PD-ABF-957
82492

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

Detailed Implementation Plan

Cooperative Agreement # PDC-0284-A-00-1123-00

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Section A. DIP Country Project Summary Table

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Section B. Location and Formal Agreements

B.1 The project is located in the Lower Shire Valley (LSV) of Malawi, a rural area comprising the two southern region districts of Chikwawa and Nsange. The project will extend work from the previous 45 villages to the entire district of Chikwawa which is composed of 370,790 people and 475 villages and several small trading centers. The project will also work with the Adventist Development and Relief Agency (ADRA) providing vitamin A technical assistance for their child survival project in the northern half of Nsange district.[1]

In this new project IEF will identify project villages as those that comprise the "catchment" areas of the district's eleven fully staffed primary health centers. The initial group of three health centers and their corresponding villages (153) selected by the IEF and the Ministry of Health to receive interventions are Chipwaila, Dolo, and Makhwira. Additional health centers (8) and their "catchment populations" will be phased into the program during the first, second, and third years of operation. The Chikwawa District health centers are listed in Appendix #1. See the map of the project area on the following page.

B.2 The Lower Shire Valley was chosen because of its dense population, high rate of infant and child mortality (IMR 157/1000), and chronic malnutrition. A survey conducted in 1983 found that 22.3% of the under five population were stunted (<90% HA); 2.8% showed signs of severe wasting (<80% WH). Ocular signs of vitamin A deficiency were reported to be 4% among the under six population indicating a rate 5-10 times higher than the WHO criteria for identifying a problem of public health significance. Chronic malnutrition-related health problems are exacerbated by the severe water shortages in the LSV which contributes to diarrheal diseases. HIV infection in rural areas threaten gains made in child survival.

These problems have been worsened by the integration in the villages and refugee camps of 800,000+ displaced persons from Mozambique over the past four years, increasing land pressure and adding to the already heavy health burden. Most recently the drought affecting the nations of southern Africa, considered the worst in a century, has eliminated 98% of the 1992 LSV maize crop. Emergency food distribution operations are planned for the area but have been hampered by a late response, lack of government plans, and a shortage of funding.

Village Health Committees have potential for extending health care services in rural areas. However, many of the village health committees formed in the 70's and 80's are chronically inactive due to infrequent follow-up and support. The previous IEF CSV project worked with village health committees with varying success. The current project will require considerable time reorganizing existing village health committees or forming and supporting new village health committees where they do not exist.

[1] This project is based upon the previous Vitamin A and Nutrition Project. See final evaluation of Cooperative Agreement No. ORT-0500-A-00-9159-00.

SVII DIP TABLE A: COUNTRY PROJECT SUMMARY

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O/Country Malawi

SIZE OF THE POTENTIAL BENEFICIARY POPULATION AND INTERVENTIONS

e: POTENTIAL BENEFICIARIES is defined as the total population in the project area who are eligible to receive services for a given age group, the percent you expect to provide services to – which may be smaller than the eligible population.

1. AGE GROUP	2. POPULATION OF PROJECT AREA (a) Total	(b) Female	(c) Male	3. POTENTIAL BENEFICIARIES* (if different from POPULATION, explain in narrative) (d) Total	(e) Female	(f) Male	4. INTERVENTIONS (age groups covered) (h) Code** for which interventions apply
) 0–11 months	14,188	7,132	7,056	14,188	7,132	7,056	O,I,NB,NW,NV
12–23 months	12,577	6,321	6,256	12,577	6,321	6,256	O,I,NV
) 24–59 months	37,732	18,964	18,768	37,732	18,964	18,768	O,NV
60–71 months	12,713	6,407	6,306	12,713	6,407	6,306	NV
6–9 years	50,854	25,225	25,629				
10–14 years	45,643	21,543	24,100				
15–19 years	37,467	17,830	19,637	37,467	17,830	19,637	I,NV,AC
20–24 years	28,214	14,517	13,697	28,214	14,517	13,697	I,NV,AC
25–29 years	26,067	13,884	12,183	26,067	13,884	12,183	I,NV,AC
30–34 years	20,179	10,764	9,415	20,179	10,764	9,515	I,NV,AC
35–39 years	19,729	10,308	9,421	19,729	10,308	9,421	I,NV,AC
40–44 years	13,190	6,774	6,416	13,190	6,774	6,416	I,NV,AC
45 and older	52,237	26,762	25,475				
O T A L	370,790	186,431	184,359	222,056	112,901	109,155	

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

** CODES FOR INTERVENTIONS

INTERVENTION	CODE
RT	O
mmunization	I
utrition	
Breastfeeding	NB
Weaning Process	NW
Maternal Nutrition	NM
Vitamin A	NV
LRI	A
amily Planning	FP
igh Risk Birth	HR
Malaria Control	MC
Other AIDS	AC
Other Eye Care	EC

NUMBER OF POTENTIAL BENEFICIARIES BY INTERVENTION

INTERVENTION	BENEFICIARIES
1. ORT	64,497
2. Immunization	100,842
3. Nutrition	0
a. Breastfeeding	14,188
b. Weaning Process	14,188
c. Maternal Nutrition	0
d. Vitamin A	84,304
4. ALRI	0
5. Family Planning	0
6. High Risk Birth	0
7. Malaria Control	0
8. Other AIDS Control	74,077
9. Other Eye Care	0

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

e dollar amount (in thousands) only in shaded cell

Total A.I.D. Contribution to Country Project (refer to TABLE A – Page 3)	800,000
Total Potential Beneficiaries (sum of column d from table above)	222,056
A.I.D. Funding per Beneficiary for Project (line 1 divided by line 2)	3.602695
A.I.D Funding per Beneficiary per year (line 3 divided by 3 years)	1.200898

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

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C. ACTIVITIES: Circle all activity codes that apply for each intervention

1. ORT

(1) = Distribute ORS packets
(2) = Promote use of ORS packets
3 = Promote home-mix
4 = Promote SSS home-available fluids
(5) = Dietary management of diarrhea
(6) = ORT training
(7) = Hand washing
Other _____
(specify)

2. Immunization

1 = Distribute vaccines
2 = Immunize mother/children
(3) = Promote immunization
(4) = Surveillance for vaccine preventable diseases
(5) = Training in immunization
Other _____
(specify)

3. Nutrition

1 = Distribute food
(2) = Provide iron, folic acid, vitamins
3 = Provide scales and growth charts
4 = Sponsor mother-to-mother breastfeeding/promotion support groups
(5) = Conduct food demonstrations
(6) = Counsel mothers on breastfeeding and weaning practices
(7) = Conduct group sessions
(8) = Training in breastfeeding and weaning
9 = Training in maternal nutrition
10 = Training in growth monitoring
Other _____
(specify)

4. Vitamin A

(1) = Vitamin A deficiency treatment
(2) = Vitamin A supplementation
3 = Vitamin A fortification
(4) = Vitamin A education
5 = Vitamin A food production
Other _____ (specify)

5. ALRI/Pneumonia

1 = Promote antibiotics
2 = Health education
3 = Improve referral sites
4 = Training
Other _____
(specify)

6. High Risk Births/Maternal Care

1 = Distribute contraceptives
2 = Promote exclusive breastfeeding to delay conception
3 = Promote child spacing or family planning
4 = Antenatal care
5 = Promote malaria prophalaxis
6 = Train TBAs in improved birth practices
7 = Family planning training

7. Malaria Control

1 = Residual insecticides
2 = Larvaciding
3 = Provision of bednets
4 = Provision of commodities
5 = Treatment
6 = Health education
7 = Training
Other _____
(specify)

8. Other **Specify**

AIDS Control
Primary Eye Care

D. PROJECT DURATION: 1. Start Date (mm/dd/yy) 01/01/92 2. Estimated Completion Date (mm/dd/yy) 08/31/94

E. BUDGET: In thousands of dollars ($000) Place dollar amounts in shaded areas only

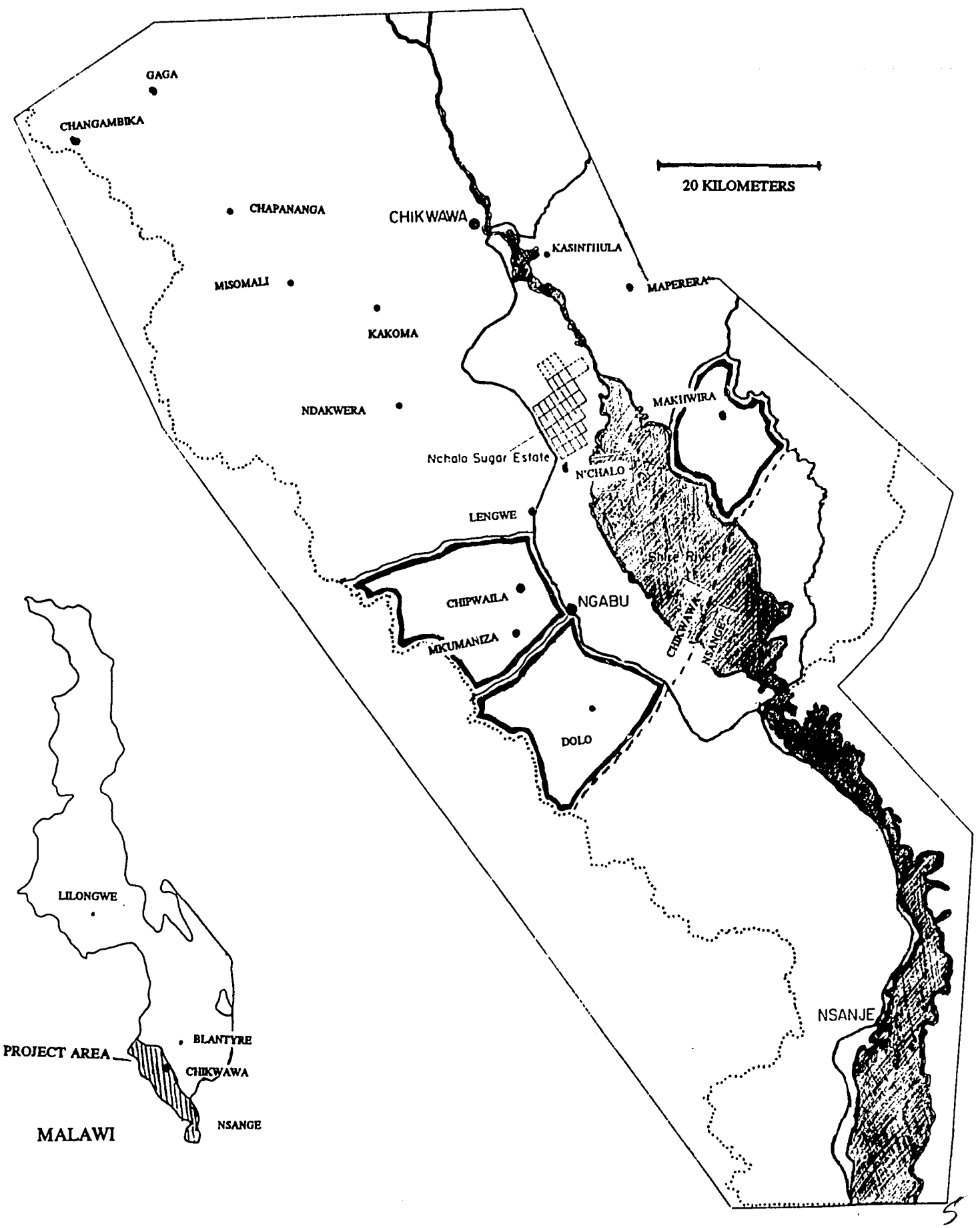
I. BY YEAR OF PROJECT	A.I.D. CONTRIBUTION (a)	PVO CONTRIBUTION (b)	TOTAL CONTRIBUTION (c)
Year 1	239,422	81,444	320,866
Year 2	268,932	94,398	363,330
Year 3	291,646	91,179	382,825
COUNTRY PROJECT TOTAL:	800,000	267,021	1,067,021

II. PERCENT OF TOTAL A.I.D. FUNDS REQUESTED BY INTERVENTION (sum to 100%)

Place percentage amounts in shaded areas only

INTERVENTION	PERCENT OF A.I.D. FUNDS (%)
A. ORT	25%
B. Immunization	20%
C. Nutrition (sum of 1, 2, & 3 below)	45%
1. Breastfeeding	15%
2. Weaning Process	15%
3. Maternal Nutrition	15%
D. ALRI	0%
E. Family Planning/Maternal Care	0%
F. Other (specify) AIDS/Eye Care	10%
TOTAL (100%)	100%

CHIKWAWA AND NSANGE DISTRICTS



The potential constraints to the project are:

o The current 1991-1992 drought has resulted in the destruction of 98% of the maize crop in the LSV. The LSV is the most affected region in Malawi and currently requires an estimated 4,700 metric tons of maize per month. Relief efforts are being planned. Understandably, the majority of the population are preoccupied with household food security.

o The majority of the population are subsistence farmers cultivating staple food crops (maize) and cash crops (cotton) with a low per capita income. There are few employment opportunities in the LSV.

o The population is characterized by low rates of literacy and few children continue their education beyond elementary school.

The health infrastructure of Chikwawa District consists of one district hospital, two smaller rural hospitals (one MOH and the other Private Hospital Association of Malawi, PHAM), and a series of eleven health centers/dispensaries. There are two medical doctors, both expatriate, in the district. Operating from these health units are a network of Under-Five clinics for EPI and other primary health care services. Health centers are often understaffed and drug supplies are limited.

B.3 In the previous IEF project, the Ministry of Health (MOH) was involved both operationally through seconded staff and in the mid-term and final evaluations. Currently, the level of MOH support for the project is greater. The District Health Officer (DHO) and his staff have been involved in the planning of the current project as well as the execution of the baseline survey. The project communicates regularly through the Primary Health Care Technical Sub-committee under the jurisdiction of the District Commissioner and the Program Advisory Committee (PAC) formed at the district hospital. In addition, the project has a written letter of agreement with ADRA and a letter of support from the MOH (see Appendix #2, letters of agreement). The IEF also has a formal Country Agreement with the Government of Malawi.

Section C. DIP Sustainability Strategy

C.1 One of the major goals of the project is to strengthen the existing health delivery infrastructure in the LSV. Strengthening infrastructure will help ensure that key child survival interventions associated with the project will continue through the MOH and the private hospitals in the LSV. Specifically the project's sustainability goals are:

o integrate vitamin A interventions (primarily supplementation) into the existing EPI structure and Under-Five clinic network. This includes the ordering and supply of capsules through the Central Government Medical Stores (CMS).

o establish a community-based worker system supported by village health committees in 90% of the villages in Chikwawa District. Assist ADRA in achieving the same coverage in Nsange District.

o integrate "village health volunteers" into the MOH health delivery system and standardize their training and support mechanisms.

o increase community demand for child survival services through more direct involvement and support of volunteers and village health committees.

- o establish a community-based blindness prevention program in 50% of the villages.

- o increase the MOH capacity in monitoring and evaluation and in conducting operational research.

To achieve this, the project is: 1) planning all phases of the project in conjunction with the MOH (District and Regional) through the Program Advisory Committee; 2) working directly with existing health centers, their staff, and the villages comprising their "catchment" areas; 3) identifying Health Surveillance Assistants (HSA) from the communities they will serve and training them through the USAID/MOH FIX project; 4) strengthening MOH capacity to monitor and evaluate their programs; 5) providing technical assistance in vitamin A nutrition including the reordering of capsule supplies through CMS; 6) organizing, training and supporting village health committees and encouraging more direct involvement in support of volunteers, and; 7) coordinate program activities with other NGO organizations in the LSV.

An important part of the project is the identification, training, and support of village health volunteers (VHVs). In the previous project, IEF, among other PVOs, provided "incentives" in the form of shoes and soap. In response to MOH criticism of these incentives to volunteers the project is investigating how communities themselves can provide incentives to their volunteers. To obtain additional information IEF conducted two workshops on volunteer incentives and is also planning operational research to investigate other key issues related to volunteers. IEF will continue its collaboration with other NGOs, e.g., Giants of Malawi, Concern Universal, and Lions Club for water projects.

The project indicators to monitor sustainability are:

- o sufficient supplies of VACs are available in all health centers; are routinely monitored and distributed through the EPI and Under-Five clinic structure; and are reordered regularly.

- o number of health centers routinely monitoring and supervising volunteers.

- o the volunteer's attrition rate.

- o the number of VHCs meetings held annually.

- o district health staff ability to monitor and evaluate key health programs through the design, implementation, and analysis of population based surveys.

IEF feels that "sustainability" will be difficult to achieve given the short three year time period. Achievement of these goals will be particularly difficult given the impending drought relief efforts in the LSV.

C.2 Evidence that the communities want child survival services is in the continued requests by villages for their own volunteers. Communities in the previous project valued their volunteers because they brought services into their villages. Each village health committee will be asked to select volunteers for training and identify how they can support their own volunteers -- through a community fund or in-kind donations (food, assist in agriculture work, housing, etc.) This is expected to be difficult because communities have not been asked to do so previously. However, there are cultural precedents ("ganu") which will be explored. Additionally, each community will be asked to provide an area in their village in which to organize health activities. IEF will also identify HSA's from the communities that they will serve. Where possible, communities will be asked to provide support for the HSA.

Feedback to the communities through the health information system will also be an important way in which to support communities. The project will continue to investigate effective means of communicating health statistics and using participatory evaluation techniques.[2]

The selection and support of volunteers; their regular meetings and the communities participation in health events are the information the project will use to monitor public support over time. The project has not worked directly with community groups in the development of this DIP, but received numerous comments during the final evaluation of the previous project.

The project has worked closely with the Regional Health Officer (south) and his staff, the District Health Officer (DHO) (Chikwawa and Nsange) and their staff, Montfort Hospital staff, and ADRA project personnel in the development of the DIP.

C.3 The project is working with the following key collaborating groups:

- District PHC Sub-committee: The project has approval from the District Primary Health Care Technical Sub-committee under the District Development Committee (DDC).

- Program Advisory Committee (PAC) (Chikwawa and Nsange): The project also asked the Chikwawa DHO to form a Program Advisory Committee (PAC) in which to channel input into the project. The PAC is composed of the DHO staff, Montfort Hospital staff, the Agriculture Development Division (ADD), and SUCOMA.

- Private Hospital Association of Malawi (PHAM): The project is coordinating with Montfort Hospital and Trinity Hospital through their network of Under-Five clinics.

- Adventist Development and Relief Agency: The project in collaboration with the ADRA child survival project in northern Nsange District has provided technical assistance, training, and VAC supplies for their project under an agreement made in 1991. In addition IEF and ADRA have made plans to jointly conduct operational research into what makes a good "volunteer".

- US Peace Corps: There are currently two PCVs working with the project and a third PCV is anticipated in 1992.

- NGO Collaborative Group: IEF played a key role in the development of the NGO Collaborative Group. This informal group meets regularly to discuss child survival project activities.

- Drought Relief Coordinating Unit (DRCU): IEF played a key role in the formation of the DRCU in response to the drought.

Although there is no direct financial exchange anticipated between any of these groups, the project has provided training for ADRA in vitamin A nutrition and is providing VACs for their project. IEF is exploring the need to provide additional technical support, training, and VACs to other NGOs in the southern region.

[2] IEF conducted a small operational research study in 1991 to determine how best to communicate health statistics graphically to illiterate women.

C.4 IEF does not anticipate handing over major program responsibilities to a local NGO. Instead, the project is working directly through the DHO, his health centers and staff. MOH staff are involved in planning, implementation, monitoring and evaluation of the project activities through their existing network of health centers and Under-Five clinics. Training through small workshops is provided to MOH staff on an ongoing basis. MOH staff were extensively involved in the baseline survey including, design, interviewing, data entry, and analysis. Particular emphasis will be placed on training in monitoring and evaluation. The DHO and staff will also be directly involved in the annual review of project activities and in the mid-term and final evaluation. It is anticipated that the MOH will have gained additional skills to train and supervise volunteers and monitor and evaluate project activities by the end of the project.

C.5 The project will not be involved in revenue generation strategies. However, the project will encourage communities to provide some form of incentives to their volunteers. The form that these incentives will take will be explored directly with the communities and are likely to be in the form of communal labor in the volunteer's field, or small donations (money, food, housing). IEF feels strongly that communities should contribute more directly to child survival activities. While it is still official MOH policy that all health services are free, this policy may be revised in the near future. There are no plans to test the feasibility and acceptability of cost recovery strategies.

Section D. Project Design

D.1 Mother's knowledge and practices of immunization and diarrheal disease control has shown improvement. Complete immunization for children 12-23 months (66.8%) could be increased further by carefully targeting the age at which measles vaccination is given. Coverage of TTV immunization is low as is vitamin A supplementation for children and mothers. Although breastfeeding is a universal practice, nearly half of all children <3 months are receiving complementary foods. Mothers often reported an appropriate action to take for their children's diarrhea indicating that they recognize diarrhea as a danger for their children. Most women have also heard of AIDS. However, many do not understand how AIDS is transmitted and very few women reported that their husbands have used a condom in the past year. There was often a discrepancy between mother's knowledge and practices and literacy and educational level was often a predictor of knowledge and practices.

D.2 IEF, in close collaboration with the MOH, will recruit, train, and supervise volunteers in Chikwawa District for vitamin A deficiency, nutrition education (emphasizing exclusive breastfeeding), EPI, ORT, AIDs education, and primary eye care. The project will select three primary health centers to serve as the initial pilot areas. Villages within the catchment area of these health centers will be contacted through their village health committee to participate in the project. Each participating community will be asked to select volunteers and to provide some form of support. Additional health centers and their catchment areas will be phased into the project so that by the end of three years the majority of the district's health centers and villages will be included in the project. The problem of vitamin A deficiency in the LSV is well established. Furthermore, research has been shown that vitamin A supplementation can reduce childhood mortality by as much as 33-55%, irrespective of other demographic and nutritional factors. Over the past two years, IEF has demonstrated community-based supplementation through volunteers can be an effective method of ensuring high coverage rates. The baseline survey was completed in collaboration with the MOH. The results of the survey assisted the project in defining objectives and establishing feasible indicators.

D.3 Measurable objectives by intervention are: 1) 90% of the children 12-23 months of age will be completely immunized by the end of the project; 2) 50% of women 15-45 years of age will have received three or more doses of tetanus toxoid by the end of the project; 3) 75% of children 0-35 months will have received ORT during episodes of diarrhea by the end of the project; 4) 80% of children 6 months to 6 years will receive vitamin A supplementation in the past six months; 5) 80% of women will receive vitamin A supplementation within two months of delivery; 6) 60% of lactating women will exclusively breastfeed their infants up to 4 months of age; 7) 85% of women can correctly identify the protective nature of condoms in AIDS prevention, and; 8) 80% of the village health volunteers can correctly identify five signs of a healthy eye. The planned inputs and outputs are:

Inputs	Outputs
Budget	$800,000 (AID)
Project staff	Health information system
Training for HSAs	12 HSAs trained
Training for VHCs	400+ VHCs trained
Training for VHVs	1,000 VHVs trained
Vitamin A capsules	400,000 VACs distributed

D.4 Children less than six years, their mothers, and pregnant women will be registered on a Household Roster by the volunteer. Each volunteer will be responsible for approximately 60-80 households. This roster will be used by the volunteer for organizing women to receive services and to identify those households that require individual follow-up visits. The HSAs will abstract data from these rosters during their supervisory visits. The data from these reports will be reviewed with the HSAs and summarized quarterly to estimate progress towards achieving project objectives. Simple graphic presentations of village specific data will be shared on a quarterly basis with project staff, MOH staff, village health committees, volunteers, and with other agencies working in health and agriculture. The project will also conduct smaller Lot Quality Assessment Surveys (LQAS) periodically as well as baseline and end of project surveys.

D.5a - Immunization (EPI)

5a.1 Baseline survey data for children 12-23 months indicate improved immunization rates. Coverage for DPT1, DPT3, and measles were 89.9%, 87.8%, 86.8% respectively. The estimated dropout rate for DPT is .0238 and for OPV is .0295. Nevertheless, the rate for complete immunization for children 12-23 months is 66.8%. Complete immunization is defined as documented immunization on a Under-Five card; all antigens received within the first year of life; and measles given between 9-11 months. Fifty-six percent of mothers had a TTV card. One quarter of mothers had no TTV inoculation and only 31% of mothers had more than 2 TTV inoculations. The proportion of births that are fully protected by TTV is unknown.

5a.2 In response to a question concerning when measles immunization should be given to children, nearly one-quarter (24.5%) felt that measles immunization should be given before 9 months of age; an additional 26.6% of mothers did not know when immunization should occur. Thus, only half of the mothers were aware of when to have their children receive measles immunization. Thirty-nine percent of women did not know that TTV immunization was for protection against tetanus.

5a.3 The current MOH/EPI immunization schedule (0-11 months) is found in Appendix #3. The estimated number of children incompletely immunized is approximately 4,710 infants 0-11 months and 4,176 children 12-23 months. The estimated number of births per year in Chikwawa District are 14,188.[3] Assuming five clinic visits are required to reach full coverage of children by 12 months of age the minimum number of contact points are 70,940. High risk for immunization means any child not enrolled in EPI by age three months, or not completely immunized by age 12 months.

The estimated number of women 15-45 years eligible for TTV are 74,077. TTV coverage in the area is low. Only 31% of mothers had more than 2 TTV inoculations and only 0.8% of mothers had received all five inoculations. High risk for TTV immunizations means any mother without a TTV card and with less than three doses of TTV.

5a.4 The objectives for EPI are:

- 95% of the children 0-23 months of age will be completely immunized by the end of the project.
- 50% of women 15-45 years of age will receive three or more doses of tetanus toxoid by the end of the project.
- 85% of mothers can correctly identify the months when measles vaccination should be given to children.
- 65% of women can correctly identify the protective nature of TTV vaccination.

The number, by age, of the beneficiary population eligible to receive immunization are:

Age	Est. No.	Current %	1st year	2nd year	3rd year
0-11 mo	14,188	*66.8% 9,478	77% 10,925	87% 12,344	95% 13,479
12-23 mo	12,577	66.8% 8,401	77% 9,684	87% 10,942	95% 11,948

* Assumed percentage based on 12-23 month.

Age	Est. No.	Current %	1st year	2nd year	3rd year
15-45 yr	74,077	31% 22,964	35% 25,927	45% 33,335	50% 37,039

5a.5 IEF will assist the MOH to deliver immunizations to the project population. This will be accomplished through the MOH Under-Five clinics (static and mobile) that operate from health centers. Immunization is offered daily at the static clinics and monthly during the mobile clinics. To assist the MOH to achieve high coverage rates volunteers in each village will have a roster of eligible children,

[3] CBR = 38.4/1000/year, MOH Census, 1987.

their mothers, and pregnant women. The rosters indicate those children without complete coverage and those women without TTV-3 or greater. The volunteer will assist the HSA and others to organize eligible children for vaccination and will make follow-up visits to those households who have failed to attend clinic services. Immunization will be phased into project activities according to the existing MOH Under-Five clinics schedule. Additional clinic sites, if required, will be phased into the project.
The planned inputs and outputs for immunization are:

INPUTS : Baseline survey data on immunization coverage; Enrollment of eligible children and mothers in roster books; Planning with MOH staff to coordinate clinic schedules and establishment of new clinic sites (if necessary); Organization of communities through the VHCs; Training for MOH staff, project HSAs, VHVs, and VHCs; Continuous monitoring of the HIS; Monitoring of the cold chain at health centers; a quality assessment survey; End of project survey data on immunization coverage.

OUTPUTS : Identification of "high risk" children and mothers; Immunization plan and quarterly schedule for MOH clinics; Increased knowledge and skill of MOH staff; Increased knowledge of community members; Increased demand for immunization services; Better data on quality of services delivered for use in training staff.

5a.6 The person with overall technical oversight of the immunization component is Mr. M'Manga, the Training and Supervision Coordinator under direction from the Project Director. Mr. Mekisini, Information Coordinator, and Mr. Alifinali, Training and Supervision Assistant will have responsibility for quarterly monitoring of progress. See Appendix #4 and Appendix #5 for job descriptions and resumes.

5a.7 Training in EPI will be a joint effort between IEF and the MOH using existing trainers and curricula. Fifteen IEF project staff and 1,000 VHV will receive training in EPI. IEF supervisory staff will receive approximately 4 hours of in-class training; HSAs and volunteers will receive approximately 6 hours of training. Emphasis will be on practical training during clinics. Subsequent in-service training will be offered to HSAs and volunteers throughout the life of project. Training will emphasize supervision, monitoring the cold chain, immunization schedules and procedures, sterilization, quality assessment, communication and motivation, and monitoring and evaluation. Training for IEF staff began in May 1992 and will begin in July for volunteers. Training will be evaluated by pre/post-tests during training and through monitoring and evaluation data.

5a.8 The project will use the MOH/EPI immunization card attached in Appendix #3. Clinic cards will be distributed to all eligible children during enrollment of the eligible population. In the case that a mother does not have a card for her child, one will be issued on the spot. In the case that the mother forgets to bring her child's card, the volunteer will record the name of the mother and child for later recording on the clinic card. Because the project will work within the existing MOH clinic structure, IEF will not conduct mass campaigns as in the previous project.

5a.9 The strategy for decreasing dropouts and missed opportunities is based on the volunteer roster book. Each roster records immunization status. Those children and their mothers who are incompletely immunized will be identified by the volunteer for special attention and encouragement. A simple graphic representation of village vaccination coverage will be posted in each village. The baseline survey will be further analyzed by area to identify where immunization coverage is the weakest. Furthermore, particular attention will be paid to the age that measles vaccination is provided.

5a.10 The strategy for decreasing dropouts and missed opportunities for TTV vaccination is also based on the volunteer roster. Each household with a mother incompletely vaccinated will be targeted for a visit by the volunteer. The volunteer will hold individual and group sessions with mothers to discuss the importance of TTV vaccination. Simple graphic representations of TTV coverage rates will also be posted by village as a further encouragement. Furthermore, the village health committee will be encouraged to assist in organizing mothers for TTV.

5a.11 In general, the MOH cold chain is adequate. The weak links in the cold chain are the health center refrigerator and vaccine transport from the health center to the field (in cold boxes) during mobile clinics. If necessary, IEF will provide additional training for health center staff in cold chain maintenance. All health center refrigerators will have backup thermometers and minor parts, and where electricity is not available, an extra supply of kerosene. Where the MOH is unable to make necessary repairs to equipment due to lack of funds, the project will provide the funding. The project will also ensure that a refrigerator maintenance schedule, to be checked twice per day, is established. The MOH protocol for monitoring vaccine temperature follows WHO/UNICEF guidelines and is found in Appendix #3. The project will also purchase a refrigerator and cold boxes as back-up sources for refrigeration.

5a.12 The project will conduct limited disease surveillance activities in project villages. All roster books record deaths that occur to children and mothers by drawing a line through the name of the deceased person and recording the reported date of death. During routine supervisory visits the HSA reconfirms data with the volunteer and records any deaths in a death register. Attempts will be made to conduct verbal autopsy with an emphasis on measles in a sample of villages. This data will be collected and summarized semi-annually.

D.5b - Diarrheal Disease Control (CDD)

5b.1 The prevalence of diarrhea (three or more watery stools) reported in the baseline survey was 32.3% in infants 0-11 months and peaked between the ages of 12-23 months at 39.6%. Reported prevalence declined in children 24-35 months (25.6%) to 8.4% in children 60-71 months. The estimated number of episodes of diarrhea per year per child ranges from 6-10 during the months of March-April. The average duration is unknown.

5b.2 In the baseline survey conducted by IEF during March-April 1992, over two-thirds (68.7%) of mothers claimed they recognized the ORS packet. Of these women 83.2% correctly recognized that ORS was for the treatment of diarrhea. The majority of mothers responded that they should provide SSS (48.9%); or they should provide ORS (13.7%), if their child has diarrhea. Nearly one half (45.7%) reported that they gave ORS to their children during an episode of diarrhea.

5b.3 The objectives for the project's CDD intervention are:

- 75% of children 0-35 months of age will receive ORT during episodes of diarrhea by the end of the project.
- 75% of mothers can correctly identify one or more ORT treatment strategies for diarrhea.

The number, by age, of the beneficiary population eligible for promotion of the ORT are:

Age	Est. No.	Current %	1st year	2nd year	3rd year
0-35 mo	38,342	45.7% 17,979	55% 21,088	65% 24,922	75% 28,757

5b.4 Although the project will target children 0-35 months, all children 0-59 months (64,495) are eligible for the CDD component. Those children considered at risk are those children under three; malnourished children; and mothers who lack knowledge of ORT.

5b.5 The MOH/CDD policy on case management of diarrheal diseases is broken into three treatment plans: Plan A is to prevent dehydration; Plan B is to treat dehydration using ORS; and Plan C is to treat severe dehydration. The MOH/CDD program emphasizes treatment plan A (prevention of dehydration) and plan B (treatment of dehydration). For the complete description of the MOH/CDD protocol for the case management of diarrheal diseases see Appendix #3.

The strategy for home management of diarrheal diseases in infants and children will follow the MOH/CDD Treatment Protocol. All staff and volunteers will be trained in diarrheal disease management and will be provided ORS packets from the MOH regional office. During household visits with mothers and in group sessions volunteers will provide training in recognition of diarrhea and dehydration; early use of home available fluids (thin porridge made from maize flour); continued breastfeeding for infants; continued feeding for older infants and children; treatment with ORS using the cleanest water available; convalescent feeding; and when to seek assistance from the health center. Back-up support for volunteers and HSAs is found at the health centers where ORT Corners are established. ORT corners are supplied with ORS and manned by a MOH staff person to demonstrate preparation to any mothers with children presenting with diarrhea.

5b.6 The project will promote the use of ORS packets. ORS packets are provided free of charge by UNICEF and are distributed through the MOH/EPI network. ORS and one liter plastic containers will be supplied from the MOH regional office to the district office. Health centers distribute ORS packets to field staff on an "as needed" basis. The volunteer will be supplied with a limited number of ORS packets for distribution free of charge to mothers. Mothers will be resupplied by presentation of empty packets. There is some concern by the Chikwawa DHO concerning the supply of ORS packets in his district as previous provisions have often been sporadic. The project will assist the district in securing a supply directly from the UNICEF office for use as a backup supply.

5b.7 The project will promote the use of home-based fluids as the first line "treatment" for dehydration. The most available grains available in the LSV are maize and millet flour, and some rice. Preparation of a watery porridge made from maize flour during the preparation of the family staple "nsima" is the most common form of a home-based fluid. Because nsima is the well accepted staple for the population, mothers need little instruction on how to prepare weaker preparations.

5b.8 The project will not stress improvement in the case management of diarrheal diseases at the health centers. However, the project will provide joint training in diarrheal disease management and will assist the MOH in monitoring and evaluation of ORT training and the ORT Corners established at health centers.

5b.9 During 1990-1991 the Malawi company, Rob Processors of Malawi, provided IEF with a small amount of funding to build water wells in the LSV. In 1992, IEF has been approached by Concern Universal, a UK based PVO, and the Giants, a Malawi based Indian social organization, to develop collaborative water projects in Chikwawa District. A list of priority water points has been drafted for Concern Universal and the Giants. Work will begin in mid-1992. The MOH places considerable emphasis on environmental sanitation (promotion of pit latrines). These activities will be ongoing in the project area through the MOH HSAs.

5b.10 MOH/CDD services are an ongoing activity at existing clinics. CDD will be introduced in all areas at the same time as EPI activities.

5b.11 Technical oversight of the CDD component is by the same team described in section 5a.6, page 9.

5b.12 Training in CDD will be a joint effort between IEF and the MOH using existing trainers and curricula. Fifteen IEF project staff and 1,000 volunteers will receive training in CDD. IEF supervisory staff will receive approximately 4 hours of training; HSAs and volunteers will receive approximately 6 hours of training. Subsequent in-service training will be offered to HSAs and volunteers throughout the life of the project. Training will emphasize Treatment Plans A and B, communication and motivation, quality assessment, and monitoring and evaluation. Training for IEF staff began in May 1992 and will begin in July for volunteers. Training will be evaluated by pre/post-tests and through monitoring and evaluation data.

5b.13 The primary messages to communicate with mothers are based on the CDD Treatment Protocols and are found in Appendix #3. Education of mothers will rely primarily on informal one-on-one communication between the volunteer and the mother. The volunteer will also hold group sessions of mothers in her village on a regular basis. The volunteer will make several visits to each household to teach mothers how to manage diarrhea. Routine follow-up visits are anticipated. The project will monitor use of ORS (number of packets distributed) on a monthly and quarterly basis. The project will evaluate the CDD intervention through the baseline and end of project survey and through a smaller quality assessment survey in 1993. The project does not anticipate developing educational materials for the CDD intervention.

D.5c - Nutritional Improvement

5c.1 A survey conducted in 1983 found the prevalence of moderate to severe wasting (<80% WH) was 2.8%. The prevalence of moderate to severe stunting (<90% HA) was 22.3% with 1.3% of the children exhibiting combined moderate to severe wasting and stunting. There was an unexpected tendency for boys to be both more wasted and stunted than girls.[4] The results of a UNICEF anthropometric survey conducted in the LSV in 1991 have not yet been released. The National Sample Survey for Agriculture conducted in 1981 indicated malnutrition related to the pre-harvest and post-harvest seasons.

[4] LSV Ocular Disease Survey, MOH/WHO/IEF/HKI/JHU, 1983.

5c.2 Breastfeeding on demand is a universal practice among Malawian women. However, early introduction of foods other than breast milk is common. Among women in the baseline survey over one-third (36.4%) reported that weaning foods should be introduced before the third month of life -- 5.5% of mothers said this should be in the first month of life. Exclusive breast-feeding was reported for 78% of infants one month or younger and decreased to 40% of the two month old infants and 25% of the three month old infants. By four months 91% of the infants were receiving supplemental foods. Clearly, the early weaning of these children is far more common than that reported by mothers. Most women (62.4%) felt that breastfeeding should be abruptly discontinued with the pregnancy of another child. The usual foods introduced to infants is a watery porridge ("phala") made from maize flour often with salt added. Milk, sugar, and ground nuts may be added to the porridge although these items are often not available. At four to six months of age children are introduced to other soft foods: "nsima", mashed vegetables, banana, mango, and papaya.

5c.3 The objective for nutrition is:

- 60% of lactating women will exclusively breastfeed their infants up to 4 months of age.

5c.4 The number, by age, of the beneficiary population for promotion of breastfeeding are:

Age	Est. No.	Current %	1st year	2nd year	3rd year
15-45 yr	14,188	48% 6,810	50% 7,094	55% 7,803	60% 8,513

The roster of households will be used to identify pregnant women for nutrition education.

5c.5 The rationale for focusing on breastfeeding is based on the myriad of constraints to changing nutrition feeding practices of infants and children in the LSV. The LSV is dry, hot and prone to drought and the majority of the population are poor. Household food availability is a major constraint to changing mother's infant and child feeding practices. Many households may want to provide their children with an increased quantity and variety of foods but are unable. The overriding concern, made acute by the current drought, is household food security. Breastfeeding is a universal cultural practice. Promoting increased duration of exclusive breastfeeding requires no financial resources on the part of the mother and yet has a significant impact on infant morbidity and mortality. The precise focus, educational objectives, and messages will be confirmed by formative research scheduled for July 1992. However, the educational messages likely to be promoted are found in Appendix #6.

Exclusive breastfeeding and delayed weaning will be promoted through a variety of communication channels capitalizing on the inter-personal communication between the volunteer and the mother. Nutrition promotion will be phased into the project along with EPI and ORT components. The design of an Information Education and Communication (IEC) component will be assisted by formative research which will look more closely at feeding patterns and the cultural and economic factors which affect them. The project is seeking technical assistance to conduct formative research and to develop the IEC component in early July 1992.

5c.6 The project will not address low birth weight babies.

5c.7 The project does not have a specific strategy for improving the nutritional status of pregnant and lactating women. However, pregnant and lactating women are incorporated within the IEC intervention promoting exclusive breastfeeding. Pregnant and lactating women are identified through the volunteer roster and are targeted for nutrition education through small group sessions and inter-personal communication channels.

5c.8 The project will not provide supplementary foods. It should be noted, however, that the project is operating during the first year under a drought emergency. IEF has played a key role in the organization of the Malawi NGO Drought Relief Coordinating Unit (DRCU) established to respond to the drought situation. Free food distribution is anticipated in the LSV beginning in June 1992. IEF is currently preparing a proposal to be submitted to the Office of Foreign Disaster Assistance (OFDA) to respond to the crisis. See Appendix #7 for a description of the DRCU and Appendix #8 for an abstract of the OFDA proposal.

5c.9-10 Technical oversight of the nutrition component is by the same team described in section 5a.6 on page 9. Technical assistance for formative research in breastfeeding and infant and child feeding practices and development of IEC strategies is anticipated in July. A collaborative project between IEF and Wellstart is currently being negotiated. The services of a Malawian human nutritionist is also being investigated. In addition the project works closely with the Public Health Nurses (MOH and private hospital) on the regional and district levels.

5c.11 The precise focus, educational objectives, and messages will be confirmed by formative research scheduled for July. However, the educational messages like'y to be promoted are found in Appendix #6. Educational methods and techniques will include a variety of presentation materials (small flash card); flip charts; drama; small group sessions; and inter-personal communication. Change in mother's knowledge and practices will be measured through the baseline and end of project surveys and through smaller surveys. Formative research will be conducted in July to develop specific educational objectives and their corresponding indicators. The project will continue to conduct key informant interviews and focus group sessions periodically.

5c.12 A major focus of the project is the prevention and treatment of vitamin A deficiency. Ocular signs of vitamin A deficiency in the LSV were reported to be 4% among the under six population indicating a rate 5-10 times higher than the WHO criteria for identifying a problem of public health significance.[5] There have been no large scale surveys since 1983 and there is no data on the prevalence of nightblindness in infants and children in Malawi. The project is considering conducting a small survey using conjunctival impression cytology (CIC) in Chikwawa District in mid-1992. The baseline survey indicated only 10.3% of children had received vitamin A supplementation in the past six months. Only 27% of mothers of children 12-23 months had received vitamin A within two months of delivery. The food sources of vitamin A are primarily seasonal green leafy vegetables (cowpea leaves, cassava leaves etc); fruits (papaya, mango); and limited animal sources (dried fish and meat).

[5] LSV Ocular Disease Survey, 1983.

5c.13 The objectives for vitamin A nutrition are:

- 80% of children 6 months to 6 years of age will receive vitamin A supplementation every six months.
- 80% of women will receive vitamin A supplementation within two months of delivery.

5c.14 The number, by age, of the beneficiary population for vitamin A supplementation are:

Age	Est. No.	Current %	1st year	2nd year	3rd year
0-71 mo	77,210	10.3% 7,953	40% 30,884	60% 46,326	80% 61,768

Age	Est. No.	Current %	1st year	2nd year	3rd year
15-45 yr	14,188	27% 3,831	40% 5,675	60% 8,513	80% 11,350

The roster of households will be used to identify children and pregnant women for vitamin A supplementation. Because of the high rate of malnutrition and xerophthalmia in the LSV all children under six are considered at risk of vitamin A deficiency.

5c.15 During a two month period twice a year vitamin A supplementation campaigns will be organized through routine MOH monthly Under-Five clinics. Children 6-12 months will receive 100,000 IU and children 12-71 months will receive 200,000 IU twice a year. Those children who did not receive supplementation during the Under-Five clinic will be visited by the volunteer. Those women who have not given birth at the health center (and hence have not received supplementation) will be visited by the volunteer. Women will receive 200,000 IU within two months of delivery. The volunteer will keep a small supply of VACs in a plastic film canister to be resupplied periodically by the HSA and the health center staff. Supplementation will be recorded on the child's Under-Five card and on the rosters. All children with clinical signs of vitamin A deficiency will receive a treatment dose. See Appendix #3 for IVACG guidelines. Vitamin A capsules have been ordered through the Central Government Medical Stores to promote sustainability. UNICEF also has on order 2.3 million capsules for distribution through EPI programs in all 24 districts. In addition, IEF will also keep an independent supply of VACs (provided by Task Force Sight & Life, Hoffmann La-Roch Co., Basel Switzerland) to ensure availability for the project and to supply other PVOs in the southern region of Malawi. Promotion of consumption of available vitamin A-rich foods is part of the nutrition education component. Gardening promotion will play a minor role in the project due to the current water constraints in the LSV. Only in those areas where there is ample water will seeds be distributed to interested farmers. IEF will investigate developing collaborative activities with HKI-VITAP and VITAL for gardening and food preservation projects.

5c.16 Technical oversight of the vitamin A component is by the same team described in section 5a.6 n page 9.

By the end of the project, twelve HSAs and 1,000 volunteers will have received training in vitamin A. The training of the first three HSAs began in April. These HSAs will begin training of the first 495 volunteers in June. HSAs are the primary supervisors of the volunteers. In collaboration with ADRA, IEF has also completed a one week training for project staff of the ADRA child survival project in Nsange district. Twenty-two ADRA staff and 400 ADRA volunteers were trained in 1991.

5c.17 The project does not anticipate developing additional educational materials for nutrition education and vitamin A promotion. However, during the planned technical assistance to conduct formative research and develop an IEC component materials development needs may be identified.

5c.18-24 The MOH promotes growth monitoring for all children during routine monthly Under-Five clinics using Salter scales. The project will not include a growth monitoring component in the program. A copy of the MOH growth monitoring card is found in Appendix #3. Ample cards are provided free of charge. While IEF will not officially promote growth monitoring, all staff and volunteers will have working knowledge of growth monitoring to assist the MOH to perform these routine activities when requested.

D.5f - Acquired Immunodeficiency Syndrome (AIDS)

5f.1 The estimated prevalence of infection with HIV among women attending ante-natal clinics in the southern region capital of Blantyre is 24%. Among blood donors at Chikwawa District hospital, 12% are HIV positive. Models projecting the impact of AIDS on infant mortality indicate an increase in IMR from 151/1000 to 178/1000 and < 5 mortality from 250/1000 to 326/1000.[6] Clearly AIDS has the potential to slow or eliminate gains in child survival.

Mothers knowledge of AIDS has increased since the epidemic began. Almost all women interviewed in the baseline survey (96.5%) had heard of AIDS. Just over half (58.3%) of the women felt that condoms could protect against AIDS, however, only 7.3% reported that their husbands had used a condom in the past year, primarily as a child spacing method. Most women (82%) whose husbands used condoms understood their protective nature while only 56% of women whose husbands did not use condoms understood the protection that condoms offer. Only 13.4% of mothers had ever sought child spacing services from the health clinics or hospital.

Current interventions to address AIDS are limited to education. Condoms are only distributed through the MOH child spacing program. Most MOH health centers in the LSV offer child spacing counseling and services through maternity clinics. The church related hospitals are still reluctant to promote the use of condoms.

5f.2 The objective for AIDS education is:

- 85% of women and their husbands can correctly identify the protective nature of condoms in AIDS prevention.

[6] The underlying assumptions in the model are: HIV prevalence among women = 30%; transmission from mother to infant = 40%. Johns Hopkins University AIDS project, 1991.

The number, by age, of the beneficiary population (women) for AIDS education is:

Age	Est. No.	Current %	1st year	2nd year	3rd year
15-45 yr	74,077	58.3% 43,187	65% 48,150	75% 55,558	85% 62,965

The project will extend the MOH's AIDS education campaign to all project villages in Chikwawa. The volunteer roster will be used to identify beneficiary households. The volunteers will be the primary contact for basic information. The HSAs and health center staff will reinforce AIDS prevention at health centers. Although mothers are the primary contact, fathers and other men will not be excluded. The project will look for ways to include the village health committees in AIDS education. The project will also investigate distribution of condoms, but is dependent on the supply of condoms through the MOH. Additional formative research will be conducted to assist in the development of messages and materials. AIDS education will be phased into the project in 1993.

5f.3 Technical oversight of the AIDS component is by the same team described in section 5a.6 on page 9. Additional technical assistance will be provided from the AIDSCOM project, Family Health International, and the Johns Hopkins University AIDS project. All IEF staff and volunteers will receive training in AIDS education. The content and duration of the training has not yet been developed. The addition of AIDS education is not expected to add significantly to the volunteer workload.

D.5g - Primary Eye Care (PEC)

5g.1 Ocular signs of vitamin A deficiency are estimated to be 4% in children under 6, almost 10 times the rate WHO defines as a problem of public health significance. Blindness due to trachoma, vitamin A deficiency and cataract affects 1.5% of the population in the LSV. This rate is believed to be the highest in Malawi and considerably higher (x3) than WHO criteria for a problem of public health significance.[7] The baseline survey revealed that eye disease was reported in over half (53%) of the households in the past year. Severe viral conjunctivitis is common during the dry season.

IEF has been involved with the National Prevention of Blindness Program from its inception in 1979. In the LSV there are currently three Ophthalmic Medical Assistants. OMAs are responsible for screening, out-patient treatment, and minor surgery at hospitals. In the previous IEF CS project OMAs (with assistance from HSAs) conducted eye screening, treatment and referral activities during mobile mass campaigns in project villages. Volunteers were under-utilized during this process.

5g.2 The objective of the Primary Eye Component (PEC) is:

- 80% of the village health volunteers can correctly identify five signs of a healthy eye and will identify and refer children and mothers for treatment.

[7] LSV Ocular Disease Survey, 1983.

The number of VHVs to be trained are:

Age	Est. No.	Current %	1st year	2nd year	3rd year
15-45 yr	1,000	0% 1,000	32% 320	75% 750	100% 1,000

The project will extend the blindness prevention program in the LSV by training all volunteers entering the project over the life of the project. Although eye disease is not a life threatening condition, an eye care intervention is included to prevent avoidable blindness and to enhance the quality of life in the LSV. The volunteers will be provided a basic training to identify the "five signs of the healthy eye". Volunteers visit 60-80 households on a routine basis and are closely involved in delivery of child survival interventions. Any children or mothers identified with eye problems will be referred to the health center staff. Cases that health center staff are unable to treat are referred to the OMA at the hospital. Periodic campaigns may be organized subject to availability of antibiotics. Preventative hygiene measures (face and hand washing) will be promoted. The addition of an eye care intervention is not expected to burden the volunteers.

5g.3 PEC will be phased into the project in 1993. The project Ophthalmic Consultant, Dr. Susan Lewallen, (currently the only ophthalmologist in the southern region) will have primary responsibility for technical oversight of this intervention. See Appendix #5. Dr. Lewallen and Dr. Courtright are also involved in research investigating eye care issues in Malawi ("Cultural Barriers to Cataract Surgery", "Traditional Healers and Eye Care").

Section E. Project Health Information System

E.1 The primary means of tracking the project is via the village roster book which the volunteers maintain and the monthly reports which the HSAs are responsible for completing. Rosters list all children in the village under six years of age, their mothers and fathers, and pregnant women. Each volunteer is responsible for an average of 60-80 households. The volunteer uses the roster to record distribution of vitamin A, EPI, ORT, and to monitor births, deaths, and migrations. Although a computer system was developed for the HIS, all reports are hand tabulated. Abstracting and analysis of mortality data is completed annually.

This system has proven to be sufficiently reliable to monitor capsule distribution and vital statistics in the previous project. The same roster system will be adapted to reflect the additional interventions in the expanded project. Newer versions of the roster and supervisors' report will be field tested in the first three sub-project areas. An additional staff person, Mr. Mekisini, has been hired to assist in monitoring the HIS. Computerization, while not essential, will be considered. The HIS will be fully operational by July-August 1992. See Appendix #9 for HIS forms.

E.2 All households with children 6 years of age, their mother and father, and pregnant women will be enrolled by the volunteer. After volunteers complete their initial one week training (in groups of 20) their first task is to enroll 60-80 households. This process takes approximately one-two weeks. The HSA verifies completeness of the roster by visiting each volunteer to examine her roster book and, if needed, to visit a sample of households to verify household information. The training of 495 volunteers and enrollment of all households in the initial three sub-project areas is expected to begin in June and to be completed by August. Updating of rosters for births, deaths, and migration is completed by the volunteer

continuously. However, this information is abstracted by project staff on a quarterly and annual basis for analysis. PCVs are used to assist the Information Coordinator for this purpose.

E. The data to be collected by intervention are summarized:

IMMUNIZATION		
WHAT	WHO	WHEN
Immunization by: child/antigen/village	VHV, HSA, IC	EOP Survey Qrt. HIS
TTV dose by: mother/village	"	"
Immunization sessions conducted: date/location	"	"
Mothers KAP by: knowledge of protective practices	HSA, IC	EOP survey
Cold chain by: health center/staff	HSA, IC	Mo. HIS
No. health workers trained by: HSA/area	TSC	Mo. HIS

DIARRHEAL DISEASE		
WHAT	WHO	WHEN
Diarrhea in past 2 weeks by: child/age/village	HSA, IC	EOP Survey
ORS packets provided by: VHV/child/age/household/village	VHV, HSA IC	Qtr. HIS
Mothers KAP by: knowledge of protective practices	HSA, IC	EOP survey
No. health workers trained by: HSA/area	TSC	Mo. HIS

NUTRITION		
WHAT	WHO	WHEN
Exclusive breastfeeding by; mother/infant/age/village	VHV, HSA, IC	EOP survey
Introduction of weaning foods by: mother/infant/age/village	HSA, IC	Survey
Weight/height/age data by: child/age/village	"	"
Vitamin A supplementation by: child/age/VHV/village	VHV, HSA, IC	EOP survey Qtr. HIS
Vitamin A supplementation by: mother/age/VHV/village	VHV, HSA, IC	EOP survey Qtr. HIS
No. health workers trained by: HSA/area	HSA, TSC	Mo. HIS
Mothers KAP by: knowledge of protective practices	HSA, IC	EOP survey

OTHER: AIDS, PEC		
WHAT	WHO	WHEN
Mothers KAP by: Knowledge of protective practices	HSA, IC	EOP Survey
Condoms provided by: Household/age/village	HSA, IC	Qtr. HIS
No. health workers trained by: VHV/HSA/area	TSC	Mo. HIS

HSAs visit volunteers on a monthly basis and abstract data from the volunteer household roster on a quarterly basis. Reports are summarized and analyzed by the Information Coordinator with assistance from the Project Manager and Country Director. A computer program for the HIS is not essential but will be investigated. Summarized data are reported to staff monthly and quarterly. Analysis of data will be reported to the MOH Technical Advisory Committee quarterly. Simple graphic presentation of data will be used to report community participation to the volunteers and their communities on a quarterly basis. To protect the confidentiality of data the roster book is the responsibility of the volunteer, the village health committee, and the HSA only.

E.4 All project staff receive training in operation of the HIS. Project staff, including the staff of the MOH, participated in the baseline survey conducted from March 25th - April 20th 1992 -- field testing, data collection, data entry, and analysis. A sample was established based upon the most current census

figures available for Chikwawa District. The sampling method was a two-stage cluster sample with the first stage being a proportional population sample (PPS) by enumeration area (Traditional Authorities) and the second stage (again PPS) by village. A cluster was defined as 20 households with one or more children under the age of six years. A total of 2,147 mothers and 3,579 children under six years were included in the survey. The baseline survey report is attached as Annex #1.[8]

A meeting is planned for IEF staff and the MOH in July 1992 to discuss the results of the baseline survey and data interpretation. Staff will again participate in smaller surveys (LQAS) and formative research planned for mid-1992. The person responsible for the routine maintenance of the HIS is Mr. Mekisini, Information Coordinator under supervision from the Project Manager and Country Director. Technical Assistance from VITAL to update the computer software program will be considered.

Section F. Human Resources

F.1 The organizational chart is found on the following page. Overall management and technical oversight is provided by the Country Director, Paul Courtright, Dr.PH. The Project Director, Mr. Chikhosi, an experienced ex-MOH civil servant, is responsible for all management of the field office assisted by an Administrative Coordinator and support staff. Oversight of technical health activities including training is the responsibility of the Training and Supervision Coordinator and the Assistant Training and Supervision Coordinator under direction of the Project Director and the Country Director. The TSC is a health inspector by training from the University of Malawi (Polytechnic). Oversight of the health information system is the responsibility of the Information Coordinator who has recently been hired as a full-time employee. Two Peace Corps Volunteers (PCV) are currently working with the project. PCVs will work under the direction of the TSC and will also assist the Project Director in special activities (surveys, HIS quality assessment, etc.). A third PCV will join IEF in 1992 to ensure overlap for the PCVs who finish their service. All key in-country staff have been hired, received their initial training, and are in-place in Chikwawa District.

The Program Advisory Committee (PAC) was organized by request of IEF to coordinate project activities with the District Health Officer and his staff. The purpose of the PAC is to guide the development, implementation, and evaluation of the IEF project in Chikwawa District. In particular, the PAC will ensure that there is no duplication of activity by IEF and other governmental or non-governmental agencies and strengthen the coordination between existing primary health care activities. Over the span of the project (3 years) the PAC will meet every 4 months to:

1) review the DIP and ensure that it reflects what is a) needed in Chikwawa District and b) what is realistic to accomplish;

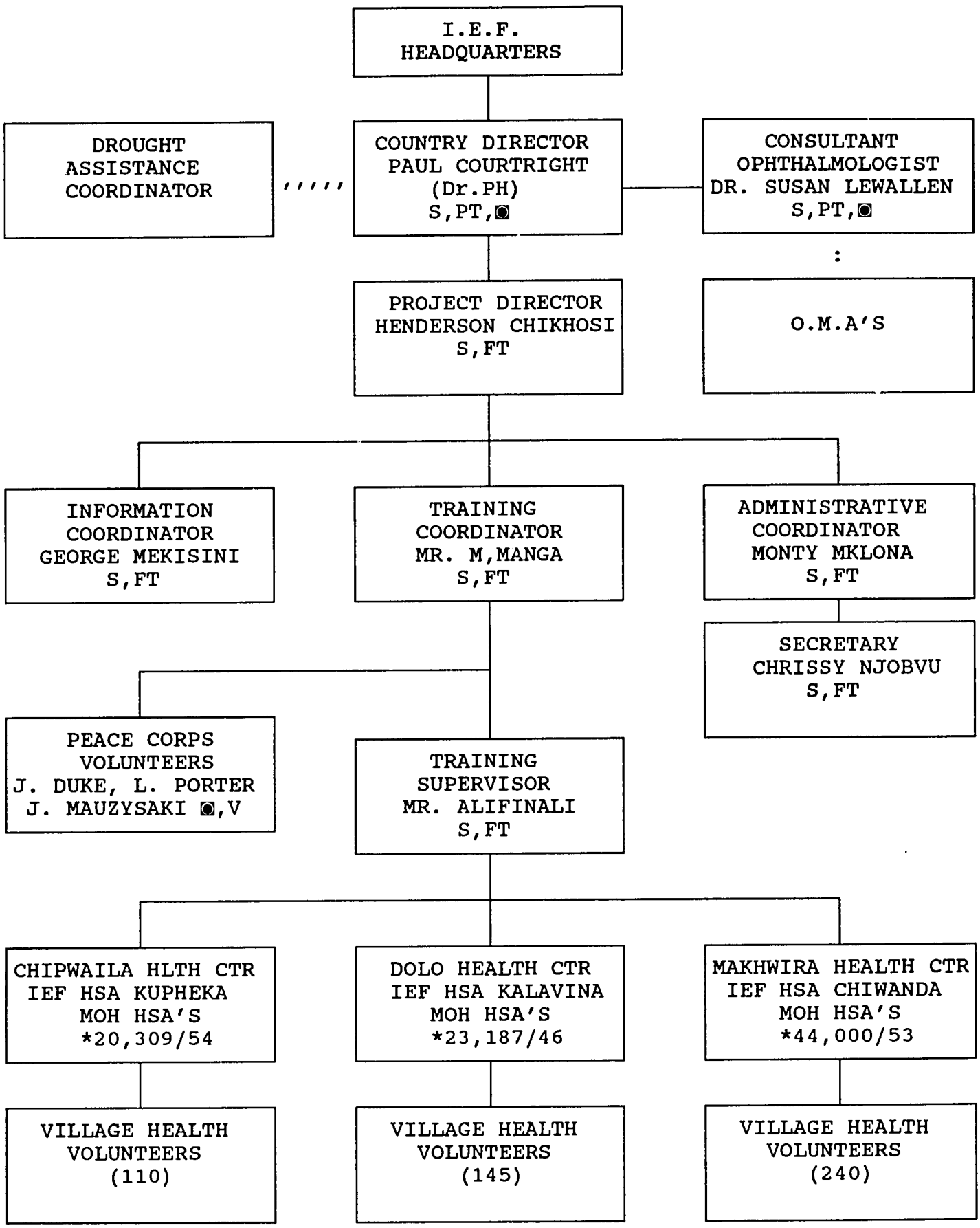
2) receive periodic reports of activities and ensure that the project remains "on track" throughout implementation;

3) provide recommendations for changes in program activities and;

4) assist in defining the needs for a baseline and follow-up survey and evaluation requirements.

[8] Note: The attached report is only a brief interim report. A full report will be available by the end of June, 1992.

MALAWI ORGANIZATIONAL CHART



KEY			
◉	Expatriot	V	Volunteer
PT	Part Time Employee	S	Salaried Employee
FT	Full Time Employee	*	Pop. / # of Communities

Members of the PAC consist of IEF staff, DHO staff, and Montfort Hospital staff. The project also meets regularly with the District Primary Health Care Technical Advisory Group of the District Development Committee, and the Regional Health Officer (south).

F.2 Technical "backstopping" for the project will be provided by John Barrows, MPH, Child Survival/Vitamin A Coordinator, of the IEF headquarters in Bethesda, Maryland. See Appendix #5 for resume. The CS/VA Coordinator will make 2 visits per year to the project for a period of one to two weeks. While in Malawi the CS/VA Coordinator also works with country staff on other projects. The Director of Programs and other IEF headquarters staff make management trips to Malawi annually.

F.3 The project does not anticipate working directly with community groups and mother's clubs, etc. However, where such groups exist project staff will support their activities. For instance in the previous project a volunteer organized a women's income-generating project -- cotton growing -- which has enabled the women to purchase food. This volunteer had weekly meetings with mothers, in which mothers brought different foods for cooking demonstrations. The project will identify and encourage those volunteers and community members willing to pursue group activities and provide support where possible. This support for women will be strengthened by:

1) ensuring that the volunteer is a standing member of the VHC;

2) creating a mechanism for volunteers to visit exceptionally active or well-organized villages to demonstrate what can be done, and as a way to acknowledge the volunteer who has organized them;

3) make special visits to village leaders to praise exceptional work of their volunteer;

4) use the more advanced volunteers to assist in the training of new recruits;

5) seek the volunteer's advice regularly.

F.4 The total number of village health volunteers planned will number approximately 950-1,000. Volunteers are selected by the community through the village health committee. Basic criteria for selection are basic literacy and acceptance by the community as a credible child caretaker. Volunteers will be responsible for 60-80 households and most villages will have two or more volunteers. Training of volunteers is conducted by the HSAs in small groups of twenty over a period of four to five days with additional training provided on an ongoing basis throughout the life of the project. The primary supervisors of the volunteers are the HSAs. Unlike the previous project the volunteer will increasingly use the health centers as a base for some of her services, especially those to be performed on a mass basis (eg., capsule distribution, immunization). This has logistical advantages and also potentially raises the volunteer's credibility in the eyes of the villagers and MOH staff. The selection of male volunteers will also be considered.

The total number of IEF HSAs will number twelve by the end of the project. Each health center has at least one HSA and one Health Assistant in addition to a Medical Assistant, one to two Nurses and support staff. The initial three HSAs were selected in March and are currently in training. The project anticipates adding an additional three sub-project areas on an average of every six months. Therefore, three new HSAs and a representative number of volunteers will be added to the project until all eleven health centers are covered. The pace at which new health centers are included is contingent upon evaluation of how well initial sub-project areas are operating, resource constraints, and MOH approval.

F.5 Training of project staff (primarily HSAs) includes an initial one week workshop covering the basics of child survival, specific IEF project interventions, and a one month field practical. The Training and Supervision Coordinator has the primary responsibility for training HSAs. District MOH staff are invited to cover specific technical issues. Coordination with the MOH is through the DHO's office and the Program Advisory Committee. The field practical consists of organizing village health committees; selection and training of volunteers; supervising enrollment of households; and organizing and conducting Under-Five clinic sessions. Periodic refresher courses are provided throughout the length of the project. All HSAs were involved in the baseline survey (data gathering, and interpretation) and are themselves training volunteers. For IEF HSAs to be absorbed by the MOH by the end of the project they must complete a standard national MOH training. This training consists of a twelve week course conducted by MOH trainers at a central training center. Training for volunteers consists of a four to five day initial training. Training of volunteers is considered ongoing with periodic workshops throughout the length of the project.

F.6 In the previous project, volunteer attrition was low (6%). Volunteer drop-out was due to migration, job offers and deaths. Replacement of volunteers was achieved by "pairing" the new volunteer with an existing volunteer; incorporating new volunteers into periodic refresher training courses and close supervision by the HSA and Training and Supervision Coordinator. Volunteer "drop-out" may be greater in the new project because NGOs are subject to MOH restrictions on provision of incentives. Nevertheless, replacement of volunteers will continue as in the previous project.

F.7 In the previous project volunteers were provided a uniform, badge, bag, and shoes once; and soap monthly. A considerable amount of motivation derives from the esteem associated with the "job". Incentives to volunteers has become an issue between NGOs and the MOH. Various NGOs in Malawi, as well as the MOH, work with volunteers, each providing a different level and kind of incentives. Some groups claim that the differing incentives provided has caused "competition" among them. The MOH claims that they do not provide incentives and that their unwritten policy is that none should be given. However, the MOH provides 25 Kwacha per day ($8) during its week-long training -- a considerable amount by Malawi standards, and more than the value of IEF material compensation. IEF is concerned with the issue of sustainability and is working with the district MOH to define what incentives will be provided to volunteers. To provide clarification, IEF and other NGOs have conducted joint workshops to discuss issues related to volunteers. The first workshop was organized and conducted between IEF and ADRA in July 1991 and the second follow-up workshop was organized and conducted between IEF and SCF-UK in May 1992. See Appendix #10. These workshops have not yet resulted in any policy decisions by the MOH. In addition to these workshops, operational research is proposed. See Appendix #10 for an abstract of the proposed study design.

Section G. Management and Logistics

G.1 The management structure consists of a Country Director, Project Director, Training and Supervision Coordinator, Assistant Training and Supervision Coordinator, Information Coordinator, Office Administrator, and support staff. An ophthalmologist provides technical assistance to the project. Expatriate staff are the part-time Country Director and Ophthalmologist. The Project Director is a senior Malawian who was previously a MOH hospital administrator. Mr. Chikhosi has overall management responsibility under direction from the Country Director. All field staff reside in Chikwawa District.

The project office will move from the Agriculture Development Division (ADD) office in Ngabu to the more centrally located Nchalo trading center where housing is less problematic. All staff have been encouraged to become computer literate with basic software programs. The Office Coordinator completed a four week course in computer spreadsheet operation and other staff are being tutored in word processing by a PCV. The IEF headquarters administrator provides frequent feedback to the project administrator on financial reports. The Project Director will attend the XV International Vitamin A Consultative Group meeting (IVACG) to take place in Tanzania in February 1993. Four abstracts related to vitamin A and measles/malaria and programmatic issues were submitted as potential papers for presentation. Short training courses that may be appropriate for staff training will be considered.

G.2 The project currently has one 4x4 club-cab pick-up truck, two sedans, and five motorcycles. Additional motorcycles are on order so each PCV and all HSA have transport. The use of the truck will be less than in the previous project because IEF will not be operating mobile mass campaigns. The distance that the HSA must travel to reach his villages is also reduced because project areas are the health center catchment populations defined by a 10+ kilometer radius from the health center. Vehicles are often ordered jointly with another project (eg. ADRA) to save costs of shipping. The Administrative Coordinator is responsible for scheduling routine maintenance. HSA and PCVs receive training in motorcycle operation and routine maintenance procedures.

G.3 Basic supplies and equipment required include vitamin A capsules; a back-up supply of salter scales; a refrigerator, minor spare parts for refrigerators; conjunctival impression cytology kits; and back-up cold boxes. Supplies and equipment have been ordered and the majority of items received in-country. IEF headquarters prepares and sends small shipments to Malawi periodically either through commercial companies or by hand during periodic visits. The Administrative Coordinator makes arrangements for Malawi customs clearance and transport to the project area.

Section H. DIP Schedule of Activities

Table B: SCHEDULE OF ACTIVITIES, is attached on the following pages.

Section I. Country Project Justification

Table C: COUNTRY PROJECT BUDGET, is attached on the following pages.

CSVII DIP TABLE B: COUNTRY SCHEDULE OF ACTIVITIES (disk filename: WP5-1\DIPB

(Check box to specify Quarter and Year)

PVO: International Eye Foundation (IEF)

Country: Lower Shire Valley MALAWI

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
1. Personnel in Position												
a. Project Manager	X											
b. Technical Coordinator	X											
c. Health Information System Manager	X											
d. Community/Village health workers	X	X	X	X	X	X	X	X	X	X		
e. Other Support	X											
2. Health Information System												
a. Baseline Survey	X											
- Design/preparation	X											
- Data collection and analysis	X	X										
- Dissemination and feedback to community and project management		X										
b. Consultants/contract to design HIS		X										
c. Develop and test HIS	X	X										
- Implementation	X	X		X		X		X				
- Development and feed back to community and project menagement		X	X	X	X	X	X	X	X	X	X	X

CSVII DIP TABLE B: COUNTRY PROJECT SCHEDULE OF ACTIVITIES (disk filename: WP5-1\DIPB)

PVO: International EyeFoundation

Country: Lower Shire Valley MALAWI

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
3. Training												
a. Design	X											
b. Training of trainers	X	X		X		X		X				
c. Training sessions		X		X		X		X		X		X
d. Evaluation of knowledge of skills		X		X		X		X		X		X
4. Procurement of Supplies	X				X				X			
5. Service Delivery to be initiated												
a. Area 1 (Chikwawa: by # sub-project areas)		3		6		9		11				
- ORT		X		X		X		X				
- Immunization		X		X		X		X				
- Nutrition:												
Breastfeeding		X		X		X		X				
Maternal Nutrition		X		X		X		X				
Vitamin A		X		X		X		X				
- Other AIDS Control/Primary Eye Care					X		X		X		X	

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CSVII DIP TABLE B: COUNTRY PROJECT SCHEDULE OF ACTIVITIES (disk filename: WP5-1\DIPB)

PVO: International Eye Foundation

Country: Lower Shire Valley MALAWI

	Year 1				Year 2				Year 3			
	1	2	3	4	1	2	3	4	1	2	3	4
6. Technical Assistance												
a. HQ/HO/Regional office visits		X		X		X		X		X		X
b. Local Consultants		X										
c. External technical assistance								X				X
7. Progress Reports												
a. Annual project reviews				X				X				X
b. Annual reports				X				X				X
c. Mid-term evaluation								X				
d. Final evaluation												X

27-May-92 INTERNATIONAL EYE FOUN VITAMIN A FOR CHILD SURVIVAL PROJECT

FORMAT G:

	Year 1 AID	IEF	Year 2 AID	IEF	Year 3 AID	IEF	Totals AID	IEF	Total
IEF:HQ									
I. PROCUREMENT									
SUPPLIES									
Computer	0	300	0	300	0	300	0	900	900
General office	0	500	0	500	0	500	0	1,500	1,500
Prof./technical	0	0	0	500	0	0	0	500	500
EQUIPMENT									
Computer Upgrade	0	1,000	0	0	0	0	0	1,000	1,000
SERVICES/CONSULT									
DIP Admin Support	0	400	0	0	0	0	0	400	400
SUBTOTAL (PROC.)	0	2,200	0	1,300	0	800	0	4,300	4,300
II. EVALUATION									
Admin/Report Costs	0	500	0	500	0	500	0	1,500	1,500
SUBTOTAL (EVAL.)	0	500	0	500	0	500	0	1,500	1,500
III. INDIRECT COST (See G & A Line Item on Next Page)									
IV. OTHER PROGRAM COSTS									
A. PERSONNEL									
TECHNICAL									
Public Health Program Coordinator (40%)									
Salary ($38,000)	10,000	5,200	10,500	5,460	11,000	5,600	31,500	16,260	47,760
Fringe (26%)	2,600	1,352	2,730	1,420	2,860	1,456	8,190	4,228	12,418
PROGRAM SUPPORT STAFF									
Director of Programs (8%)									
Salary ($51,000)	2,040	2,040	2,140	2,140	2,250	2,250	6,430	6,430	12,860
Fringe (26%)	530	530	556	556	585	585	1,671	1,671	3,342
Program Assistant (8%)									
Salary ($26,000)	1,040	1,040	1,090	1,090	1,150	1,150	3,280	3,280	6,560
Fringe (26%)	270	270	283	283	299	299	852	852	1,704

27-May-92 INTERNATIONAL EYE FOUN VITAMIN A FOR CHILD SURVIVAL PROJECT

FORMAT G:

	Year 1 AID	IEF	Year 2 AID	IEF	Year 3 AID	IEF	Totals AID	IEF	Total
Administrative Officer (8%)									
Salary ($40,000)	1,600	1,600	1,680	1,680	1,765	1,765	5,045	5,045	10,090
Fringe (26%)	416	416	437	437	459	459	1,312	1,312	2,624
SUBTOTAL (PERS.)	18,496	12,448	19,416	13,066	20,368	13,564	58,280	39,078	97,358
B. TRAVEL COSTS									
SHORT-TERM									
Public Health Program Coordinator									
2 RT airefare pa	3,000	3,000	3,300	3,300	3,600	3,600	9,900	9,900	19,800
50 days per diem pa	2,000	2,250	2,200	2,500	2,400	2,750	6,600	7,500	14,100
Professional Meetings (AID wkshops,etc.) 1 RT airfare pa & 6 days per diem pa	1,000	0	1,200	0	1,400	0	3,600	0	3,600
Program Mgt. Travel									
1 RT airfare pa	0	1,500	0	1,700	0	3,600	0	6,800	6,800
15 days per diem pa	0	1,000	0	1,000	0	1,650	0	3,650	3,650
SUBTOTAL (Trav.)	6,000	7,750	6,700	8,500	7,400	11,600	20,100	27,850	47,950
C. OTHER DIRECT COSTS									
Office Operations									
Telephone	0	1,800	0	2,000	0	2,200	0	6,000	6,000
Postage	0	750	0	800	0	850	0	2,400	2,400
A-110 Audit Fees	0	1,500	0	1,600	0	1,700	0	4,800	4,800
Subtotal (Other)	0	4,050	0	4,400	0	4,750	0	13,200	13,200
SUBTOTAL (IV)	24,496	24,248	26,116	25,966	27,768	29,914	78,380	80,128	158,508
SUBTOTAL I,II,IV	24,496	26,948	26,116	27,766	27,768	31,214	78,380	85,928	164,308
G&A Costs 24.41%	5,979	6,578	6,375	6,778	6,778	7,619	19,132	20,975	40,107
TOTAL HQ. COSTS	30,475	33,526	32,491	34,544	34,546	38,833	97,512	106,903	204,415

27-May-92 INTERNATIONAL EYE FOUN VITAMIN A FOR CHILD SURVIVAL PROJECT

FORMAT G:

	Year 1 AID	Year 1 IEF	Year 2 AID	Year 2 IEF	Year 3 AID	Year 3 IEF	Totals AID	Totals IEF	Total
FORMAT G: ESTIMATED COUNTRY PROJECT BUDGET									
I. PROCUREMENT									
A. EQUIPMENT and SUPPLIES									
TECHNICAL									
1. Refrigerator	0	1,500	0	0	0	0	0	1,500	1,500
2. Camera	200	0	0	0	0	0	200	0	200
3. Motorcycles (12)	0	13,200	0	13,200	0	0	0	26,400	26,400
OFFICE EQUIPMENT									
1. Computer	0	1,500	0	0	0	0	0	1,500	1,500
2. Printer	0	500	0	0	0	0	0	500	500
3. Volt. Reg./UPS	0	400	0	0	0	0	0	400	400
5. Office/House Fur.	3,000	0	0	0	0	0	3,000	0	3,000
6. FAX	0	400	0	0	0	0	0	400	400
7. Main./Ins.	500	0	500	0	500	0	1,500	0	1,500
SUPPLIES									
1. General Office	1,500	0	1,600	0	1,750	0	4,850	0	4,850
2. Paper/Printing	750	0	750	0	750	0	2,250	0	2,250
3. Comp. Software	1,000	0	0	0	0	0	1,000	0	1,000
4. Vitamin A	750	750	1,500	1,500	2,000	2,000	4,250	4,250	8,500
5. Medical Supplies	3,375	3,375	3,500	3,500	3,750	3,750	10,625	10,625	21,250
6. Teaching Aids	1,500	0	1,500	0	0	0	3,000	0	3,000
7. Roster Books/Bags	4,500	0	4,500	0	0	0	9,000	0	9,000
B. SERVICES									
1. Tr. Consultant (80 days @ $50)	1,000	0	1,100	0	1,200	0	3,300	0	3,300
2. SURVEYS - Enumer. & logist. support	1,500	0	500	0	1,500	0	3,500	0	3,500
SUBTOTAL I.	19,575	21,625	15,450	18,200	11,450	5,750	46,475	45,575	92,050
II. EVALUATIONS									
Midterm/Final Evl (Airfare, consult fees, per diem)	0	0	3,000	3,000	6,000	6,000	9,000	9,000	18,000
SUBTOTAL II.	0	0	3,000	3,000	6,000	6,000	9,000	9,000	18,000

27-May-92 INTERNATIONAL EYE FOUN VITAMIN A FOR CHILD SURVIVAL PROJECT
FORMAT G:

	Year 1 AID	IEF	Year 2 AID	IEF	Year 3 AID	IEF	Totals AID	IEF	Total
III. INDIRECT COSTS (See G & A line item)									
IV. OTHER PROGRAM COSTS									
A. PERSONNEL									
1. Country Director									
Salary ($50,000)	25,000	7,500	26,500	8,000	28,000	9,000	79,500	24,500	104,000
Fringe (35%)	8,750	2,625	9,275	2,800	9,800	3,150	27,825	8,575	36,400
2. Ophthal. Consul.									
Salary ($50,000)	12,000	4,000	13,000	5,000	14,000	5,500	39,000	14,500	53,500
Fringe (25%)	3,000	1,000	3,250	1,250	3,500	1,375	9,750	3,625	13,375
3. Project Director									
Salary ($6,500)	6,500	0	7,000	0	7,500	0	21,000	0	21,000
Housing (200/mo.)	2,400	0	2,500	0	2,600	0	7,500	0	7,500
4. Admin. Coordinator									
Salary ($3,700)	3,700	0	3,900	0	4,100	0	11,700	0	11,700
Housing (150/mo.)	1,800	0	1,900	0	2,000	0	5,700	0	5,700
5. Training Coordinator									
Salary ($4,000)	4,000	0	4,200	0	4,400	0	12,600	0	12,600
Housing (150/mo.)	1,800	0	1,900	0	2,000	0	5,700	0	5,700
6. Asst.Train.Coord.									
Salary ($1,600)	1,600	0	1,700	0	1,800	0	5,100	0	5,100
Housing (100/mo.)	1,200	0	1,300	0	1,400	0	3,900	0	3,900
7. Information Coord.									
Salary ($2,200)	2,200	0	2,350	0	2,500	0	7,050	0	7,050
Housing (100/mo.)	1,200	0	1,300	0	1,400	0	3,900	0	3,900
8. Trainers (6,9,12)									
Salary ($750)	4,500	0	6,975	0	9,600	0	21,075	0	21,075
Housing (50/mo.)	3,600	0	5,400	0	7,200	0	16,200	0	16,200
9. Secretary									
Salary ($1,300)	1,300	0	1,400	0	1,500	0	4,200	0	4,200
Housing (50/mo.)	600	0	630	0	660	0	1,890	0	1,890

FORMAT G:

	Year 1 AID	IEF	Year 2 AID	IEF	Year 3 AID	IEF	Totals AID	IEF	Total
PERSONNEL (con't.)									
10. Drivers(2)									
Salary ($1,250)	2,500	0	2,600	0	2,700	0	7,800	0	7,800
Housing (50/mo.)	1,200	0	1,300	0	1,400	0	3,900	0	3,900
11. Peace Corps (3)									
Housing	4,500	0	5,000	0	5,500	0	15,000	0	15,000
SUBTOTAL IV. A.	93,350	15,125	103,380	17,050	113,560	19,025	310,290	51,200	361,490
B. TRAVEL AND PER DIEM									
1. Short-term									
a. Training Consultant									
(30 days pa @$40)	1,200	0	1,300	0	1,400	0	3,900	0	3,900
b. Local Staff Trav.	3,800	0	4,200	0	4,600	0	12,600	0	12,600
c. Int. Prof. Meet.									
(1 RT Airfare)	2,300	0	2,500	0	2,700	0	7,500	0	7,500
(pd @10 days pa)	1,200	0	1,300	0	1,400	0	3,900	0	3,900
d. Training Sessions									
(VHP, TBA & HSA)									
Travel	1,625	0	2,500	0	6,000	0	10,125	0	10,125
Per Diems	13,000	0	19,000	0	24,000	0	56,000	0	56,000
2. Long Term									
a. Country Director									
Relocate (rt air)	0	0	1,500	1,500	0	2,000	1,500	3,500	5,000
Housing by GOM	0	0	0	0	0	0	0	0	0
Security	2,400	0	2,500	0	2,600	0	7,500	0	7,500
Shipping	0	0	2,500	2,500	0	2,500	2,500	5,000	7,500
Storage	0	0	750	0	800	0	1,550	0	1,550
Home Leave	2,000	1,100	0	0	0	0	2,000	1,100	3,100
b. Ophthal. Consul.									
Relocate (rt air)	0	0	0	3,000	0	2,000	0	5,000	5,000
Housing by GOM	0	0	0	0	0	0	0	0	0
Security	0	0	0	1,200	0	1,500	0	2,700	2,700
Shipping	0	0	0	2,500	0	2,500	0	5,000	5,000
Storage	0	0	0	750	0	800	0	1,550	1,550
Home Leave	0	3,100	0	0	0	0	0	3,100	3,100
Subtotal IV. B.	27,525	4,200	38,050	11,450	43,500	11,300	109,075	26,950	136,025

27-May-92 INTERNATIONAL EYE FOUN VITAMIN A FOR CHILD SURVIVAL PROJECT
FORMAT G:

	Year 1 AID	IEF	Year 2 AID	IEF	Year 3 AID	IEF	Totals AID	IEF	Total
C. Other Direct Costs									
1. Vehicle Operat.									
Fuel & Oils	9,500	0	10,000	0	10,500	0	30,000	0	30,000
Maint./Spares	3,000	0	4,000	0	4,400	0	11,400	0	11,400
Ins/Lic/Reg	3,000	0	3,150	0	3,300	0	9,450	0	9,450
2. Motorcycle Oper.									
Fuel & Oils	2,500	0	2,750	0	3,000	0	8,250	0	8,250
Maint./Spares	1,000	0	1,100	0	1,200	0	3,300	0	3,300
Ins/Lic/Reg	750	0	850	0	950	0	2,550	0	2,550
3. Office Operations									
a. Blantyre									
Rent by GOM	0	0	0	0	0	0	0	0	0
Telephone	1,200	0	1,300	0	1,400	0	3,900	0	3,900
Postage/Courier	500	0	550	0	600	0	1,650	0	1,650
Freight	0	1,000	0	1,000	0	0	0	2,000	2,000
b. Nchalo									
Rent	2,400	0	2,500	0	2,600	0	7,500	0	7,500
Telephone	600	0	650	0	700	0	1,950	0	1,950
Postage	200	0	220	0	240	0	660	0	660
Security	500	0	550	0	600	0	1,650	0	1,650
4. Training Sessions									
Supplies	1,600	0	1,750	0	1,805	0	5,155	0	5,155
Facilities	750	0	800	0	850	0	2,400	0	2,400
Subtotal IV. C.	27,500	1,000	30,170	1,000	32,145	0	89,815	2,000	91,815
SUBTOTAL IV. A.B.	148,375	20,325	171,600	29,500	189,205	30,325	509,180	80,150	589,330
SUBTOTAL	167,950	41,950	190,050	50,700	206,655	42,075	564,655	134,725	699,380
G & A 24.41%	40,997	5,968	46,391	9,154	50,445	10,271	137,833	25,393	163,226
TOTAL COUNTRY	208,947	47,918	236,441	59,854	257,100	52,346	702,488	160,118	862,606
TOTAL COSTS	239,422	81,444	268,932	94,398	291,646	91,179	800,000	267,021	1,067,021

APPENDICES

Appendices are attached.

DISTRIBUTION LIST : HEALTH CENTERS

MINISTRY OF HEALTH

Chikwawa District Hospital	-	-
Ngabu Rural Hospital	-	-
HEALTH CENTRE		
Chang'ambika	-	-
Chapananga	-	-
Chipwaila	-	-
Dolo	-	-
Gaga	-	-
Kakoma	-	-
Mkumaniza	-	-
Makhwira	-	-
Ndakwera	-	-
DISPENSARY		
Kasinthula	-	-
Lengwe	-	-
HEALTH POSTS		
Kavalo	-	-
Kubalalika	-	-
Mandalade	-	-
Maparera	-	-
Masanduko	-	-
Mbande	-	-
Mpheza	-	-
Mpokonyola	-	-
Msomo	-	-
Nkhate	-	-
Saopa	-	-
Therere	-	-

LOCAL GOVERNMENT

Chitumba / Maternity	-	-

PHAM

Montfort Hospital	-	-
Misomali Maternity/clinic	-	-

MYP

Gola	-	-

SUCOMA

Factory Clinic	-	-
Kalulu Clinic	-	-
Lengwe Clinic	-	-
Mangulenje Clinic	-	-
Mwanza Clinic	-	-
Nkombedzi Clinic	-	-

Appendix 2, Letters of Support

Telephone: Blantyre 636 377

In reply please quote No. RHO/FH/2/51

MINISTRY OF HEALTH
REGIONAL HEALTH OFFICE
P.O. BOX 3
BLANTYRE
MALAWI

6th December, 1990

The Executive Director
International Eye Foundation
6801 Northfolk Avenue
Bethesda
Maryland
United States of America

c.c. : The Secretary for Health
P.O. Box 30377,
LILONGWE 3
MALAWI

: The District Health Officer
P.O. Box 30,
NSANJE

: The District Health Officer
P.O. Box 32,
CHIKWAWA

Dear Sir,

LETTER OF SUPPORT FOR THE VITAMIN A/ CHILD SURVIVAL PROJECT OF THE INTERNATIONAL EYE FOUNDATION IN THE LOWER SHIRE (1991/94)

Hereby, the Regional Health Office (South) is expressing strong support and willingness to accept the assistance proposed for the above mentioned project.

This office fully agrees with the Project objectives and the activities proposed and is especially welcoming the intention of working within the existing organisational structures, namely; Ministry of Health, Private Hospital Association of Malawi (PHAM) and Non-governmental Organisations (NGOs). By working within the existing organisational structures, the activities are much more sustainable.

Therefore, this office sincerely hope that this Vitamin A/ Child Survival Project will meet with the donors approval and can be implemented as scheduled.

Yours faithfully,

Dr. A. Jonkman
REGIONAL HEALTH OFFICER (S)

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EASTERN AFRICA ADRA

ADVENTIST DEVELOPMENT AND RELIEF AGENCY INTERNATIONAL

P.O. BOX 951
TEL.: 620 264/620 297
BLANTYRE
TELEX: 4216
MALAWI

December 3, 1990

Paul Courtright, Project Director
International Eye Foundation
P.O. Box 2273
Blantyre, Malawi

Dear Mr. Courtright:

I appreciated meeting with you the other day to discuss how the IEF Vitamin A Project might interface with the ADRA/USAID Child Survival VI three-year project in Nsange District in Malawi.

As you describe the focus and objectives of the Vitamin A program, we can see a fine opportunity to collaborate with IEF, the Ministry of Health and other NGO's. Such efforts would conceivably include joint orientation/training of both paid staff and the volunteer village health workers (mother-visitors).

For long-term maintenance of effort, we expect to work with IEF and the MOH to marshall resources for ongoing recruitment, training, provision of services, managing the health information system and evaluation of our integrated efforts in Child Survival, of which Vitamin A/Nutrition is a part.

We will be happy to continue planning with you for obtaining the maximum use of resources to accomplish mutual objectives for the health of the children in Nsange District.

Sincerely,

Bee Biggs-Jarrell

Bee Biggs-Jarrell, RN, MPA
Coordinator
Child Survival Project

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APPENDIX 3, Protocols

The curent MOH/EPI immunization schedule for children 0-11 months is:

Age	Vaccine
Birth	BCG, OPV (in addition to standard 3 doses)
6 weeks	DPT-1, OPV-1
10 weeks	DPT-2, OPV-2
14 weeks	DPT-3, OPV-3
9 months	Measles vaccine

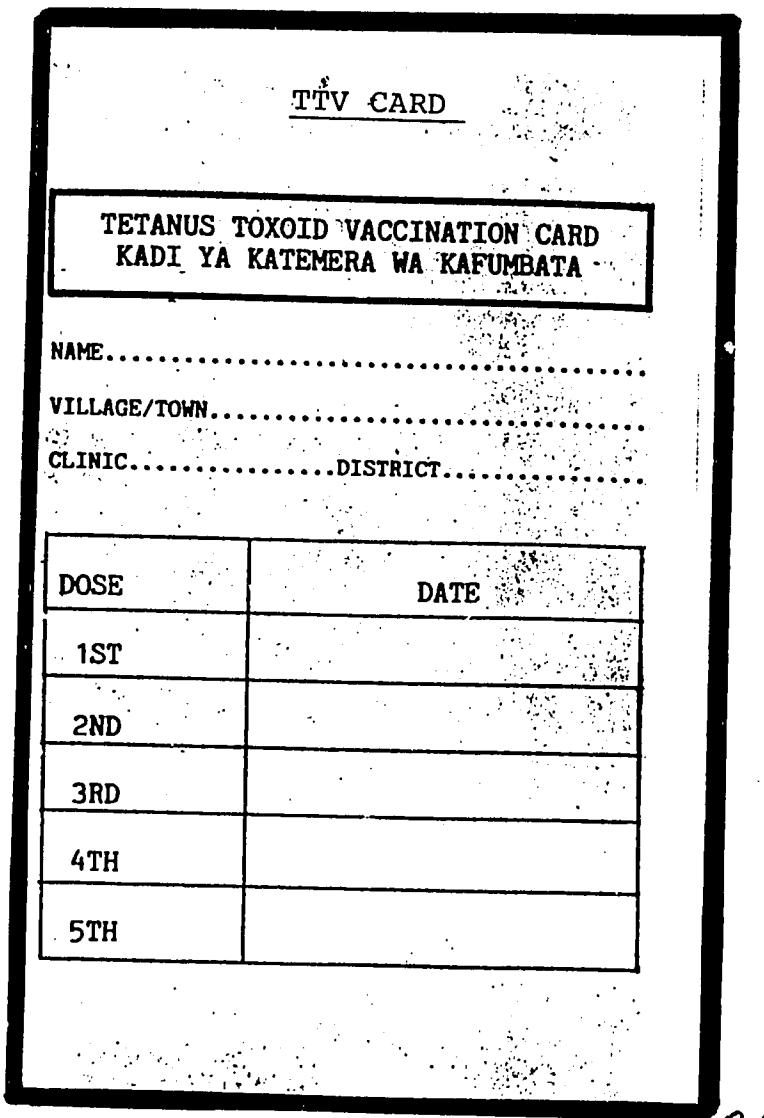
The current MOH/EPI immunization schedule for women 15-45 years is:

TTV-1	At first contact
TTV-2	4 weeks later
TTV-3	6 months after first vaccination
TTV-4	1 year after #1
TTV-5	1 year after #4

The cold chain monitoring protocol is:

Check temperature (freezer and refridgerator sections) once in the morning and once in the afternoon.

Measles 0- -20 C
OPV -20 C
BCG 0 - +8 C
DPT+4 - +8 C
TTV+4 - +8 C



TTV CARD

TETANUS TOXOID VACCINATION CARD
KADI YA KATEMERA WA KAFUMBATA

NAME.....

VILLAGE/TOWN.....

CLINIC.....DISTRICT.....

DOSE	DATE
1ST	
2ND	
3RD	
4TH	
5TH	

Date	COMMENTS / TREATMENT	Next appt.

MALAWI

CHILD HEALTH CARD

CLINIC

CHILD'S NAME

FATHER'S NAME

MOTHER'S NAME

WHERE THE FAMILY LIVES

VILLAGE / CHIEF

DISTRICT

BIRTH DATE — HOME ☐ HOSPITAL ☐

BIRTHWEIGHT — SMALL ☐ AVERAGE ☐ LARGE ☐

NUMBER OF CHILDREN BORN TO MOTHER

TOTAL	ALIVE	DIED

IMMUNIZATION RECORD

BCG (at BIRTH) — DATE GIVEN ____ SCAR CHECK ____

DPT 1 (at 6 weeks of age or later) — DATE GIVEN ____

DPT 2 (one month after first injection) — DATE GIVEN ____

DPT 3 (one month after second injection) — DATE GIVEN ____

Polio 1 (at 6 weeks of age or later) — DATE GIVEN ____

Polio 2 (one month after first dose) — DATE GIVEN ____

Polio 3 (one month after second dose) — DATE GIVEN ____

Measles (not before 9 months) — DATE GIVEN ____

MOTHER

Tetanus Toxoid first ☐ second ☐ third ☐

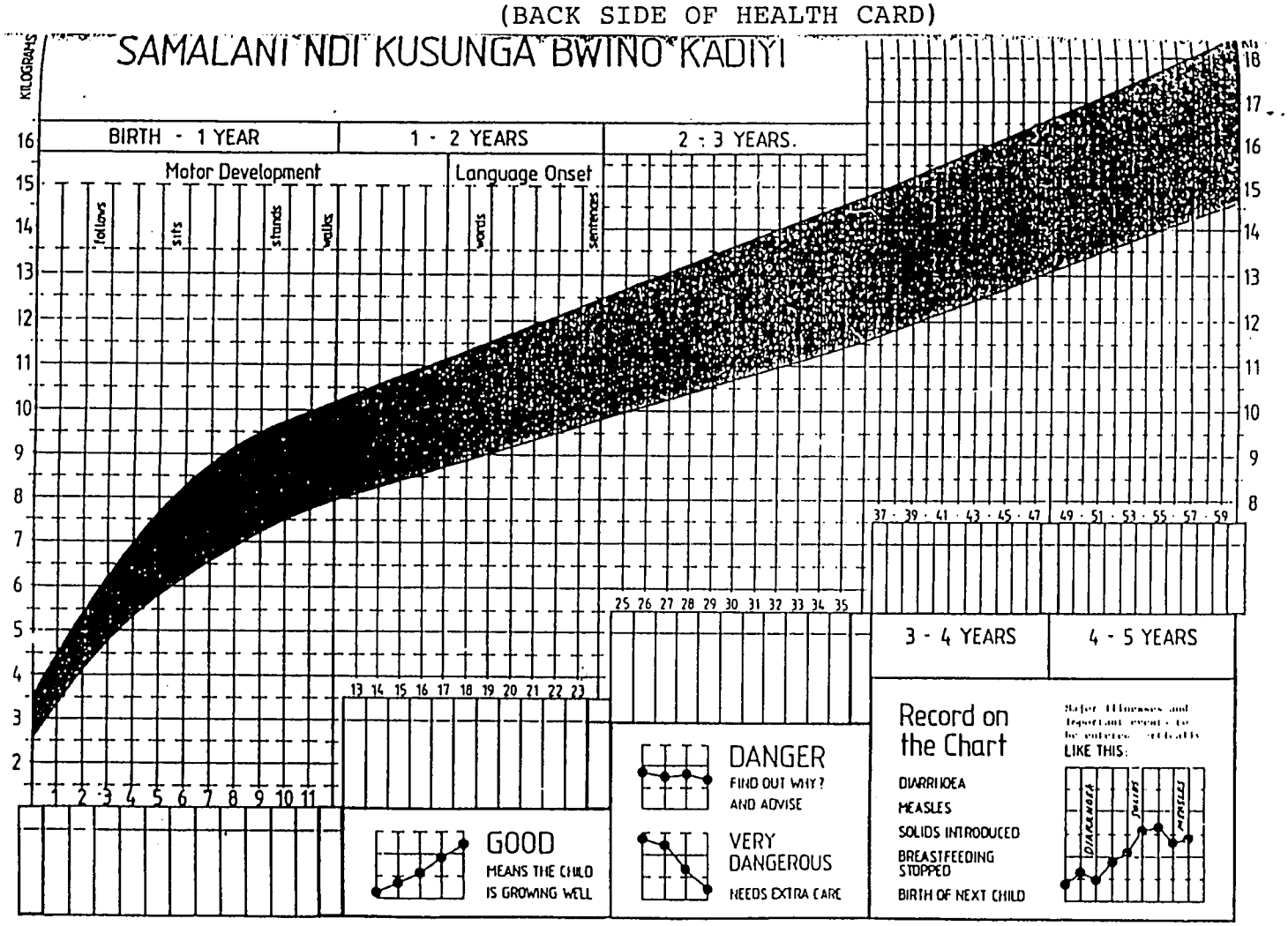
Child Spacing Discussed ____ ☐

REASONS FOR SPECIAL CARE

Tick ☑ any of the following RISK FACTORS present at birth

- Birthweight less than 2.5kg ☐
- Single parent ☐
- Brothers or sisters not growing well ☐
- Fifth child or more ☐
- Birth less than 2 years after last birth ☐
- Twin ☐
- 2 or more children in family died ☐

(BACK SIDE OF HEALTH CARD)



TREATMENT PLAN A
To Prevent Dehydration

EXPLAIN TO THE MOTHER HOW TO TREAT DIARRHOEA AT HOME FOLLOWING 3 RULES:

1. GIVE YOUR CHILD MORE FLUIDS THAN USUAL, such as:
   - dilute porridge, soup, weak tea, fruit juice, or rice water
   - breast milk or milk feeds mixed with equal parts of water
2. GIVE YOUR CHILD FOOD:
   - as much as he wants
   - 5 to 7 times a day
   - which is easy to digest
   - which contains potassium (such as bananas)
3. WATCH FOR SIGNS OF DEHYDRATION. (show the mother how to ASK, LOOK and FEEL for the signs. Then ask her to show you what she has learned.)

BRING YOUR CHILD BACK IF:
- you see any signs of dehydration
- your child has diarrhoea for another 2 days

TELL THE MOTHER THESE RULES ARE IMPORTANT

DEMONSTRATE TO THE MOTHER THAT AFTER EACH LOOSE STOOL, SHE SHOULD GIVE:

- 50-100ml (¼ – ½ cup) of any appropriate fluids for a child less than two years old
- 100-200 ml for older children
- IF THE CHILD VOMITS, tell her to wait 10 minutes and then continue slowly giving in small amounts

ADULTS CAN TAKE AS MUCH AS THEY LIKE

EXPLAIN THAT SHE CAN PREVENT DIARRHOEA IF:

- She only breastfeeds for the first 4 – 6 months and continue breastfeeding for at least 18 months.
- She introduces clean nutritious weaning foods at 4 – 6 months.
- She gives her child freshly prepared and well cooked food and clean drinking water.
- She quickly dispose of the stool of a young child into a latrine or by burying it.
- All family members wash hands after defaecating, before eating or preparing food.
- All members use latrine

TREATMENT PLAN B
To Treat Dehydration with ORS Solution

1. USE THIS TABLE TO SEE HOW MUCH ORS SOLUTION IS SUITABLE FOR 2-4 HOUR TREATMENT

Patient's weight in kilograms	3	5	7	9	11	13	15	20	30	40	50
Patient age *	2	4	6	8	10	12	18	2	3	4	6	8	15	adults
	months							years						
Give this many milliliters of solution in 2-4 years	200-400		400-500		600-800			800-1000		1000-2000				2000-40

*Use the patients age only when you do not have the weight

IF THE PATIENT WANTS MORE ORS SOLUTION, GIVE MORE. If the eyelids becor puffy, stop and give other fluids. If diarrhoea continues, use ORS solution again when t puffiness is gone.

If the child vomits, wait 10 minutes and then continue giving the fluid more slowly in sm amounts

2. IF THE MOTHER CAN STAY AT THE HEALTH UNIT
- tell her how much ORS solution to give her child
- show her how to give it
- watch her give it

3. AFTER 2-4 HOURS REASSESS THE CHILD. THEN CHOOSE THE SUITABLE TREATMEN PLAN.

ADVISE THE MOTHER TO GIVE:
- breast-milk between ORS solution, or
- 100-200ml clean water before continuing ORS, if she is not breast-feeding

4. IF THE MOTHER MUST LEAVE ANY TIME BEFORE COMPLETING TREATMENT PLAN B, ADVISE HER:
- to finish the 2-4 hour treatment as in 1. above
- to give the child as much ORS solution as he wants after treatment
- to look for signs of dehydration and if there is any, to return to the health facility

SUPPLY 100ml/kg OF PREPARED ORS SOLUTION TO TAKE HOME AND EXPLAIN BRIEFLY HOW TO PREVENT DIARRHOEA AND DEHYDRATION

DIARRHOEA TREATMENT CH

How to Assess Your Patient for Dehydration		A	B	C
(1) **ASK ABOUT**	DIARRHOEA	Less than 4 liquid stools per day	4 to 10 liquid stools per day	More than 10 liquid s
	VOMITING	None or a small amount	Some	Very frequent
	THIRST	Normal	Greater than normal	Unable to drink
	URINE	Normal	A small amount, dark	No urine for 6 hours
(2) **LOOK AT**	CONDITION	Well, alert	Unwell, sleepy or irritable	Very sleepy, unconsci or having fits
	TEARS	Present	Absent	Absent
	EYES	Normal	Sunken	Very dry and sunken
	MOUTH	Wet	Dry	Very dry
	BREATHING	Normal	Faster than normal	Very fast and deep
(3) **FEEL**	SKIN	A pinch goes back quickly	A pinch goes back slowly	A pinch goes back ve
	PULSE	Normal	Faster than normal	Very fast, weak, or yo it
	FONTANELLE (in infants)	Normal	Sunken	Very sunken
(4) **TEMPERATURE**		If the temperature is **38**^{oC} or greater Consider Malaria or infection outside intestines		
(5) WEIGHT IF POSSIBLE		Loss of less than 25 grams for each Kilogram of body weight	Loss of 25-100 grams for each kilogram of weight	Loss of more than 1C each kilogram of weig
(6) **DECIDE**		The patient has **no** signs of **dehydration**	If the patient has 2 or more of these signs, he has **some dehydration**	If the patient has 2 o of these danger signs, **severe dehydration**

BETHESDA, MARYLAND

TABLE 1 – Prevention Schedule

Children between 1 and 6 years of age or less than 110 cm in height (may be adjusted up to puberty)	– 200,000 IU vitamin A orally every 3 months
Infants less than 12 months	– 100,000 IU vitamin A orally every 3 months
Lactating women	– 200,000 IU vitamin A orally once during the first 2 months after delivery
Pregnant women	– No more than 10,000 IU per day during first half of pregnancy or, when necessary, 100,000 IU orally once during last trimester of pregnancy

TABLE 2 – Treatment Schedule

Immediately on diagnosis	– 200,000 IU vitamin A orally*
Next day	– 200,000 IU vitamin A orally*
1–4 weeks later	– 200,000 IU vitamin A orally*

* *Use half dose for infants less than 12 months of age.*

TABLE 3 – High-priority Risk Groups

Children and adults with severe protein-energy malnutrition	– Full treatment schedule* and continue in prevention program
Children with measles	– Single dose or full treatment schedule (see text)*
Children with diarrhea, lower respiratory tract disease, or other acute infections	– 200,000 IU vitamin A orally* once and continue in prevention program

* *Use half dose for infants less than 12 months of age*

PROJECT DIRECTOR

The Project Director (PD) is responsible to the IEF/Malawi Country Director (CD), based in Blantyre. The PD is responsible for the overall management of the Lower Shire Valley Vitamin A Project. Details are given below.

The preparation and timely submission of the following reports:

1. A monthly activity report (hard copy and diskette).

2. A monthly financial report (with appropriate documentation) by the 5th of the following month. Both the cheque and petty cash registers should be listed on LOTUS 1-2-3.

3. Any other reports as requested by IEF/Bethesda or the IEF/Malawi Country Director

4. A copy of the monthly activity report should also be submitted to the District Health Officers of Chikwawa and Nsanje District, the Regional Health Officer (South), the ADRA Child Survival Project Director (Ngabu), and the USAID Health Officer (Lilongwe)

Supervision of IEF personnel in the Lower Shire Valley

1. The PD will be responsible for the supervision of all IEF staff in the Lower Shire Valley. Every six months a performance review (see attached sheet) will be prepared for each IEF staff member, submitted to the IEF CD, and upon approval, reviewed with the appropriate staff member.

2. The PD will help supervise the Peace Corps Volunteer(s) with the CD.

Interaction with Ministry of Health & non-governmental organizations

1. The PD will be the primary link between the IEF and the various governmental agencies at the district and regional level. As such, the PD will be the chairman of the IEF Programme Advisory Committee and will represent IEF on the ADRA Child Survival Advisory Committee.

2. The PD will ensure that IEF activities are coordinated with the MoH (district and region) and other appropriate non-governmental organizations (i.e., ADRA, Montfort Hospital, Trinity Hospital).

3. Any conflicts that arise will be reported immediately to the CD.

4. The PD will also ensure that good communication exists between the project and the communities served through the project.

The PD is responsible for the disbursement of all project funds. This includes:

1. Initiation of major procurement. This must be approved by the CD before ordering and subsequently, before remittance.

2. With the office manager, procurement of other supplies and equipment.

3. Payroll

4. Maintenance and inventory of all IEF property in Malawi, especially vehicles and computers.

The PD is responsible for all administrative functions relating to project activities. This includes:

1. The purchase and maintenance of insurance for vehicles and computers, appropriate licenses, compliance with government regulation and maintenance of building and office space.

2. The maintenance of vehicles and computers.

The PD will work closely with the CD in the following areas:

1. The development and amendment of IEF policy in Malawi.

2. The preparation and implementation of all evaluation activities including submission of reports to headquarters and local organizations.

3. The development of feasible proposals for expansion of the project and additional funding in Malawi.

4. Liaison with potential in-country donors.

5. The maintenance of good level of communication between IEF and Ministry of Health/Lilongwe.

6. Recruitment and termination of project staff. Recruitment and termination must be approved by the CD in advance. This also includes short-term local consultants as needed by project activities.

7. All major conflicts will be mediated by the PD with a report submitted to the CD.

The PD will ensure that all office communications will be documented and filed in a consistent manner. If not computer literate, the PD is expected to become so (Word Perfect) within one month of start of employment. All documentation will be kept on computer diskette with a hard copy filed in Ngabu.

PD will ensure a good level of communication with the CD concerning programme-related issues and respond to miscellaneous communications to IEF. The PD will represent IEF at professional conferences and workshops.

TRAINING & SUPERVISION COORDINATOR

The Training and Supervision Coordinator (TSC) will be responsible to the Project Director (PD) and located in the Lower Shire Valley. The TSC will collaborate with the MoH, ADRA, Montfort Hospital, Trinity Hospital and other NGO personnel to coordinate and ensure the smoothing operation of IEF's health training activities. The TSC will be responsible for the coordination and continual upgrade of the IEF's health education programme in the Lower shire Valley.

1. The TSC will collaborate with ADRA in the training of ADRA HSAs so that they can instruct village health volunteers in vitamin A deficiency and better nutrition. The TSC will evaluate this training with ADRA personnel as well as evaluate the training of the volunteers conducted by ADRA HSAs. The TSC will continue to conduct workshops with ADRA personnel as directed by the PD and Country Director (CD). The TSC will provide a training plan (on computer) to the PD and to ADRA at least 2 weeks prior to all workshops. The TSC will prepare a report of all trainings, submitting a copy to both the PD and to ADRA within 2 weeks of completion of training.

2. The TSC will be responsible for trainers hired by IEF. The TSC will train the trainers in vitamin A deficiency, how to develop a training plan, how to train others, etc. and supervise their training of village health volunteers. The TSC will ensure that the trainers have all supplies needed to undertake their job. The TSC will conduct periodic evaluation of the trainers as directed by the PD.

3. The TSC will conduct a meeting of the trainers every two months. A plan of the meeting will be submitted to the PD at least <u>one month</u> in advance. The TSC should ensure that the meeting includes one outside speaker on a topic related to child health.

4. The TSC will ensure that monthly reports from the trainers are submitted to the PD by the 10th of the following month.

5. The TSC will develop a system to assess the training needs of the village health volunteers.

6. The TSC will submit a monthly report of activities by the 10th day of the following month. The report will also include a description of activities planned for the up-coming month.

7. The TSC must have a driver's license by October 31, 1991.

8. The TSC, in collaboration with the office manager, will prepare a budget for all trainings to be submitted to the PD at least two weeks prior to the scheduled training. At the end of the training a financial statement of the training will be submitted to the PD with the training report.

9. The TSC will undertake other duties as directed by the PD and CD.

JOD DESCRIPTION

HEALTH SURVEILLANCE ASSISTANT

The Health Surveillance Assistant [HSA] will be responsible to the Training and Supervision Coordinator [TSC] and will be located in one of the Ministry of Health , Health Centres in Chikwawa District. The Health Surveillance Assistant duties will include;

1] Hire, train, supervise village health volunteers in his given catchment area in collabaration with Ministry of Health personnel,
2] Visit each village health volunteer within two weeks after village health training to encourage roster preparation. If the roster has not been started he will assist the village health volunteer in initiating the roster.He will ensure that a full roster is completed within 4 weeks of completion of village health volunteer training,
3] Conduct periodic meetings of all village health volunteers in his catchment area. He will direct the 1-2 hour meeting by first conducting a health/nutrition session as designed by the Trainig and Supervion Coordinator. The first meeting will start within six months of village health volunteers training,
4] Visit each village health volunteer in their village every month. At this time he will restock Vitamin A capsules, TEO, AND ORS.He will review the roster with the Village Health Volunteer,
5] Assist village health volunteer in assessing the adequancy of the diet of children or mothers that failed to attend the previous nutrition education class. He will fill in the monthly report for each village health volunteer,
6] Submit monthly report to the TSC before 5th day of the following month,
7] Undertake any other duties as directed by the TSC, and the Project Director.

JOB DESCRIPTION

INFORMATION COORDINATOR

The IEF Interviewer selected will have experience in conducting interviews and surveys and have excellent penmanship. The interviewer will be based in Ngabu and be responsible to the Project Director. The selected interviewer must be able to ride a motorbike and have a motorbike driver's license within 60 days of accepting the position. The selected interviewer must be able to work independently with minimum supervision. The interviewer's duties will include:

1. Conduct of interviews for the IEF and collaborating agencies as directed.

2. Assist IEF staff in surveys as designated.

3. Maintain accurate records of all interviews conducted, interviews not completed (and reasons) and field expenses.

4. Maintain cordial relations with interviewees, Ministry of Health staff, village leaders, and others.

5. Training of other IEF staff or associated groups in interview techniques and methodology.

6. Assist IEF staff as directed by the Project Director or Country Director.

JOB DESCRIPTION

OFFICE MANAGER/BOOKKEEPER

The IEF/Malawi Office Manager/Bookkeeper (OMB) will be accountable to the Project Director (PD) and will be responsible for the following.

1. Maintain accurate and detailed project bookkeeping ledgers with accompanying receipts on a daily basis.

2. Prepare the end of month financial report for the PD to be submitted to Bethesda no later than the end of the first week of every month. A listing of cheques and petty cash on Lotus 1-2-3 should also be submitted, both on diskette and a hard (paper) copy.

3. Perform all banking function, pay all bills, and maintain the IEF cheque book.

4. Prepare monthly payroll and maintain tax files for all Malawian IEF employees.

5. Assist the PD in office operations, including word processing of documents, duplication, handling telephone calls and correspondence where appropriate.

6. Work with the training and supervision coordinator to prepare training budgets to be submitted to the PD two weeks prior to the start of all trainings. A financial statement of all trainings should be submitted to the PD within two weeks of completion of training.

7. Maintain the filing system (hard copy and computer) including a complete inventory of all IEF project equipment and goods.

8. Order supplies as directed by the PD.

9. Monitor vehicle maintenance ensuring that all vehicles are in the best working order.

10. To undertake any other duties as directed by the PD and Country Director.

CURRICULUM VITAE

PAUL DOUGLAS COURTRIGHT, DrPH

ADDRESSES: P.O. Box 2273
Blantyre, MALAWI
phone: 265-635917

[redacted]

DATE OF BIRTH: [redacted]
PLACE OF BIRTH:
LANGUAGES: Korean

EDUCATION

1986-1988	Doctor of Public Health Department of Epidemiology University of California, Berkeley, California
1983-1984	Master of Public Health Department of International Health Johns Hopkins School of Hygiene & Public Health Baltimore, Maryland
1983-1984	Scholar in Preventive Ophthalmology Wilmer Eye Institute, Johns Hopkins Hospital Baltimore, Maryland
1976-1978	Bachelor of Arts, Education Boise State University Boise, Idaho

WORK EXPERIENCE

1990-present	Country Director International Eye Foundation Blantyre, Malawi
1989-present	Consultant International Centre for Eye Health Institute of Ophthalmology, London
1984-1988	Research Associate F.I.Proctor Foundation for Research in Ophthalmology University of California, San Francisco
1981-1983	Instructor Monroe Elementary School, Boise, Idaho Seoul International School, Seoul, Korea
1980-1981	Leprosy Eye Project Director Peace Corps, Korea

OTHER

Idaho Standard Teaching Credential No. 095866
California Community College Limited Service Credential No. 274634

MEMBERSHIP

Fellow, Royal Society of Tropical Medicine & Hygiene
Member, Medical Association of Malawi
Member, Society for Epidemiologic Research

PUBLICATIONS

CURRICULUM VITAE

Susan Lewallen, M.D.

Birth date: [redacted]
Birthplace:
Address: PO Box 2273
Blantyre, Malawi
Tel: (265)-635-917 [redacted]

Education:

09/76-08/80	University of Colorado Health Sciences Center Denver, Colorado M.D.
09/72-05/76	Harvey Mudd College Claremont, California B.S. Physics: Honors and Distinction

Post Graduate Training

07/87-07/88	Fellow at Francis I Proctor Foundation for Research in Ophthalmology, University of California San Francisco
07/82-06/85	Resident in Ophthalmology University of Colorado Health Sciences Center Denver, Colorado
06/81-12/81	House surgeon North Canterbury Hospital Board Christchurch, New Zealand
01/81-05/81	Intern Presbyterian Medical Center Denver, Colorado

Work Experience

07/90-present	International Eye Foundation Ophthalmologist Queen Elizabeth Central Hospital Blantyre, Malawi
07/89-07/90	Consultant Ophthalmologist National Programme for Prevention of Blindness Addis Ababa, Ethiopia
10/88-10/90	Korea Eye Care Project Ophthalmologist Taegu, South Korea
02/87-03/87	SEVA Foundation Ophthalmologist Biratnagar, Nepal
05/86-05/87	International Eye Foundation Ophthalmologist St. Kitts, West Indies
07/85-04/86	Eye Associates Inc. Ophthalmologist Pueblo, Colorado (private practice)

Boards and Licenses	Certified by American Board of Ophthalmology, 10/86 Colorado Medical License #26892
Languages	French Spanish

CURRICULUM VITAE

MONTFORT M. MKONA

ADDRESS: IEF
Private Mailbag
Ngabu
Malawi

DATE OF BIRTH:
BIRTHPLACE:

EDUCATION

1971	Certificate, Primary School Methodology Wattle Park Teachers' College Adelaide University South Australia
1966-1968	T2 Certificate Domasi Teachers' Training College Malawi
1962-1965	General Certificate of Education Likuni Boys Secondary School Malawi

WORK EXPERIENCE

1990-present	Administrative Officer International Eye Foundation Lower Shire Valley, Malawi
1988-1989	Administrative and Management Consultant G.T.Z. (German Agency for Technical Cooperation) Malawi
1984-1988	Administrative Officer and Sponsorship Coordinator Save the Children Federation, U.S.A. Malawi
1981-1984	Business Promotion Officer Rural Growth Centers Project Malawi
1979-1980	Junior Accounts/Audit Clerk
1974-1979	Teacher, Primary Science and Health Education
1968-1973	Teacher, College Demonstration School

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CURRICULUM VITAE

MATHEWS D. ALIFINALI

ADDRESS: IEF
Private Mailbag
N'gabu
Malawi

EDUCATION

1980 Primary School Leaving Certificate

WORK EXPERIENCE

1992-present Trainer
International Eye Foundation
Lower Shire Valley, Malawi

1986-1991 Health Surveillance Assistant
Ministry of Health
Malawi

1980-1986 Clinic Attendant
TALRES Leprosy Control Project

CURRICULUM VITAE

GEORGE T. MEKISENI

ADDRESS: IEF
Private Mailbag
Ngabu
Malawi

EDUCATION

Malawi School Certificate of Education

WORK EXPERIENCE

1992-present Information Coordinator
International Eye Foundation
Lower Shire Valley, Malawi

1983-1992 Qualified Teacher

1980 Temporary Teacher

1978-1979 Veterinary Scout

1977 ADMARC Checker

CURRICULUM VITAE

HENDERSON L. CHIKHOSI

ADDRESS: IEF
Private Mailbag
Ngabu
Malawi

DATE OF BIRTH: [redacted]
BIRTHPLACE:

EDUCATION

1976 Diploma, Social Planning
Swansea University College
Wales, United Kingdom

1965-1968 Diploma, Social Policy and Administration
Makerere University College
Uganda

WORK EXPERIENCE

1991-present Project Director
International Eye Foundation
Lower Shire Valley, Malawi

1989-1990 Center Manager
Malawi Against Polio Rehabilitation Center
Blantyre

1987-1988 Hospital Administrator
Queen Elizabeth Central Hospital
Blantyre

1981-1987 Chief Community Development Officer

1978-1981 Principal Community Development Officer

1974-1978 Senior Community Development Officer

1968-1974 Social Welfare Officer

CURRICULUM VITAE

RICHARD B.G. M'MANGA

ADDRESS: IEF
Private Mailbag
Ngabu Malawi

DATE OF BIRTH: [redacted]
BIRTHPLACE:

EDUCATION

1986-1989 Diploma, Public Health
University of Malawi, Polytechnic
Blantyre, Malawi

WORK EXPERIENCE

1989-1992 Environmental Health Officer
Lilongwe City Council
Lilongwe, Malawi

1988 Training Health Inspector
Ntcheu District Hospital
Ntcheu Malawi

CURRICULUM VITAE

JON MAUSZYCKI

ADDRESSES: IEF
Private Mailbag
Ngabu
Malawi

DATE OF BIRTH:
BIRTHPLACE:

EDUCATION

1991 Bachelor of Science, Nutritional Sciences
Kansas State University
Manhattan, Kansas

WORK EXPERIENCE

1991-present Child Survival Officer
International Eye Foundation/Peace Corps
Lower Shire Valley, Malawi

1990-1991 Physical Therapy Assistant
Menorah Medical Center
Kansas

1989-1990 Research Assistant
Nutrition Laboratory
Kansas State University

CURRICULUM VITAE

JESSICA E.A. DUKE

ADDRESSES: IEF
Private Mailbag
Ngabu
Malawi

DATE OF BIRTH:
BIRTHPLACE:

EDUCATION

1985-1989 Bachelor of Arts, International Relations
University of California
Santa Barbara, California

WORK EXPERIENCE

1992-present Child Survival Officer
International Eye Foundation/Peace Corps
Lower Shire Valley, Malawi

1989-1991 Rural Community Development Agent
Peace Corps
Benin, West Africa

1986-1989 Advisor, Youth and Government Program
Young Men's Christian Association
Santa Barbara, California

1987-1989 Language Assistant
English Language Program
University of California Extension
Santa Barbara, California

CHILD SURVIVAL COORDINATOR
(John M. Barrows)

EDUCATION:

1/88-1/89 Boston University School of Public Health, Boston, MA
Master of Public Health
Health Services/International Health

9/75-6/79 Elmira College, Elmira, NY
Bachelor of Arts
Anthropology/Political Science

EXPERIENCE:

8/89-Present INTERNATIONAL EYE FOUNDATION, BETHESDA, MD
Child Survival Coordinator: Responsible for technical and management support to child survival and vitamin A projects.

7/89 HELEN KELLER INTERNATIONAL, NEW YORK
Consultant: Assisted in development of the IEF Vitamin A project Detailed Implementation Plan, Malawi.

3/89-6/89 CENTER FOR SURVEY RESEARCH, BOSTON, MA
Coder: Prepared survey material, coded and entered.

9/84-3/87 SAVE THE CHILDREN FEDERATION, MALAWI FIELD OFFICE
Health and Nutrition Coordinator: Established health sector projects in Malawi Rural Development Linkage Program. Developed projects in 1) water development, 2) primary health care training, 3) health posts and drug funds, 4) child survival project.

2/81-8/84 UNITED STATES PEACE CORPS, MALAWI
Community Health Volunteer: Promoted health projects on district level. Supervised field staff in MCH/EPI, water and sanitation, primary health care training, evaluation of PHC program.

12/80-1/81 VOLUNTEERS IN SERVICE TO AMERICA, HOUSTON, TX
Community Services Volunteer: Assisted Board and Executive Director of the Coalition For Barrier Free Living in establishing the Houston Center For Independent Living project.

LANGUAGES: Chichewa, Chitumbuka

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NUTRITION FACTS FOR MALAWIAN FAMILIES

Inter-Ministerial Food and Nutrition Committee
Office of The President and Cabinet
Department of Economic Planning and Development
(Food Security and Nutrition Unit)

1990

NUTRITION FACTS:

1. FACTS ON FOOD PRODUCTION AND HOUSEHOLD FOOD SECURITY

1. Use of improved varieties of food crops will increase the household food supply.
2. Farmers who follow recommended agricultural practices and seek advice from extension workers produce more food.
3. Use of fertilizers, farm yard manure and compost manure will improve soil fertility and increase crop yields.
4. Growing maize, other cereals and root crops will ensure that families have food the whole year.
5. The household maize stocks will last longer if eaten as mgaiwa instead of ufa woyera.
6. Growing many different types of food will supply a variety of food in family meals.
7. Growing more pumpkins, beans, cow peas, bonongwe and other vegetables along with field crops in the rainy season improves and increases the family food supply.
8. Growing dark green and orange vegetables during the dry season will improve family meals.
9. Planting fruit trees, such as pawpaws, peaches, guavas, mangoes, bananas and citrus will provide good snacks for the family.
10. Oilseeds, such as groundnut, sesame, sunflower, pumpkin and soyabeans should be grown and used to improve family meals.
11. Rearing small animals such as poultry, goats, sheep, rabbits and ducks can improve the family food supply.
12. Goat's milk is as good as cow's milk.

NUTRITION FACTS:

3. FACTS ON CHOOSING FOOD FOR THE FAMILY

1. Mgaiwa has more food value than ufa woyera and can be used for nsima and phala.
2. Processing mgaiwa takes much less time, energy and money than processing ufa woyera.
3. Pulses, groundnuts and dried fish are as good as meat for ndiwo.
4. Rabbit meat is as good as any meat and tastes just like chicken.
5. Dark green and orange vegetables and tomatoes have more food value than pale vegetables.
6. Home-made phala is cheaper and can be made better than commercial weaning foods.
7. Soured milk is a good food for the family, is safe to eat, keeps longer and is just as good as fresh milk.
8. Fresh milk is better and cheaper than soft drinks.

NUTRITION FACTS:

4. FACTS ON FEEDING ADULTS AND OLDER CHILDREN

1. People who work hard in the field need to eat more food to be strong.
2. Pregnant or breast feeding women who are also working in the fields need more food than men.
3. Children who are given food in the morning before going to school are in general more alert in class.
4. Children need snacks in between meals both at school and at home to grow well.
5. A pregnant teenager needs plenty of food for the growth of herself and her baby.

NUTRITION FACTS:

5. FACTS ON NUTRITION AND WOMEN

1. Women who are pregnant need extra food for the growth of the baby.
2. More food and a good variety of food during pregnancy increases the chances of the mother having a healthy baby, fewer complications and remaining healthy herself.
3. Pregnant women need to eat fresh tomatoes and fruits with their meals to prevent anaemia.
4. Drinking alcohol or smoking during pregnancy will harm the baby.
5. Pregnant women who attend the antenatal clinic will receive good advice on nutrition and health.
6. Taking anti-malarial and iron tablets given at the antenatal clinic during pregnancy reduces possible complications and protects the baby.
7. Frequent pregnancies weaken the mother and increase the risk of having a small weak baby.
8. Getting pregnant at an early age or very late age increases the health risks for both mother and baby.
9. A pregnant teenager needs plenty of food for the growth of herself and her baby.
10. Women and other people with goitre need to go to the clinic as soon as possible while the goitre is still small. This is especially important if they are pregnant or planning to become pregnant.
11. A woman who gets tired easily and is sometimes dizzy may have anaemia and needs to consult a health worker.
12. If a mother rests 2- 3 years between pregnancies, she can breast feed for a long time, have time to care for the baby properly and can fully recover from child bearing.

NUTRITION FACTS:

6. FACTS ON BREAST FEEDING

1. Almost all mothers breast feed their babies for a long time in Malawi.
2. The first milk produced by mothers (colostrum) protects babies from later infections.
3. Mothers breast feed successfully when the baby is put to the breast immediately after birth.
4. Frequent breast feeding both day and night stimulates the mother's breast to produce more milk.
5. Breast milk alone is the best food and drink for babies until they are 4 months old, and they need nothing else.
6. Children need to be breast fed until they are at least two years old.
7. It is safe for pregnant mothers to breast feed.
8. It is always safe for sick mothers to continue breast feeding. If a mother is forced to stop for a few days she can start again if the baby suckles frequently.
9. Most breast feeding problems need to be discussed with a health worker to be corrected.

NUTRITION FACTS:

7. FACTS ON FEEDING INFANTS AND PRESCHOOL CHILDREN

1. Breast milk alone is not enough after the age of 4 months. Other foods need to be introduced gradually in order for the baby to continue to grow well.
2. The right foods for babies aged around 4-6 months are mixed phala and other available foods such as mashed banana, sweet potato, pawpaw and other fruit. Breast feeding also needs to be continued.
3. Frequent feeding is necessary for young children because they have small stomachs and cannot eat much at one time.
4. Babies aged 6-8 months are more likely to get enough if fed at least 4 times a day in addition to breast feeding.
5. At around 8 months a child needs to start eating the family meals in addition to weaning foods and breast milk.
6. Food for a young child needs to be put on a separate plate. If young children eat from the same plate as the rest of the family they may not get enough.
7. Young children that are given snacks between meals are likely to eat enough food. Good snacks are fruits, chikondamoyo, mkate, chiponde, boiled potatoes and cassava.
8. A greater variety of food will ensure that young children eat better and grow well.
9. Children with diarrhoea often die because they do not drink enough. They need to be given plenty of fluids and food, as well as should continue to be breast fed.
10. Children recovering from an illness need extra food to regain lost weight and strength.

NUTRITION FACTS:

8. FACTS ON CHILD GROWTH

1. In Malawi there are many children suffering from Protein Energy Malnutrition.
2. Every child under 5 years needs to have a growth chart and be weighed regularly. Children under three years should be weighed every month.
3. If a child's weight curve is going up that means the child is gaining weight and is probably well fed and healthy.
4. If a child's weights curve is flat that means the child is not gaining weight and something is wrong. The child needs extra care because she may not be eating enough or may be ill.
5. If a child's weight curve is going down that means the child is in danger. The child and family needs immediate help from a health worker.
6. Children often stop gaining weight when they start weaning. At this time their growth needs to be watched carefully.
7. Families need to spend plenty of time talking, playing and showing love to young children because these are essential for their physical, mental and emotional growth.
8. Children who are malnourished and/or have measles are at risk of serious eye disease. They need to be taken to the clinic immediately for a complete course of vitamin A capsules.

NUTRITION FACTS:

9. FACTS ON PREVENTING INFECTION

1. When children are fully immunized, particularly against measles, they are at less risk of becoming ill.
2. Diarrhoea and other diseases can be prevented by using latrines and keeping them clean.
3. Washing hands very well after using the latrine and before handling food prevents diarrhoea and other diseases.
4. Infections can be prevented by keeping the kitchen area and utensils clean and by using a rubbish pit.
5. Covering food prevents diarrhoea and other diseases by protecting the food from flies and germs.
6. Diarrhoea can be avoided by reheating cooked food thoroughly.
7. Diarrhoea and other infections can be prevented by protecting wells and boiling drinking water.
8. Young children should be protected from mosquito bites, especially at night.
9. Communities should destroy mosquito larvae and prevent mosquitoes from breeding.
10. Wherever malaria is common, pregnant women should take anti-malaria tablets throughout pregnancy.
11. Wherever malaria is common, a child who has a fever should be taken to a health worker. If malaria appears to be the cause, the child should be given a full course of an anti-malarial drug.
12. A child with a fever should be kept cool but not cold.
13. A child recovering from malaria needs plenty of liquids and food.

Appendix 7, Drought Response Coordination Unit

NGO DROUGHT RESPONSE COORDINATION UNIT

PLAN OF ACTION

1) Set up the DRCU. It will be independently funded and responsible to the NGO's under the auspices of CONGOMA. The Drought Relief Coordinator (DRC) will have prior experience in large scale food distribution and other relief work. The DRC and other administrative staff will be hired on a full time basis

2) Agree with WFP, donors and Government, on inland transportation mechanisms, including costs, to be followed for movement of food to distribution points

3) Establish guidelines for:
-Determining food available locally and monitor relief supplies
-Identifying the most vulnerable groups
-Mechanisms to serve the vulnerable groups (Under 5 Clinics, church groups, village structures, etc.) with a maximum of local community involvement

4) The Coordinator will liaise with Government and NGO's to endeavor to cover areas not currently served by NGO's

5) In liaison with district authorities, the coordinator will set up District level coordinating mechanisms with NGO's based un standard guidelines

6) Within these District level structures, additional programs will be coordinated to provide emergency health provision, water supply and supplementary feeding programs

7) To set up a system that will provide monthly District level reports on drought relief efforts

8) At District level, in coordination with ADMARC and the Ministry of Agriculture, to identify seed requirement for the 1992 planting, separately for hybrid and traditional maize varieties and to facilitate that these seeds are available (linked to food distribution immediately prior to planting time).

9) Set up education and training programs, and provide seed, for alternative crops (cassava, sorghum, sweet potatoes) that will assist future resistance to the impact of the drought.

IV. GOALS & OBJECTIVES

The overall goal of the project is to reduce the impact of the drought on the rural population of three Chikwawa district health center catchment areas: Dolo, Chipwaila, and Makhwira.

Objectives of these projects are divided into three areas: food delivery, health and nutrition, monitoring, evaluation, and community mobilization.

a. Food Delivery

1. A community-based food distribution network will be established in project area.

2. Food rations (emergency levels 110 kgs maize/person/year) will be delivered in the project area.

3. Emphasis on children under five and pregnant and lactating mothers will be targeted.

4. Supplemental feeding centres will be established in each village if malnutrition (<80% HA) increases above 30%.

b. Health & Nutrition

1. All children under six years of age will receive Vitamin A every six months. Mothers will receive vitamin A within two months of the delivery. Children under six will receive a treatment dose following WHO/IVACG guidelines.

2. ORT will be taught to a community health "volunteer' who will provide ORS as indicated.

3. Village health "volunteers" will support MoH/PHAM EPI initiatives, especially for measles.

4. Nutrition education (especially encouragement of exclusive breast feeding for the first 6 months of life) will be conducted in project villages.

c. Monitoring, Evaluation, & Community Mobilization

1. Anthropometric measures will be taken on a subsample of the population (5 to monitor health and nutrition.

2. Limited surveys assessing the effectiveness of diarrhea control measures, EPI coverage, and health/nutrition knowledge will be conducted.

3. Existing community-based data collection (village rosters) reporting systems will be used to measure childhood mortality and population shifts.

4. Communities will be strongly encouraged to mobilize all their efforts to lessen the impact of the drought. Village health and water committees will be organized and trained in methods to support village health "volunteers," food distribution, and community

ROSTER OF FAMILIES WITH PREGNANT WOMEN AND CHILDREN UNDER 6

NAME	BIRTH DAY	EPI	TTV	YEAR ONE				YEAR TWO			
				VIT A	ORS	VIT A	ORS	VIT A	ORS	VIT A	ORS
FATHER_____	__/__/__			o	oooooo	o	oooooo	o	oooooo	o	oooooo
MOTHER_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo

NAME	BIRTH DAY	EPI	TTV	YEAR ONE				YEAR TWO			
				VIT A	ORS	VIT A	ORS	VIT A	ORS	VIT A	ORS
FATHER_____	__/__/__			o	oooooo	o	oooooo	o	oooooo	o	oooooo
MOTHER_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo
CHILD_____	__/__/__	o	ooo	o	oooooo	o	oooooo	o	oooooo	o	oooooo

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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 6 MONTHS - 6 YRS RECEIVED VIT A CAPSULE:						
TOTAL # MOTHERS WITH INFANTS <2 MONTHS:						
# MOTHERS (WITH INFANTS <2 MONTHS) GIVEN CAPSULE BY VHV:						
# MOTHERS (WITH INFANTS <2 MONTHS) GIVEN CAPSULE BY OTHER 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:						

VILLAGE HEALTH VOLUNTEERS: MAXIMIZING A RESOURCE AN IEF/ADRA HOSTED SEMINAR
July 1991

EXECUTIVE SUMMARY

On 26 March 1991 the International Eye Foundation and Adventist Development & Relief Agency organized and sponsored a workshop on village health volunteers, bringing together representatives from Malawi-based non-governmental organizations, the Ministry of Health, and USAID. Exploring seven objectives to define recruitment, training, rewards, retention, and roles of village health volunteers participants concluded that Malawi health organizations (governmental and non-governmental) need a clear policy for village health volunteers in order to decrease confusion and maximize these people as health resources in the villages.

Objectives of the Workshop

1. Describe in detail the strategies used by agencies to recruit, support, and define working conditions for village health volunteers.

2. Review the Malawi MoH policy regarding village health volunteers.

3. Assess what motivates a villager to volunteer for this role.

4. Determine the minimum support and supervision needed to sustain volunteers and examine the community's role in sustaining volunteers.

5. Discuss income generating activities in the village setting.

6. Create recommendations for further operations research in the areas of recruiting and sustaining volunteers.

7. Stimulate NGOs and the MoH to establish guidelines for village health volunteers.

Recommendations

Recognizing the opportunity to maximize the potential resource (and potential liabilities) of village health volunteers we offer the following recommendations as a challenge to the seminar participants and others:

The Ministry of Health should empanel and convene a "blue-ribbon" committee on village health volunteers composed of representatives from non-governmental organizations, local leaders, and government personnel to:

1. Authorize and jointly fund appropriate operations research to address at least the questions raised in objectives 2, 5, 6, and 7.

2. Following the findings in such research, issue policy guidelines for the recruitment, training, retention, and utilization of village health volunteers.

3. Complete its work in two years or less, meeting no oftener than quarterly.

ABSTRACT

Background

Village health volunteers form an integral part of child survival programmes developed and implemented in Malawi. Using volunteers is not new; publications on teaching community health volunteers are available from the MoH. 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 complex role of the village health volunteer is not well understood; this has led to considerable disparity, confusion, and conflict in recruitment, support and supervision, working conditions and hours, and incentives for village health volunteers in Malawi.

Rigorous evaluations of village health volunteer programmes are few and far between and have not been conducted in Malawi. We propose to conduct a study of village health volunteers in Malawi to answer the following questions:

1. What is the true attrition rate for VHVs in different programmes 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 programme 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?

Information from this study will help all agencies provide better services for child survival in Malawi.

Methods

We will conduct a prospective study of volunteers in a number of NGO sponsored programmes 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.

Collaboration

IEF, ADRA, and Save the Children-UK have interest in addressing this question and will collaborate throughout the period of study. Because of Trinity Hospital's long-term experience and continuing interest in volunteers Dr. Peter Cuppen and Miss Grace Chikweza will also be co-investigators, involved in the design, implementation, and evaluation of this study. Funds will be requested with support also provided by IEF, ADRA and Save the Children-UK. Research funds will be channeled through the appropriate structures.