and coordination with MOH and other NGO health centers and programmes.
2. **PROVIDE DAILY SUPERVISION:** Provide constant supervision of Community Health Supervisors/HSAs and all other health program staff within Impact Area. Supervise and assist in training of VHPs and conduct routine visits to such. Activate Village Health Committees in collaboration with Community Development Assistants (CDAs). Check on the operations of Drug revolving funds and provide timely feedback to Programme Administrator and Impact Area Programme Manager.
3. **ORGANIZATION OF TRAINING ACTIVITIES:** Be responsible for organizing training activities according to the intervention in collaboration with the IA Programme Manager and prior consultation with Programme Administrator. Prepare appropriate plans and budgets, including broad and specific objectives of trainings, training tools for evaluation, and any other instruments for approval of the Programme Administrator prior to implementation.
4. **SUPERVISE DATA COLLECTION:** Be responsible for supervising the collection, computation, and timely completion and submission of

project data reports from CHS/HSAs. Ensure that data meets established standards and can be used as an instrument for monitoring project activities and fulfilment of objectives.

5. PROVIDE TIMELY FEEDBACK: Provide feedback to Program Manager of administrative and logistical problems within impact area and assist in appropriate resolution. Provide feedback to Programme Administrator on health status of the programme within the impact area. Based on the epidemiological information through the analysis of data, provide feedback to the community and assist them in find appropriate solutions to addressing problems.
6. MAINTAIN STATIC AND OUTREACH ACTIVITIES: Participate in the organization and operation of static and outreach project activities in order to be up to date with field activities as well as providing on-the-spot training to CHSS and VHPs.

**REPORTING RESPONSIBILITIES:**

1. MONTHLY ACTIVITY AND PROGRESS REPORTS: Ensure that monthly activity reports from CHS/HSAs are compiled and submitted promptly by established deadlines. Check and ensure accuracy, consistency, and realism of data provided. Ensure that copies of monthly reports are submitted to other local authorities as directed.
2. PREPARE PERFORMANCE REPORTS: Submit, through the Program Manager, to the Program Administrator, performance reports of all other Health personnel under their supervision. Provide recommendation for staff development and training needs as identified, and maintain discipline within project staff and ensure that established agency policy is maintained and enforced at all times.
3. ROUTINE BRIEFING REPORTS: Provide routine briefs to Programme Administrator on all aspects of project operations and the status of field activities. Hold routine planning and coordination meetings with other project personnel.
4. AGENCY REPORTS: Ensure that all confidential health related materials written or otherwise are not distributed to any organization without prior approval by the Program Administrator. Seek guidance in times of doubt.

I have read or had read to me all points noted above, I understand them, and considering myself qualified, agree to perform these tasks to the fullest measure of my ability.

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**SUMMARY OF COORDINATORS REPORT**

MONTH		LOCATION	
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**1. NUMBERS OF DEATHS**

	0-11 MONTHS		5-14 YRS		12-59 MONTHS		12-59 MONTHS		ABOVE 15 YEAR
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**2. CAUSES OF DEATHS:**

	MALNUTRITION		ARI		MALARIA		MATERNAL		OTHER
	DIARRHOEA		T.B.		STD		NEONATAL		NOT SURE

**3. PREGNANCIES**

	NUMBER OF PREGNANCIES REPORTED
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**4. BIRTHS:**

	NO. OF CHILDREN BORN ALIVE		ALL OTHER BIRTHS
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**5. MIGRATIONS**

	IN-MIGRATIONS		OUT-MIGRATIONS
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**6. DISEASE SURVEILLANCE**

	MALARIA		STD		DIARRHOEA		WHOOPING COUGH		PNEUMONIA		EYE DISEASE
	MALNUTRITION		ANAEMIA		TETANUS		HYPER-TENSION		MEASLES		OTHER NOT/SURE

**6. IMMUNISATIONS**

	COMPLETED 0-11 MONTHS		COMPLETED 12-59 MONTHS		CHILDREN BELOW 9 MONTHS		NOT COMPLETED
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**7. CHILD SPACING:**

	NEW ACCEPTORS		CONDOMS DISTRIBUTED		NUMBER OF FAMILIES TRAINED
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NAME OF REPORTER: \_\_\_\_\_ DATE : \_\_\_\_\_

21