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

***QUARTERLY PROGRESS REPORT #4  
OCTOBER - DECEMBER, 1992***

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

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## **I. PROJECT SUMMARY**

The following is the fourth quarterly report for the IEF project "Vitamin A For Child Survival" in Chikwawa District, Lower Shire Valley, Malawi, Cooperative Agreement # PDC-0284-A-00-1123-00. The reporting period covers October 1st through December 31st, 1992.

### **A. Project Objectives**

The major project objectives are:

- 1) 95% of children 0-23 months of age will be completely immunized;
- 2) 50% of women 15-45 years of age will receive three or more doses of TTV;
- 3) 75% of children 0-35 months of age will receive ORT during episodes of diarrhea;
- 4) 60% of lactating women will exclusively breast feed their children up to 4 months of age;
- 5) 80% of children 6 months to 6 years of age will receive vitamin A supplementation every six months;
- 6) 80% of women will receive vitamin A supplementation within two months of delivery;
- 7) 85% of women and their husbands can correctly identify the protective nature of condoms in AIDS prevention;
- 8) 80% of village health volunteers can correctly identify five signs of a healthy eye, and identify and refer children for treatment.

The schedule of events is attached as Schedule of Activities.

## II. THIRD PROGRESS REPORT, OCTOBER - DECEMBER, 1992

### A. Administrative:

- Renovations on the Nchalo office are still in process. Completion is anticipated in January 1993. Renovations to the Chikwawa house were completed and two Peace Corps Volunteers are currently settled.
- The Malawi Kwacha was devalued from 3.85 MK = \$US 1 in October to 4.2 MK = \$US 1 in December. Additional devaluations are expected.
- Several project staff took their leave during the reporting period including Dr. Courtright and Dr. Lewallen.
- A new Health Surveillance Assistant, Mr. Lewis, was hired to work on Nsua island in October.
- Dr. Mary Jean Cuaycong substituted for Dr. Lewallen at the Queen Elizabeth Central Hospital, Ophthalmic Department, from November 16th to December 21st. Dr. Cuaycong volunteered her services to IEF.
- The draft motorcycle policy whereby IEF HSA's will be given their motorcycles at the end of the project in December 1995 was rejected by the Program Advisory Committee citing difficulties experienced with a similar Ministry policy. IEF is considering a policy developed by SCF-UK and the MOH/Mchinji as an alternative.

### B. Monitoring and Evaluation

- The baseline survey, completed in August, was distributed. A presentation *Child Spacing Practices in Chikwawa District*, based on survey data, was presented to the Medical Association of Malawi.

### C. Project Activities

#### 1. Training

- The training of village health volunteers (phase 3-the final phase) was completed. In the Dolo, Chipwaila, and Makhwira areas 51, 43, and 103 VHV's were trained and supplied. There are currently a total of 274 VHV's active in the project.
- The project will expand activities into three new Health Center Catchment Sites (HCCS) in January. The new HCCS are Maperera, Ngabu, and Ndakwera. The remain HCCS are Chikwawa, Kakoma, and Gaga. Three new HSA will be hired in January for this purpose.

## 2. Vitamin A

- IEF provided ADRA with vitamin A capsules for their project in northern Nsange district.
- Additional supplies of vitamin A were requested from Hoffmann-LaRoche and MAP International.
- UNICEF has supplied Malawi with 2.3 million vitamin A capsules to be distributed through the district EPI network. UNICEF has asked that a meeting be convened (UNICEF, MOH, IEF and other NGOs) to discuss methods of distribution.
- During a MOH drought task force meeting in Lilongwe it was recognized that resources are not available for a national vitamin A mass treatment campaign suggested by Ms. Susan Eastman during her consultant visit supported by VITAP. However, promotional activities will be launched targeting parents.

## 3. Drought Activities

- Meetings were organized and attended including:
  - October, Mr. Mauszycki, Peace Corps Volunteer (PCV), and Mr. M'manga, Training and Supervision Coordinator (TSC), attended the Chikwawa Drought Relief Meeting.
  - November 20, Mr. Mauszycki, PCV, and Mr. M'manga, TSC, attended the Chikwawa District Drought Relief Meeting.
- IEF, ADRA, and Project HOPE drafted a proposal for collaborative drought relief activities at the request of each organization's respective headquarters for consideration by USAID/FHA/PVC.
- Mr. Mauszycki, PCV, continues to coordinate IEF's nutrition assessment activities. The report for the second nutritional assessment survey was completed. The report indicated very low levels of malnutrition in the district. The October survey included the use of mid-upper arm circumference (MUAC) measurements in addition to weight and height measurements.
- IEF, other NGOs and the MOH held a National Nutritional Assessment Seminar in Lilongwe October 30th.
- IEF applied to the Drought Relief Coordinating Unit (DRCU) NGO Strengthening Fund for support of nutritional assessment activities and to extend health services to Nsua island. The proposal was accepted in December. Funds will be provided in-country in Malawi Kwacha.

- A second drought Vulnerability & Capability Analysis was completed.
- A third nutritional assessment survey was conducted in Chikwaw District in November/December. No additional increase in malnutrition was observed.
- IEF and Project HOPE will collaborate on a nutritional assessment survey to be completed in Blantyre District in February.

#### 4. Breastfeeding Activities

- Dr Sarah Castle, a consultant jointly sponsored by Wellstart and IEF, worked with IEF from October 12 - November 10th to identify major problems with breast feeding practices in Chikwawa District. The report will provide basic information in which to develop a breast feeding intervention.
- A one day workshop was held with IEF, UNICEF, and the MOH to discuss some of Dr. Castle's results.
- Ms. Jessica Duke, PCV, prepared a proposal to UNICEF for funding to hold a Southern Region Workshop on Breast Feeding scheduled to be held in January.

#### 5. AIDS Education

- IEF has been contacted by Family Health International for assistance in developing a community based AIDS control intervention that would involve female village health volunteers.
- Ms. Laura Porter, PCV, began work with IEF on October 5th. She will be responsible for assisting the project in developing AIDS education activities. Ms. Porter collected all available information in Malawi regarding community-based approaches to AIDS control for use in planning the intervention.

#### D. Other Meetings/Collaboration

##### 1. Meetings

- October 14th, Dr. Courtright chaired the Regional Health/NGO meeting.
- October 6th, Dr Lewallen presented at the Queen Elizabeth Central Hospital (QECH) clinical session.
- October 13th, Dr. Courtright presented at the QECH clinical session.

- Dr. Courtright and Mr. M'manga, TSC, attended the Medical Association of Malawi meeting on Child Spacing and Mr. M'manga presented a paper on *Attitudes & Practices Regarding Child Spacing in Chikwawa District: Results from a Population-based Survey of 2,173 Women*. The paper was based on data from the baseline survey.

- December 4th, Mr. Mauszycki attended the Regional Health meeting.

## 2. Collaboration

- IEF and Project HOPE conducted a training session on EPI-NUT for interested NGOs and Ministry personnel on October 8th.

- IEF and the MOH continue to conduct training of village health committees jointly.

- October 21st, IEF attended ADRA's Child Survival Advisory Group meeting

- IEF meet with Peace Corps health staff to evaluate PC health programs in Malawi.

- IEF assisted the MOH in conducting training on drought activities (vitamin A and diarrhea control).

- IEF continues to assist ADRA with VAC supplies and training for their project in northern Nsange district.

- IEF is working closely with Montfort Hospital in the training of village health volunteers. One IEF Health Surveillance Assistant will be jointly supervised by IEF and Montfort Hospital staff. IEF is also working with Montfort Hospital on developing AIDS control messages.

- IEF submitted a position paper on food support for village health volunteers representing IEF, Montfort Hospital, MOH. The proposal was rejected.

- UNICEF will assist the project in developing computer generated maps of project areas.

#### E. Ophthalmologic Situation

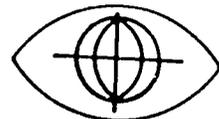
- Drs Courtright and Lewallen attended a Prevention of Blindness meeting in October.
- IEF and Sight Savers anticipate submitting a proposal to study the prevalence of refractive error in Malawi. The proposal will be submitted to the Health Science Research Committee for approval.

#### F. Other

- The interview form for the joint IEF/ADRA/SCF-UK study of village health volunteers was developed and field tested.
- The report for the joint IEF/SCF-UK workshop *How Do We Sustain Village Health Volunteers?* was completed.
- Ms. Porter, PCV, has prepared two proposals for establishing health education facilities in Thando and Nyasa villages. The proposals were submitted to the Peace Corps Self-Help Fund.

### III. APPENDIX

# International Eye Foundation



MONTHLY REPORT OCTOBER 1992

## *Administrative Issues & Personnel*

The 4 IEF vehicles (Peugeot 305, Toyota Corolla, Toyota Cressida, & Toyota 4x4) are in working order. We have taken delivery of 7 motorcycles from Stansfield Motors. Our settlement from NICO (MK 33,800) has yet to be cleared by the Reserve Bank.

Renovations of the IEF/Nchalo office are still underway and will not be finished by mid-November. Apparently, our contractor lives hand-to-mouth and we will have to give him money in advance to purchase supplies. The Chikwawa house is now occupied by Jessica Duke and Laura Porter.

There has been no additional devaluation of the Malawi kwacha. At the end of October it stood at 3.85 MK = \$US 1.

Mr. Chikhosi was on leave until 2 November. Mr. Mekiseni was on leave from 24-30 October and Mr. Lickson has been on leave since 28 September and will not return until mid-November. Mr. Friday Lewis started work for IEF on 12 October. Mr. Lewis will be responsible for Nsua Island.

Dr. Courtright gave the 5 October QECH journal club session on ocular leprosy, measles in HIV+ children, and breast feeding.

We are still having problems with our FAX line; requests to repair the line have not been fulfilled.

## *Meetings*

Mr. Mauszycki and Mr. M'manga attended the Chikwawa Drought Relief Meeting in Chikwawa. Mr. Mauszycki presented and discussed results of IEF's nutrition assessment study.

Drs. Courtright & Lewallen attended the 2 October Malawi Prevention of Blindness meeting. It was decided at this meeting to support a collaborative IEF/Sight Savers/Vision Aid Overseas study of refractive error in Malawi.

IEF and Project HOPE conducted a collaborative half-day training session on EPI-NUT (computer software for nutritional assessment) for interested NGOs and ministry personnel on 8 October. IEF provided copies of diskettes and MSF-H provided copies of the manual.

Dr. Courtright chaired the 14 October Regional Health/NGO meeting. Dr. Lewallen presented the 6 October QECH clinical session on Pediatric Proptosis and Dr. Courtright presented the 13 October session on Child Health Indices in Chikwawa District.

## *Ministry of Health/Chikwawa & IEF Collaboration*

IEF & MoH continue to conduct village health committee trainings cooperatively.

## *ADRA/IEF Collaboration*

IEF attended ADRA's Child Survival Advisory Group meeting on 21 October. Mr. M'manga has been working with Dr. Joy Cook to improve the capacity for

**FILE**

✓ *PHYSIC*  
collaboration between the two organizations. IEF will be providing a new allotment of vitamin A to ADRA in November. ADRA, Project HOPE, and IEF have drawn up a collaborative project (comprising nutritional assessment, promotion of exclusive breast feeding, improvement of measles immunization rates, investigation of supplemental feeding programmes, and capacity building) which has been sent to our "home" offices for consideration. It has been rumored that there is an availability of additional funds from drought relief activities. We are not holding our breaths.

#### *Village Health Promoters (1989-1991)*

✓ MoH/Chikwawa and Montfort Hospital have provided us with the total number of VHV's in their programmes. We hope to have a position paper on food support for village health volunteers submitted to UNICEF before mid-November.

#### *Village Health Volunteers (1992-1995)*

✓ The interview form for the joint ADRA/SCF-UK/Trinity Hospital/IEF study of village health volunteers is being translated. Field testing will start in Mchingi and Chikwawa in November.

✓ Village health volunteer training has continued in all sites. A list of the most recent trainees is given as an appendix.

✓ The report for the joint SCF-UK/IEF workshop (5 May) *How do we sustain village health volunteers?* has been completed and will be sent to all participants in November. Others interested in a copy of the report should contact SCF-UK/Lilongwe (Morag Reid). IEF and SCF-UK have prepared a manuscript for Malawi Medical Journal by the same title.

#### *IEF HSA Trainees*

✓ The training of village health committees and village health volunteers (phase 3) has occupied our HSA trainees throughout October. For phase 3 the problem of inadequate planning (having supplies ready at start of training) has been rectified. MoH had no remaining 1 liter ORS containers in the country so IEF was forced to purchase these locally.

#### *Training in October:*

✓  
Dolo            29 VHV's trained and supplied  
Chipwaila    21 VHV's trained and supplied  
Makhwira    53 VHV's trained and supplied

✓ It has been noted that in some of the villages there are no literate women. It appears that this lack of literacy has not substantially affected the ability of these women in their training programme. In some cases literate men have been selected to work with the illiterate women.

✓ The development of an IEF motorcycle policy (whereby all IEF HSAs would be given their motorcycles at the end of the project period) has been dealt a set-back. The precedent for this has proven to be problematic. In the past HSAs who "owned" their bikes (private license plates) could not obtain petrol on government vouchers and had to request petrol from MoH. There was considerable abuse of the system and the MoH has expressed its reluctance to undertake such a programme again.

#### *Expansion of the Project Site*

As per IEF's operating plan we will be expanding our activities into three

A

additional health centre catchment areas over the next few months. The catchment areas selected are Maperera (just north of Makhwira), Ngabu, and Ndakwera (southern Chapananga). Remaining catchment areas are Chikwawa, Kakoma, and Gaga.

#### *Baseline Survey*

The baseline survey report was finalized and will be distributed as soon as possible. Mr. M'manga presented *Child Spacing Practices in Chikwawa District* at the October 31/November 1 Medical Association of Malawi meeting in Lilongwe. His presentation was received very favorably; it was one of the very few presentation based upon data collected in Malawi. Dr. Courtright and Mr. M'manga are preparing a manuscript *Attitudes and practices regarding child spacing in Chikwawa District: Results from a population-based survey of 1,273 women*, as requested by Malawi Medical Journal.

#### *Exclusive Breast Feeding: Developing an Effective Programme*

Dr. Sarah Castle, a consultant from Wellstart, has been with IEF since 12 October. Dr. Castle has worked closely with Ms. Duke to identify the major problems with current breast feeding practices in Chikwawa District. Her anthropologic work has also distinguished ways in which IEF and other agencies (including the MoH) can help change current improper practices. Dr. Castle will complete her work in Malawi in mid-November and have her report finalized by mid-December. There was some miscommunication between IEF/Malawi and IEF/Bethesda regarding Dr. Castle's role. IEF/Malawi understood that Dr. Castle would also assist IEF in the creation of an exclusive breast feeding programme. Ms. Duke will work with other organizations to develop a programme by mid-December. There has been considerable interest in this work by the MoH/Southern Region, Project HOPE, ADRA, and SCF-UK. IEF will be approaching UNICEF for support of these activities.

Ms. Duke will be preparing a manuscript from the breast feeding and diarrhea results from the baseline survey and her interviews to help demonstrate the important protective role that exclusive breast feeding has on child health.

#### *AIDS Control*

IEF has been in contact with Family Health International for assistance in developing a community based AIDS control programme that would involve female village health volunteers working with other women. It is unfortunate that an FHI team will be in Malawi during Dr. Courtright's absence.

#### *Ophthalmologic Situation at QECH*

Dr. Lewallen and Dr. Chirambo have received positive endorsement from both VAO and the National Prevention of Blindness Committee and will be submitting a proposal *A study of the prevalence of refractive error in Malawi* to the Health Science Research Committee in November.

#### *PCV Activities*

Mr. Mauzyscki continued as the coordinator of IEF's nutrition assessment activities. He presented the Chikwawa District Nutrition Assessment data for IEF and MSF at the district drought relief meeting in Chikwawa and the National Nutrition Assessment Seminar in Lilongwe on 30 October. Most of Mr. Mauzyscki's time in October was devoted to training, survey, analysis of results, and report writing.

Ms. Duke spent most of the month involved in breast feeding investigations.

It is expected that Ms. Duke will be responsible for developing (with the MoH and other NGOs) a project to improve breast feeding practices in Malawi.

Ms. Laura Porter started work for IEF on 5 October. Ms. Porter has devoted part of her time to determine the reasons for failure to immunize against measles. Initial interviews with health centre staff have not proven very enlightening and she will be concentrating on interviews with the mothers themselves. These interviews would be used to determine the most common reasons for failure to immunize (incorrect knowledge of vaccination date, forgetfulness, distance to clinic, measles before 9 months, literacy, etc.) and investigate ways to intervene. Ms. Porter is also working with two villages to construct community health education centres. In the next few months Ms. Porter will also start work on focus groups regarding AIDS.

#### *Drought & Impending Famine: Nutritional Assessment*

IEF and MSF-Holland are continuing their collaborative programme for nutritional assessment in Chikwawa District. The second survey (September 25-October 8) showed that two of the six sub-district areas in Chikwawa had very low levels of malnutrition. IEF and MSF-H have prepared a report (available from the DRCU) with recommendations. Attached is the one page summary. UNICEF has graciously offered to assist in the preparation of a computer-generated (digitized) map of the districts. Mr. Mauszycki will work with UNICEF on maps for Chikwawa, Nsanje, Thyolo, Mulanje, Mwanza, and Machinga.

The October survey included the use of mid-upper arm circumference (MUAC) in order to provide information on the reliability and reproduceability of this measure of malnutrition. A one page report is given as an appendix. This information has been discussed at the Regional Health meeting and the recommendations accepted.

IEF has worked closely with the MoH and other NGOs on the 30 October National Nutrition Assessment Seminar in Lilongwe. The resolutions from this meeting are given as an appendix. IEF has applied to the DRCU (NGO Strengthening Fund) for support for nutrition assessment activities and Nsua Island health activities. In the meantime, IEF will continue these activities with MSF-Holland using existing funds. IEF has completed its second Vulnerability & Capability Analysis, a copy of which is attached as an appendix.

#### *Drought & Impending Famine: Vitamin A Supplementation*

Supplies of vitamin A are rapidly increasing in Malawi. UNICEF has recently brought in additional supplies and recommended (in early October) that the MoH/Lilongwe convene a meeting of appropriate agencies (UNICEF, MoH, IEF) to discuss and promote methods of vitamin A distribution. As yet, there has been no word from MoH/Lilongwe.

#### *Traditional Practices for Eye Disease in Malawi*

Ophthalmic medical assistants in Chikwawa and Mulanje (and Dr. Lewallen at QECH) continue to enroll corneal ulcer patients in this study. As of 31 October 397 patients with corneal ulcers were enrolled. Interviews of traditional healers have started in Chikwawa. Initial indications are that the healers have been very willing to discuss their practices and patients and sell some of the products they use for treatment.

#### *Investigation of Vitamin A Deficiency and Other Disorders in Measles*

Enrollment of cases continues. We will continue to measure these levels throughout the next months to determine if there is any increase in the number

of children who are vitamin A deficient. We have conducted an analysis of the first 237 patients. At present 36% of the patients are under 9 months of age, over 50% under 12 months of age. Overall mortality is 11%; mortality is highest in the 12-23 month age group. 70% of the mothers have treated their children prior to hospitalization, anti-malarials being the most common treatment given. Aspirin was the next most common treatment followed by traditional herbs ("chikule"). Vitamin A supplementation at onset of symptoms (prior to hospitalization) is only 17%.

In collaboration with Dr. Chris Kjolhede, Department of International Health, Johns Hopkins School of Hygiene & Public Health, we have finalized a proposal to investigate the role of vitamin A in boosting vaccine-induced measles antibody levels. The proposal, *Response to measles vaccine with and without vitamin A supplementation* will be submitted to the Health Sciences Research Committee in November. We anticipate a January or February start date.

#### *Vitamin A Deficiency and Cerebral Malaria*

Enrollment of cases will not resume again until January, 1993.

#### *Barriers to the Acceptance of Cataract Surgery*

The last interview was completed in mid-September; there are 131 patients in this study. A second interview (patient satisfaction with surgery) is still being conducted and we expect to complete these by mid-December. At present 29 interviews have been completed. The project will be completed by the end of December.

#### *Prevalence Survey of Onchocerciasis in Mwanza District.*

Plans are underway for starting the Mwanza onchocerciasis survey in January. A sample has been taken and mapped. Dr. Johnston will visit the Mwanza District Commissioner and DHO in early November to make the field arrangements.

#### *Plans for November*

Mr. Chikhosi will attend the PHC Technical Subcommittee meeting on 10 November and the District Drought Relief meeting on 18 November.

Dr. Lewallen departed for home leave on 16 October. She will be replaced by Dr. Mary Jean Cuaycong on 13 November until the end of December. Dr. Courtright will depart for home leave on 15 November. Drs. Lewallen and Courtright will return to Malawi on 22 December.

Village health committee and village health volunteer training (phase 3) will continue throughout the month of November. Distribution of ORS and vitamin A will start with the completion of the training.

The 3rd nutrition assessment survey will be carried out from 21 November to 3 December.

Dr. Sarah Castle will complete her work with IEF staff on 10 November.

#### *Financial Report*

The financial report is attached. Time sheets for Drs. Lewallen and Courtright are attached.

1ST WEEK OF VHV TRAINING

MAKHWIRA

NAME OF VHV	VILLAGE	DATE TRAINED
Estere Mwahula	Mpingasa	20th - 24th October
Annie Moses	Mpingasa	" "
Awine Webster	Bodza	" "
Maria Mara	Malata	" "
Ellena Laston	Nyaulombo	" "
Modesta Salimu	Mfunde	" "
Evelina Erick	Nchacha	" "
Catherine Peter	Mpingasa	" "
Harry April	Kavalo	" "
Mary Blaiton	Nyaulombo	" "
Joyce Mbalame	Nyaulombo	" "
Ester Njanji	Bodza	" "
Estery Dawisi	Malata	" "
Florence Benson	Nkadyamwano	" "
Mercy Chikudzu	Malata	" "
Felester Petro	Kavalo	" "
Estere Dan	Mpingasa	" "
Oliva Jefule	Nkadyamwano	" "
Polina Chamanga	Mfunde	" "
Evelin Kubwalo	Gangu	" "
Modester Manjolo	Malata	" "
Rose Namagowa	Nchacha	" "
Prisca Bande	Mfunde	" "
Fatima .B. Marko	Mmodzi	" "
Inness Botomani	Chibandwa	" "

Melvis Jankeni	Nchacha	20th - 24th Oct
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VILLAGE HEALTH VOLUNTEERS TRAINING

CHIPWAILA

NAME OF VHV	VILLAGE	DATE TRAINED
Elesitina Kautale	Paiva 11	27th - 30th October
Alinne Yonasi	Chabisala	" "
Batty Kamanga	Robert	" "
Lucy Loyd Vize	Chiutale	" "
Lenasi Tension	Miles	" "
Chrissy Chitsanathi	Gonyo	" "
Eferesi Chibisa	Mthumbi	" "
Catheren Black	Khundu	" "
Rose Chaluma	Nyangu	" "
Getrude Caume	Chokankunene	" "
Yuster Rough	Mtembeta	" "
Catheren Tito	Santu	" "
Wiston Nyampenza	Kafukiza	" "
Million Andiseni	Gonyo 11	" "
Eunice Dickson	"	" "
Martha Mkuzi	Mpheza-milisi	" "
Chrissy Sumart	Katoma	" "
Naomi Chansiku	Chidama	" "
Aluwesi Tchapo	Kalu	" "
Edesi Ganizani	Kalulu	" "

VILLAGE HEALTH VOLUNTERS TRAINING  
2ND WEEK OF 2ND PHASE MAKHWIRA

NAME OF VHV	VILLAGE	DATE TRAINED
Damisi Phiri	Mpwaila	27th - 39th Oct
Mrs. G. Gundampando	Nantusi	" "
Mrs. N. Hamitoni	Zing'ando	" "
Miss Loveness Limited	Nyambalo	" "
Mr Wadi Chasilira	Kusakala	" "
Miss Mary Manjamo	Nanthusi	" "
Miss Mercy Chatsika	"	" "
Mrs Bertha Molihe	M'modzi 1.	" "
Miss Chrissy Maluwa	Zingando	" "
Mrs Edith Nsona	Mfunde	" "
Mrs Eliza Mphonde	Chibandwa	" "
Mr Medson Kalima	Kalaundi	" "
Miss Margret Jenala	Malata 11	" "
Mr Kennex Sydreck	Mandele 1	" "
Mrs Gladys Iven	Zing'ando 11	" "
Miss Melia Gauti	Nchacha	" "
Mrs Yusta Nyaganzi	Nantusi	" "
Mrs Belita Kancheka	Nchacha	" "
Mrs Alice Khulumala	Malata 11	" "
Mrs Fanny Marko	Kalaundi	" "
Mrs Grace Robert	Mandele 1.	" "
Mrs Grace Charles	Mandele 1.	" "
Miss Zabele Filiyasi	Mandele 11.	" "
Mrs Anness Gringo	Mphaila	" "
Mrs Estere January	Mandele 11.	" "

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**Report on the 2nd Nutrition Assessment Conducted in Chikwawa District on Sept. 28th - Oct. 8th, 1992, by IEF and MSF - Holland.**

**SUMMARY**

A second nutrition status survey was conducted in Chikwawa District from Sept. 28th - Oct. 8th, by MSF - Holland and IEF. 2.0% of the children were moderately to severely malnourished.

To generate results that would allow targeting of limited resources; ie. general food rations, complementary rations, water improvement schemes, and health activities the district was divided into 6 geographic areas. (See attached map).

At a sub-district level, we found the following proportion of children to be moderately or severely malnourished. (<80% WFH).

<u>Area</u>	<u>% of children severely or moderately malnourished</u>
River/Marsh	1.2
Escarpment	2.8
Chapananga	2.4
Urban	0.4
Road	3.0
Hilly West	1.4
-----	
Overall	2.0

The data do not show significant deterioration of nutritional status in Chikwawa District at present; however, there is considerable difference between areas. Our results show that the nutritional status of children in 2 areas (River/Marsh and Urban) are better than in other areas. From field observations, it appears many people are able to cope with drought situations. Some people have access to water, access to an income, and/or other sources of food, in particular food from refugee camps. In other areas the situation is deteriorating with a depletion of food, water & livestock, and an increase in diarrhoeal diseases and malnutrition.

There have been 2 maize distributions in the district; in May/June families received 50 kg. and in September individuals received 9 kg. The water situation continues to deteriorate forcing people to dig deeper in river beds and boreholes are drying up. Diarrhoea continues to be a chronic problem with occasional outbreaks especially in areas with poor water supply. There have been no outbreaks of measles.

Based on these findings, we recommend:

1. Areas with the highest malnutrition rates (Escarpment, Chapananga, Road, and Hilly West) should receive first priority for general and complementary rations
2. The Road and Chapananga areas should receive first priority for water improvement activities
3. Throughout the district, diarrhoeal disease control activities should be strengthened
4. Nutrition surveys should be continued at the sub-district level and standardized throughout the Region.

# A Review of the Nutrition Task Force Nutrition Guidelines Regarding Mid-upper Arm Circumference (MUAC) as a Tool to Identify Children for Supplemental Feeding Programmes

## Analysis of Data from Recent Nutrition Assessment Surveys

### Background

Nutrition assessment of the individual child, diagnostic assessment, is performed to identify malnourished children and provide supplemental rations or other forms of intervention. In pre-drought times children in Malawi have been weighed and the weight has been plotted on a weight for age chart. Those children failing to thrive were provided supplemental rations. In an average year about 12% of children are underweight--eligible for supplemental foods. In order to be effective, weight for age must be done regularly. Regular weighing of all children under 5 years of age is beyond the capability of health staff and unrealistic given the distance to health centres that mothers must take children. As an alternative, MoH has developed guidelines prescribing that mid-upper arm circumference (MUAC) should be used to determine which children receive supplemental foods. These guidelines instruct health staff to provide supplemental foods to all children who are MUAC red ( $\leq 12.5$  cm) and MUAC yellow (12.6 cm to 13.5 cm). A review of the literature would suggest that these "cut-offs" may be inappropriate in Malawi. In a large study (n=4023) from West Africa it was found that MUAC identified many more "malnourished" children than the standard weight for length measures. The study also demonstrated that a better balance between sensitivity and specificity could be achieved if the "cut-off" was mid-point in the yellow MUAC ( $\leq 13.0$ ).

### Materials & Methods

In September and October 1992 three independent nutrition assessments were conducted in the districts of Chikwawa (International Eye Foundation/MSF-Holland), Nsanje (MSF-Holland), and Machinga (GTZ/ARC/MoH). In all three districts a standardized methodology was used (available from the Drought Response Coordination Unit) with weight for height measured on all children 6 months to 5 years of age. Oedema was also recorded. On all children MUAC was measured in centimeters according to standard procedures. Weight for height data was analyzed on EPI-NUT/EPI-INFO. The Chikwawa and Nsanje data sets were converted into SPSS-PC+ and the Chikwawa data set used for further analysis of MUAC and weight for length. Unless specified otherwise, the results reflect children  $>11$  months of age and without oedema.

### Results

A summary of the malnutrition results from the three district surveys is given in Table 1. Recognizing that there can be tremendous inter-observer variation in measurement of MUAC we will use the Nsanje and Chikwawa data sets for further analysis since training of staff was conducted at the same time. Nevertheless, the figures will also show the data from Machinga. In Nsanje and Chikwawa district children who were malnourished ( $<80\%$  weight for length) were most likely to be identified as

MUAC red. (Figure 1) In all, 79 children were identified as being malnourished (<80% weight for length; 48 children (60.8%) were MUAC red, 19 (24.1%) were MUAC yellow and the remainder (18.9%) were MUAC green. There was no significant difference by district. This indicates that children who are truly malnourished will most likely be assessed correctly by MUAC red + yellow. It is equally important to measure how many "false positives" MUAC creates. In both districts MUAC identified from 6.4% to 9.1% of children as MUAC red and from 19.8% to 28.6% as MUAC red + yellow. Approximately 18% of children identified as MUAC red were <80% weight for length, 50% were 80-89% weight for length and the remainder (32%) were 90% and over. (Figure 2) MUAC yellow + red tends to include even more children who are not malnourished (>90% weight for length). As seen in Figure 3 over half (53%) of children identified as red + yellow MUAC are not malnourished.

Since it appears that MUAC red is not a sufficiently sensitive measure, and MUAC red + yellow is not a sufficiently specific measure (it identifies too many children who are not truly malnourished) we chose to use the "cut-offs" suggested in the literature from West Africa. For ease of analysis the Chikwawa data is presented. As demonstrated in Table 2 a cut-off of  $\leq 13.0$  cm gives a fairly good balance between sensitivity and specificity and identifies a much more reasonable number of children that can be realistically managed within the existing supplemental feeding programme.

Data for children 6 -11 months of age were analyzed separately. As can be seen in Table 3, and demonstrated elsewhere, MUAC is not a reliable measure for use in infants.

### Discussion

In Chikwawa and Nsanje, only 8% of those yellow or red are truly malnourished; over half of these children are  $\geq 90\%$  weight for height (normal). According to the present guidelines 20% of children in Chikwawa and 29% of children in Nsanje (yellow + red MUAC) would be eligible for supplementary feeding, likely to be beyond the capability of the current supplemental feeding programme. Resources are scarce and it is essential that we ensure that the most needy children receive adequate supplemental foods. Based on these findings we would like to make the following recommendations:

1. All children (>11 months of age) who are red MUAC or with oedema should receive supplemental rations.
2. All children (>11 months of age) who are yellow MUAC should be reassessed. Those children whose MUAC measure is  $\leq 13.0$  cm or with oedema should receive supplemental rations. Children who are MUAC  $> 13.0$  cm should be considered for supplemental ration if other indications suggest (e.g. malnutrition in other family members, diarrhea, measles, etc.)
3. Children 6-11 months should be assessed according to existing guidelines (weight for age).

**Acknowledgements:**

This work was a collaborative effort involving the Ministry of Health, Medecins Sans Frontieres-Holland, American Refugee Committee and the International Eye Foundation.

**References:**

1. Ministry of Health. Chikwawa District Hospital Annual Report 1990. Chikwawa
2. Gayle HD, Binkin NJ, Staehling NW, Trowbridge FL. Arm circumference v. weight-for-height in nutritional assessment: Are the findings comparable? J Trop Pediat 1988;34:213-217

**Table 1**

District	# Children Surveyed	% Children <80% WFH (95% CI)	% MUAC Red	% MUAC Red+Yellow
Chikwawa	2,757	2.0 (1.5 - 2.5)	6.7%	19.8%
Nsanje	1,352	3.6 (2.6 - 4.6)	9.1%	28.6%
Machinga	891	9.4 (7.5 - 11.3)		

Table 2  
 MUAC as a Measure of Malnutrition:  
 Results from Chikwawa District

Children > 11 months of age & Excluding Oedema (n=2,400)

Weight for length <80%

	Red MUAC	Red + Yellow	≤13.0 cm
Sensitivity	62.8%	83.7%	79.1%
Specificity	94.7%	81.4%	87.4%
% of popul.	6.4%	19.8%	13.3%

Weight for length <-2 z scores

	Red MUAC	Red + Yellow	≤13.0 cm
Sensitivity	57.6%	81.4%	76.3%
Specificity	94.9%	81.8%	87.7%
% of popul.	6.4%	19.8%	13.3%

Table 3

MUAC as a Measure of Malnutrition:  
 Results from Chikwawa District

Children 6-11 months of age & Excluding Oedema (n=349)

Weight for length <80%

	Red MUAC	Red + Yellow	≤13.0 cm
Sensitivity	66.7%	100%	66.7%
Specificity	73.7%	54.9%	55.5%
% of popul.	26.6%	55.3%	44.7%

Weight for length <-2 z scores

	Red MUAC	Red + Yellow	≤13.0 cm
Sensitivity	75.0%	100%	75.0%
Specificity	73.9%	45.2%	55.7%
% of popul.	26.6%	55.3%	44.7%

**Nutritional Assessments for Targeting of  
Drought Resources**

**Resolutions of Participants at the  
Drought Response Coordination Unit (DRCU) Sponsored Seminar**

**30 October 1992  
Lilongwe**

1. The meeting expressed its grave concern at the deteriorating food situation in drought-affected districts, and urges the Malawi Government to take stronger measures to allocate the limited available food resources strictly according to need.
2. Targeting of drought relief should be discussed more at the national level and directives be given to District Commissioners and politicians that the resources should be allocated within their districts according to all available information regarding need.
3. At district level all available data (food availability, water situation, health status, access to other income generating activities, nutritional status, and market availability and prices) should be used to identify priority areas within the district.
4. A concerted effort should be made to conduct standardized nutrition assessments (including food and water availability) in districts at risk, but as yet unsurveyed.

**CHIKWAWA DISTRICT**  
**VULNERABILITY & CAPABILITY ANALYSIS**

Second Assessment: October 1992

*Background*

The first Vulnerability & Capability Analysis (VCA) was undertaken in April 1992. To assess changes in the populations' coping mechanisms we have conducted a second VCA in Chikwawa District. As before, we have included information based on our on-going experiences in Chikwawa District and interviews, in three different villages.

*Physical / Material Vulnerabilities & Capabilities*

Families have managed to retain cattle stocks. Cattle are let graze freely and it is reported that this has resulted in some loss of cattle. The price for a cow from the slaughter house has decreased in the last few months. Chicken stocks are reduced and disease has decimated their numbers in one of the villages interviewed. Some people have found it to be necessary to sell their bicycles, radios and other recoverable goods in order to get money to buy food.

Market maize is lower in price than ADMARC maize. Market maize is yellow--maize from the refugee camps. As reported in April, very few people purchase from ADMARC. In villages distant from the refugee camps very few people reported buying directly from refugees.

Short term paid labor ("ganyu") is difficult to find. Ganyu labor (primarily gardening for more well-off farmers) will earn K 1-1.50 per day. Both men and women are looking for casual labor opportunities. SUCOMA remains a major source of salaried labor for many families. The villages all have skilled workers for construction work, carpentry and tailoring.

A complaint voiced by all villagers was lack of food and lack of water. In some places there is access to dimba land along the Shire River and gardens are tended. The water level in the river has dropped and villagers report that the yield from these gardens has been poor and the distance is far to walk. It takes from sunrise to noon time up to afternoon hours to reach Dimba land. At times the men will stay there for days at a time to watch over the garden and care for it. Others go to get bananas to sell at the markets and others buy sugar at wholesale price to retail in villages for a small profit.

Residents in one interviewed village proudly announced they are cutting fire wood to get money to buy food at the market. Their ancestors cut trees for fire wood and they will too. These villagers felt that as long as there were trees to cut they would survive. People reported eating twice per day. If provided food, they said they would stop cutting.

Food distribution was initiated by the government in May and continued by Red Cross in June. During the first distribution 50 kilograms of maize (yellow) was given per family regardless of family size. All families in a village received the maize at the one time. Villagers report that 50 kilos were to last one to two weeks depending on the size of the household. Village leaders report that it is difficult to fulfill the custom of serving food when meetings are held (at his/her house) with this limited quantity of maize

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and their food lasted only for a few days.

The second food distribution was held in September this time by the Red Cross at the ADMARC shelters. Villagers have many complaints: the quantity of maize received did not relate to the size of the family. When a household representative said the household had ten members she was given food for eight people. There is an apparent belief (likely to be true) by food distributors that most people who claim to have 10 or more family members are not telling the truth. Unfortunately, this is also likely to penalize those households, few though they are, that do have 10 or more family members. Villagers also complained that the measuring tins were not filled completely or that they were filled "improperly". All families did not receive food at the September distribution; some are just now being called to receive their share. Rumors regarding food distribution have also circulated among villagers. For example, people report that they have heard of people buying bags of maize from Red Cross staff.

Many of the complaints regarding food distribution reflect the change in method of distribution (April to September). With the current re-registration and potential targeting complaints and rumors are sure to increase. Nevertheless, the fact that many families still have some resources (cattle, goats, chickens and items that can be sold) and the capability to purchase (refugee) maize at a much cheaper price in the markets indicate that people are continuing to cope. Some people are "falling through the cracks", in particular the elderly. The most frequently reported group not to receive general rations are the elderly. It appears that elderly residents without family members to collect food for them fail to receive their allotted ration.

### *Social / Organizational Vulnerabilities & Capabilities*

The degree of village-based collective or collaborative work does not appear to be increasing. It is likely that the effect of the drought has yet to be severe enough to force the population to collaborate more than in non-drought times. Populations are shifting to the dimba land near the river, a common practice even in normal years. There could be a greater propensity for this shift although it is difficult to measure as people are not very exact about the concepts of "more" or "less".

We discussed if they had any agricultural clubs lending money for fertilizers and seeds. In none of the villages was this the case although they have been reported in the past. The consensus was that perhaps they would try to get a club organized to help with money for seeds this year. It had yet to be discussed.

As before, health committees were either non-existent or weak. Villagers stated that they received little support from the Ministry of Health; there was little recognition of actions they could take to improve health. In one village (appeared to be the most underdeveloped village) residents protested the lack of health facilities. The nearest dispensary is ten kilometers distant. They commented on an outbreak of diarrhea and requested a supply of ORS. They felt that the ORS could be kept by the chairperson of the village health committee.

There appear to be few village-based mechanisms to administer to people less fortunate outside the support available from the immediate family. It is the first responsibility of the immediate family to provide for all members followed by the extended family. Support from the extended family is sometimes provided grudgingly or not at all.

## Motivational / Attitudinal Vulnerabilities & Capabilities

Residents in none of the villages report having food in storage from the last harvest. The yield from the cotton harvest had been very poor and there is no seed for planting cotton or maize. When asked what they will do (whether or not rains come), people shook their heads and said "we don't know". Some said "our 'Father' will help us" while others said that the government will help like they did in 1981. Rumors are rife; an oft-heard rumor is that this year people have to pay for cotton seeds. In previous years two bags of cotton seeds for seeding three acres were provided free. Now, according to the rumor, it will cost the farmers about K 15 for one bag of cotton seed. The numerous rumors tends to suggest that the population views their life as one governed by fate, rather than their own actions.

The area has a chronic food shortage and the only difference is that this year the food shortage is worse. The population will cope as best as they can with well developed coping mechanisms based on their ability to send families to the river to farm, work on SUCOMA, and the availability of refugee maize in the markets. They will continue to use these mechanisms while gladly accepting any and all sources of outside assistance. It is not uncommon for a village leader to report that he "has no food" while his wife is busy husking maize in the background.

It is commonly reported that women have to introduce weaning foods early and more frequently due to "insufficiency of breast milk" due to drought. This is a long-standing belief that can have a potentially disastrous effect on very young children.

It is our impression that villagers will make little attempt at organizing themselves to assist with the work of outside food distributors (Red Cross or government). Work done during this period is to ensure that the individual or family receives the maximum possible, not the community. The precedents that were set early in the drought (distribution of free maize to government employees, poor registration, the lack of consistent food distribution, etc.) will only encourage residents to view all outside organization with suspicion.

In summary, the population appears to still be able to cope with the present drought. Many villagers will probably be able to cope for awhile longer since they still have cattle and goats to sell, there is maize and vegetables being grown near the river, and they can purchase refugee maize at a reduced price in the market. The elderly will likely falter first as will very young children. In some areas where there is not easy access to refugee food and where the water supply is deteriorating coping mechanisms will likely collapse first. It is unfortunate that the existing social and organizational structure will not assist in identifying these groups until it is probably too late.

Paul Courtright, DrPH  
Country Director/Malawi, International Eye Foundation  
November 3, 1992

The IEF would like to thank Ms. Anne Marie Wangel for her assistance in conduct of this analysis.

**HOW DO WE SUSTAIN VILLAGE HEALTH VOLUNTEERS?:**

**Report from a  
Save the Children-UK / International Eye Foundation  
Sponsored Seminar**

**Report prepared by:**

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## INTRODUCTION

On 5 May 1992 a workshop on village health volunteer programmes was held in Blantyre with participants from Malawi based non-governmental organizations, the Ministry of Health and the donor community. A list of participants and the agenda are attached. This workshop, sponsored by Save the Children-UK and the International Eye Foundation, followed the *Village Health Volunteers - Maximizing a Resource* workshop held in July 1991. Details of the first workshop have been published in the Malawi Medical Journal. (Malawi Med J 1992;8:67-69)

The current workshop aimed to examine ways in which village health volunteers (VHVs) can become a long term sustainable resource for the communities within which they work. The participants explored ways to achieve the participation of the community in the development, implementation, and evaluation of a community-based VHV programme. Small and large group sessions focused on two main topics: (1) the prerequisites for full cooperation between villages and agencies, and (2) community support for and agency supervision of VHVs. For the sake of clarity, in this report "agency" refers to both NGOs and MoH. Although we recognize the inherent difference between "village" and "community" we use these terms interchangeably.

### PREREQUISITES FOR FULL COOPERATION BETWEEN VILLAGES & AGENCIES

#### *Characteristics that act as facilitators and barriers for full cooperation*

The relationship between the community and the agency is a key element in the ultimate effectiveness of the volunteer's work. This relationship must be based on mutual understanding and respect, effective two-way communication, the sharing of information, and the ability to adapt. Specific characteristics of both the community and the agency can determine the degree of success of a VHV programme. As such, they may act as facilitators or they may be barriers. It should be recognized that the physical resources available in the village are sufficient for sustaining a VHV programme once the organizational and attitudinal prerequisites have been fulfilled. Table 1 lists characteristics of the village which both serve as facilitators and barriers to cooperation and Table 2 lists the respective facilitators and barriers for the agency.

Table 1

Facilitators & Barriers within the Village

Facilitators	Barriers
<p><b>Organizational</b></p> <ul style="list-style-type: none"> <li>Good leadership</li> <li>Open forum representing all interests in the village</li> <li>Inclusion of women in discussion &amp; decision making</li> <li>Reasonable educational levels</li> <li>Access to accurate &amp; timely information</li> <li>Effective organizational structure</li> </ul>	<ul style="list-style-type: none"> <li>Autocratic leadership</li> <li>Lack of representation</li> <li>Women excluded</li> <li>Poor educational level</li> <li>Inadequate mechanisms to provide good information</li> <li>No organizational structure</li> </ul>
<p><b>Attitudinal</b></p> <ul style="list-style-type: none"> <li>Sense of community identity</li> <li>Ability to work toward a common goal</li> <li>Perception of their ability to effect change (empowerment)</li> <li>Awareness of the role of health in the well-being of the community</li> </ul>	<ul style="list-style-type: none"> <li>Lack of community identity</li> <li>Disparate groups and interests</li> <li>Passive, fatalistic attitude</li> <li>Lack of awareness</li> </ul>

Table 2

Facilitators & Barriers within the Agency

Facilitators	Barriers
<p><b>Organizational</b></p> <ul style="list-style-type: none"> <li>Open to consider needs expressed by the village</li> <li>High level of temporal flexibility</li> <li>Skilled staff to act as facilitators</li> <li>Close collaboration with other agencies (MoH, NGOs, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>Own agenda may be incompatible with village's felt needs</li> <li>Rigid short-term goals and objectives</li> <li>Staff poorly trained</li> <li>Unwillingness to cooperate with other agencies</li> </ul>
<p><b>Attitudinal</b></p> <ul style="list-style-type: none"> <li>Sensitivity to the community</li> <li>Willingness to view problems from a local perspective</li> </ul>	<ul style="list-style-type: none"> <li>Preconceived ideas of the community</li> <li>More concerned with goals of the agency's programme than with community development</li> </ul>
<p><b>Physical</b></p> <ul style="list-style-type: none"> <li>Adequate resource base</li> <li>Flexible resource allocation</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate resource base</li> <li>Resources allocated according to predetermined and rigid criteria</li> </ul>

*Collaboration between the village & agency in the development, implementation, and evaluation of VHV programmes*

A collaborative needs assessment is the first step in developing a programme. The village and agency should establish a reliable process for identifying specific problems that can be tackled by the village with assistance from the agency. Often, the agency needs to act as a facilitator for consensus building, foster dialogue within the village, and provide specific "technical" skills.

Once the various health needs have been identified and prioritized the course of action can be agreed upon by the village and agency. The role of the VHV must be clearly defined and the respective contributions of the village and agency agreed. This could be assisted by the development of a period of "contract" for the VHV.

Implementation of a VHV programme must reflect changing situations (e.g., drought, population shifts) and cannot be expected to progress at the same pace in all villages. On-going supervision and support by the village and agency is essential to maintain the direction and vitality of the programmes. There is, as yet, no precedent for village contribution to participation in the evaluation of VHV programmes. Expansion of existing programmes and the introduction of additional VHV activities should be predicated by a collaborative evaluation process.

**COMMUNITY SUPPORT FOR & AGENCY SUPERVISION OF VHVs**

After reviewing the need for active collaboration with the agency and village some pertinent issues related to community and agency support and supervision of VHVs were reviewed.

*Sustainable incentives by the community & agency*

Incentives should be decided through dialogue between the community and the VHV, and not unilaterally by the agency. Incentives must be culturally acceptable, determined in advance, and affordable to the community (e.g., in-kind payments). VHV terms of reference (job description) can be helpful by providing a context with which to evaluate the VHV and determine the appropriate incentive. While there is no precedent for this in Malawi, experience elsewhere has shown this to be an effective tool.

In Malawi there is a long-established practice whereby traditional birth attendants and traditional healers are rewarded for their services by individuals. By contrast, village health volunteers are to be viewed as a community-wide resource with support from the community at-large. In some settings a

revolving drug fund has been used to provide free drugs to the volunteer's family. Some villages have opted to assist with agricultural activities while small periodic payments have been the method of choice elsewhere. It is the responsibility of the village to decide upon the appropriate form of incentives.

The agency needs to assist the community in the decision making process and the development of a mechanism for incentives. These are best developed and implemented within an existing health structure (e.g. through the village health committee).

Considerable non-monetary support for VHVs can be generated by the agency. This can be provided by regular direct contacts with VHCs and VHVs, facilitating a volunteer network to share experiences and information, and providing on-going training as required. In summary, the role of the agency is to assist the community in establishing a sustainable community incentive programme, and not to impose one.

#### *Village Health Committees and VHVS*

In most places in Malawi village health committees (VHCs) are weak with no clear idea of their role or responsibilities. Strengthening of village health committees is essential to the success of VHV programmes. Orientation of VHCs on their roles and responsibilities is required prior to implementation of a VHV programme.

Members should be truly representative of the community and a tenure of office should be encouraged as this provides an opportunity to review the performance of committee members. Agencies can provide support through continuing education and capital resources where appropriate. Periodic meetings should be used to discuss relevant issues, provide compensation and feedback to the VHV and to maintain the momentum of the programme.

Clear lines of responsibility and authority between the VHC and VHVs need to be agreed upon and consistently applied. Agencies can facilitate when necessary but they should not dictate the particular mechanisms used nor take over responsibility for VHV support from the community.

#### SUMMARY

In the past VHVs have been viewed as "agency volunteers"; if programmes are to be sustainable, ownership needs to be transferred to the community. Agencies developing and implementing village health volunteer programmes would be advised to review the character of their organization to determine aspects that facilitate and create barriers for full cooperation with the community. Equally, characteristics of individual villages should be assessed to determine community facilitators and barriers. The primary role of the agency is to foster the

capability of the village and VHV to provide health activities.

For incentives to be sustainable they must be developed by and the responsibility of the village, not the agency. Village health committees can provide the focus for the village's involvement with the VHV programme. They will require support by the agency to ensure that they are effective.

## RESOLUTIONS

The participants developed the following resolutions based on their discussions.

### *Community involvement in incentives*

1. Incentives should be decided through dialogue between the community and volunteer. They should be culturally acceptable, affordable, and decided in advance.
2. Provision of incentives and supervision should originate from the community with assistance from agencies.

### *Village health committees*

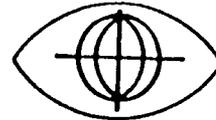
1. VHV programmes demand the existence of a functioning village health committee.
2. VHCs should be representative of the community with the full involvement of women. The responsibilities of the community can be delegated to the VHC. A policy of tenure of office for members would assist this process.
3. The VHC has the responsibility to establish clear terms of reference for the VHV and to organize their incentives and supervision.
4. Periodic discussions between VHCs, VHV's, and the agency are essential to sustain health activities.

### *The role of the agency in VHV programmes*

1. Agencies should provide support for the orientation of VHCs on their function and responsibilities. In addition, periodic village-based continuing education of VHCs should be provided.
2. It is not the proper role of the agency to provide incentives.
3. Regular supervision of VHV's (through regular contacts, on-going training, volunteer networks, etc) is essential.

4. The agency must remain flexible and sensitive to the evolving needs and capabilities of the communities.
5. Ministry of Health must be the lead agency in the development of policy regarding VHVs.
6. A framework for MoH supervision of volunteers needs to be developed and the HSA's role in this clarified. If necessary, the HSA curriculum and job description needs to be revised to reflect their supervisory responsibilities.





MONTHLY REPORT NOVEMBER/DECEMBER 1992

*Administrative Issues & Personnel*

The 3 IEF vehicles (Peugeot 305, Toyota Corolla & Toyota Cressida) are in working order. Our Toyota 4x4 is not in working order; we are awaiting the arrival of spare parts from South Africa. Our settlement from NICO (MK 33,800) has been cleared by the Reserve Bank.

Renovations of the IEF/Nchalo office has been a headache; we hope some staff will be able to move in in early January.

There has been no additional devaluation of the Malawi kwacha although there are rumors that one is imminent. At the end of December it stood at 4.2 MK = \$US 1.

In mid-December, IEF with the approval of MoH/Chikwawa, hired three additional HSA trainees. They will train with IEF and the MoH until late January. IEF hired Mr. Makata as an Administrative Assistant. He will be in position on 4 January.

Drs. Courtright and Lewallen were on leave until 19 December. Dr. Mary Jean Cuaycong substituted for Dr. Lewallen at QECH from 16 November to 21 December.

We are still having problems with our FAX line; requests to repair the line have not been fulfilled.

IEF has submitted two abstracts *How do we sustain village health volunteers?: Problems facing agencies in Sub-Saharan Africa* and *Weaning practices and the risk of diarrhea in Malawi: Implications for child survival* to USAID for the Africa Child Survival Initiative: Combatting Childhood Communicable Diseases meeting scheduled for March 29-April 2 in Abidjan, Ivory Coast. If accepted, Mr. Mmanga will present the first abstract and Mr. Mekisini the second.

*Meetings*

Mr. Chikhosi, Mr. Mmanga, and Mr. Mauszycki attended the District Drought Relief meeting on 20 November.

Mr. Mauszycki attended the Regional Health meeting of 4 December.

Dr. Courtright met with Ms. Nancy McCharen and Mrs. Daima Thyangathyanga of Peace Corps on 12 November regarding an evaluation of Peace Corps health programmes in Malawi.

Mr. Mmanga and Dr. Courtright attended the Medical Association of Malawi meeting on Child Spacing Activities. Mr. Mmanga presented a paper on child spacing knowledge, attitudes and practices in Chikwawa District. Mr. Mmanga and Dr. Courtright prepared a manuscript entitled *Attitudes & Practices Regarding Child Spacing in Chikwawa District: Results from a Population-based Survey of 2,173 Women* and submitted this to Malawi Medical Journal.

*Ministry of Health/Chikwawa & IEF Collaboration*

The IEF & MoH have continued to conduct village health committee trainings cooperatively.

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There are bottlenecks in the current system of getting ORS to the field that need to be worked out in order for IEF to obtain ORS from the district rather than from the regional office. Funds available for drugs at the district are scarce. NGOs, including IEF, have been requested to provide drugs. We will have to consider these requests.

Mr. Mmanga has assisted the MoH in the conduct of district drought health trainings. On November 23-25 and December 14-16 he taught MoH staff on two topics (vitamin A and diarrhea control) in Ngabu.

#### *ADRA/IEF Collaboration & Montfort Hospital/IEF Collaboration*

IEF has continued to provide assistance to ADRA's Child Survival Project. We have recently supplied 13,500 vitamin A capsules and Mr. Mmanga gave a talk on vitamin A deficiency and nutrition to ADRA health inspectors and HSAs.

IEF has provided funds for the training of village health volunteers as part of Montfort Hospital's expanding outreach programme. We will continue to collaborate closely with Montfort Hospital to help bolster their efforts at community health. Mr. Friday Lewis, an IEF HSA will be jointly supervised by IEF and Montfort Hospital and we hope that, in the future, he can be assumed under their programme.

Ms. Porter is working with Montfort to develop a community-based AIDS control programme. We hope to have the outlines of the programme by the end of February.

#### *Village Health Promoters (1989-1991)*

We submitted a position paper on food support for village health volunteers (MoH, Montfort, and IEF volunteers) to UNICEF in mid-November. Although UNICEF considered the proposal a valuable one they have no funds dedicated for this purpose. We have also had negative responses from World Food Programme and USAID. We will have to wait and see what transpires over the next few months.

#### *Village Health Volunteers (1992-1995)*

The interview form for the joint ADRA/SCF-UK/Trinity Hospital/IEF study of village health volunteers has been translated and field tested. SCF-UK has started interviews with their volunteers. IEF will start interviews with the next round of volunteers we recruit.

Village health volunteer training has continued in all sites. IEF is preparing a complete list of village health volunteers (currently numbers 274) and will start the first round of assessment.

SCF-UK and IEF have submitted a manuscript to Malawi Medical Journal entitled *How do we sustain village health volunteers?*

#### *IEF HSA Trainees*

The training of village health committees and village health volunteers (phase 3-the final phase) has been completed.

#### *Training in November/December:*

Dolo	22 VHVs trained and supplied
Chipwaila	22 VHVs trained and supplied
Makhwira	50 VHVs trained and supplied

This completes the training of VHVs in the three catchment areas.

IEF has received a copy of a motorcycle policy developed by SCF-UK with the MoH/Mchinji. We will use their policy to help redraft an IEF motorcycle policy that would be acceptable to MoH.

#### *Under-Five Clinic & Health Education Centre*

Ms. Porter has prepared two proposals for the creation of health education facilities in the villages of Thendo and Nyasa. Mr. Mwanga and Mr. Alifinali assisted in meeting with village leaders and preparing the plans. The proposals have been approved by the US Peace Corps and the plans will be finalized in the month of January. Construction will not begin until after the rainy season ends. The grant amount for Nyasa was 28,635 MK and for Thendo, 30,635 MK.

#### *Expansion of the Project Site*

As per IEF's operating plan we will be expanding our activities into three additional health centre catchment areas in January. Three existing IEF HSAs will move to these catchment areas and three new HSA trainees will be hired to take their place at their current posts. The placements are as follows:

Maperera	Mr. Lockie (from Makhwira)
Ngabu	Mr. Mosquito (from Dolo)
Ndakwera	Mr. Kavalo (from Chipwaila)

#### *New HSAs to existing sites:*

Makhwira	Ms. Mepher Moyo
Dolo	Mr. Charles Bonya
Chipwaila	Mr. Erick Navaya

Shifting of new and existing staff will be in January. Because of the weather conditions they will start area surveys but not start village health committee training until February or March. A map of these areas is given as an appendix. Remaining catchment areas are Chikwawa, Kakoma, and Gaga. We will expand to these areas in early 1994.

#### *Baseline Survey*

The baseline survey report was finalized and distributed. Request for additional copies should be made to IEF/Blantyre.

#### *Exclusive Breast Feeding: Developing an Effective Programme*

Dr. Sarah Castle, a consultant from Wellstart, worked with IEF from 12 October to 10 November. Dr. Castle and Ms. Duke (with assistance by Miss Washa, one of the IEF HSAs) identified the major problems with current breast feeding practices in Chikwawa District. Her report is not in a finalized form. Dr. Castle and Ms Duke conducted a one-day workshop for IEF HSAs and senior staff to review the findings and generate ideas for changing these practices. Meetings were also conducted with UNICEF (Dr. Tyson and Nadra Zaki), SCF-UK (Jane MacAskill) and the MoH Nutrition Unit (Mrs. Banda). IEF has worked with UNICEF to produce a special EPI Bulletin on Exclusive Breast feeding which should be available in February.

Based upon this information Ms. Duke prepared a proposal to UNICEF to support a Southern Region workshop to address the lack of exclusive breast feeding. This proposal was accepted by UNICEF and the workshop is scheduled for 21-22

January. The workshop will be conducted in collaboration with MoH/Southern Region with facilitation provided by Mrs. Banda at the MoH Nutrition Unit and Mrs. Selenje at UNICEF. If the Southern Region workshop is considered successful IEF will approach UNICEF for support for a workshop in the Central Region and the Northern Region. Ms. Duke will assist the MoH/Chikwawa in conducting a district workshop.

Ms. Duke met with the Johns Hopkins AIDS Project staff to review findings from IEF's breast feeding research and set up a mechanism to collect breast feeding behavior information from women enrolled in their project.

#### *AIDS Control*

IEF has been in contact with Family Health International for assistance in developing a community based AIDS control programme that would involve female village health volunteers working with other women. FHI's role is still unclear.

Ms. Porter will be collecting all available information in Malawi regarding community based approaches to AIDS control and conducting focus groups with both men and women in Chikwawa to develop an appropriate AIDS control programme.

#### *Ophthalmologic Situation at QECH*

Dr. Lewallen and Dr. Chirambo have submitted a proposal *A study of the prevalence of refractive error in Malawi* to the Health Science Research Committee.

#### *PCV Activities*

Mr. Mauzyscki continued as the coordinator of IEF's nutrition assessment activities. Details of the November/December nutritional assessment in Chikwawa are presented as an appendix. Further information is found in the section on *Drought: Nutritional Assessments*.

Ms. Duke spent most of November and December involved in breast feeding investigations and proposal preparation.

Ms. Porter has devoted most of her time to AIDS control programme development. She also supervised one team during the November/December Chikwawa District nutritional assessment.

#### *Drought & Impending Famine: Nutritional Assessment*

IEF and MSF-Holland continued their collaborative programme for nutritional assessment in Chikwawa District. The third survey (November 21-December 3) showed no increase in malnutrition in the district. Additional IEF staff were trained in these activities. There was no difference between any of the six sub-district areas in Chikwawa. The short report is given as an appendix. The full report can be obtained from IEF/Blantyre. UNICEF has graciously offered to assist in the preparation of computer-generated (digitized) maps of the districts. Mr. Mauszycki will work with UNICEF in February or March on maps for all districts in the Southern Region.

As part of the 3rd survey children who were malnourished were given a referral form to take to the nearest MoH/CHAM health centre for supplemental feeding. This referral form will be used to track all malnourished children after 60 days to determine use of health facilities, food distribution, etc.

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We are saddened to realize that the Government of Malawi is unwilling to target food supplies to needy areas.

MSF-Holland has decided to discontinue their nutritional assessments in Chikwawa District. IEF has decided to conduct one additional survey (whole district) in Chikwawa just before the harvest. IEF and Project HOPE have been approached by the MoH/Southern Region to conduct nutritional assessments in Blantyre and Chiradzulu Districts. IEF and Project HOPE will collaborate on both surveys. The Blantyre survey will start on 1 February and the Chiradzulu survey will start on 15 February. These, and all IEF survey activities are being supported by a grant from the Drought Relief Coordination Unit.

IEF is collaborating with the MoH/Southern Region, MSF-Holland, and ARC on the preparation of a manuscript, *Mid-upper arm circumference (MUAC) as a tool to identify children for supplemental feeding programmes: Correlation with weight for height in Malawian children* comparing MUAC and weight for height measures. We were pleased to hear that the work we all collaborated on has been used to change the referral criteria for supplementary feeding.

IEF has received funds from the DRCU (NGO Strengthening Fund) to support our nutrition assessment activities and Msua Island health activities. The Confordzi Estate manager generously agreed to fly Ms. Porter and Dr. Courtright over Msua Island which gave us the opportunity to map communities on the island; existing maps were extremely unreliable. At the time we also learned which Shire River dimba lands families had moved to grow maize during this time of drought. Interestingly, these people were quite near the huge irrigation project, although not benefitting from it, that SUCOMA had developed.

#### *Drought & Impending Famine: Vitamin A Supplementation*

At a recent MoH drought task force meeting in Lilongwe it was recognized that resources are not available for a massive vitamin A mass treatment campaign at the present. Instead vitamin A will be widely distributed and a publicity campaign will be launched urging parents to seek prophylaxis for 6 mo to 6 year olds. IEF will be working with the MoH/Chikwawa to conduct a workshop for church leaders and other village leaders to encourage mothers to take their children for vitamin A supplementation.

#### *Traditional Practices for Eye Disease in Malawi*

Ophthalmic medical assistants in Chikwawa and Mulanje (and Dr. Lewallen at QECH) continue to enroll corneal ulcer patients in this study. We will continue patient enrollment until March 31. Interviews of traditional healers are progressing well; healers continue to be willing to discuss their practices and patients and sell some of the products they use for treatment.

#### *Investigation of Vitamin A Deficiency and Other Disorders in Measles*

Enrollment of cases will continue until 1 March giving us a 12 month period of QECH measles admissions.

In collaboration with Dr. Chris Kjolhede, Department of International Health, Johns Hopkins School of Hygiene & Public Health, we submitted a proposal to investigate the role of vitamin A in boosting vaccine-induced measles antibody levels to the HSRC. In reviewing the proposal it appears that the committee never read anything but the title, *Response to measles vaccine with and without vitamin A supplementation*. It was rejected by the committee, the reason being that "on the ethical ground that no child should be denied vitamin A in Malawi" and "study will have a control group whose members will

be denied the vitamin". As stated in the proposal, all children will receive vitamin A supplementation; those children receiving placebo will be supplemented 4-8 weeks after the case children. We have written a letter to the HSRC pointing out this fact and requesting reconsideration.

#### *Vitamin A Deficiency and Cerebral Malaria*

Enrollment of cases will not resume again until January, 1993.

#### *Barriers to the Acceptance of Cataract Surgery*

Only 2 patient satisfaction with surgery interviews remain to be completed. These will be completed at a convenient time in the next month or two. Data analysis and report writing will start in February.

#### *Prevalence Survey of Onchocerciasis in Mwanza District.*

Plans are underway for starting the Mwanza onchocerciasis survey in January.

#### *Plans for January*

Distribution of ORS and vitamin A will continue as needed.

The IEF Exclusive Breast feeding seminar (agenda attached) is scheduled for January 21-22.

The Malawi Prevention of Blindness committee is scheduled to meet on 22 January.

Abstracts for the Medical Association of Malawi are due on 31 January. Abstracts relating to breast feeding practices, vitamin A supplementation, early measles cases, traditional eye medicines, and cataract surgery acceptance will be prepared and submitted.

#### *Financial Report*

The financial report is attached. Time sheets for Drs. Lewallen and Courtright are attached.

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# CHIKWAWA DISTRICT

MWANZA DISTRICT

BLANTYRE DISTRICT

Shire River



THYOLO DISTRICT

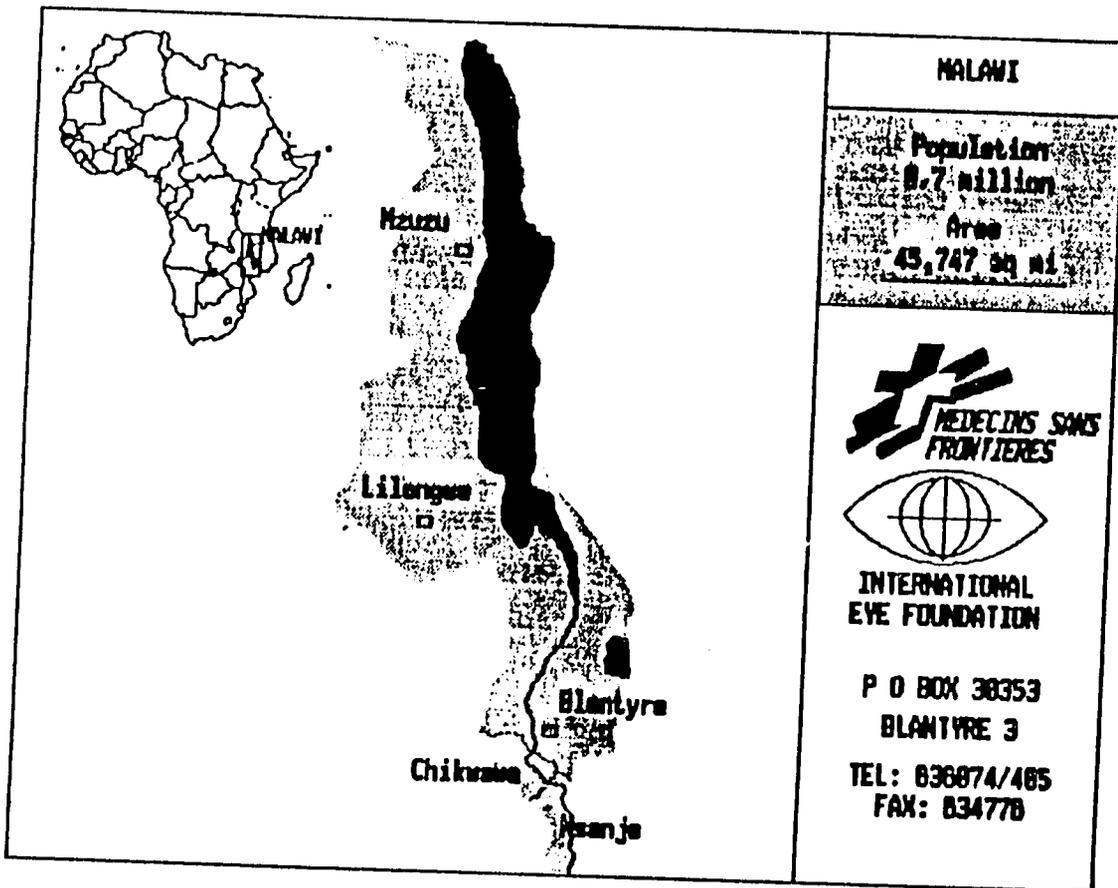
BIQUE

NSANJE DISTRICT

Centre/Hospital Catchment Areas in  
 Village Health Volunteer Programme

- (as of March, 1992)
- (as of March, 1992)
- (as of March, 1992)
- (as of January, 1993)
- (as of January, 1993)
- (as of January, 1993)
- (with Montfort Hospital-January 1993)
- (planned for January, 1994)

SUMMARY ON THE 3RD  
 NUTRITIONAL ASSESSMENT  
 in  
 CHIKWAWA DISTRICT



23 NOVEMBER - 3 DECEMBER 1992  
 by  
 THE INTERNATIONAL EYE FOUNDATION  
 and  
 MEDECINS SANS FRONTIÈRES HOLLAND

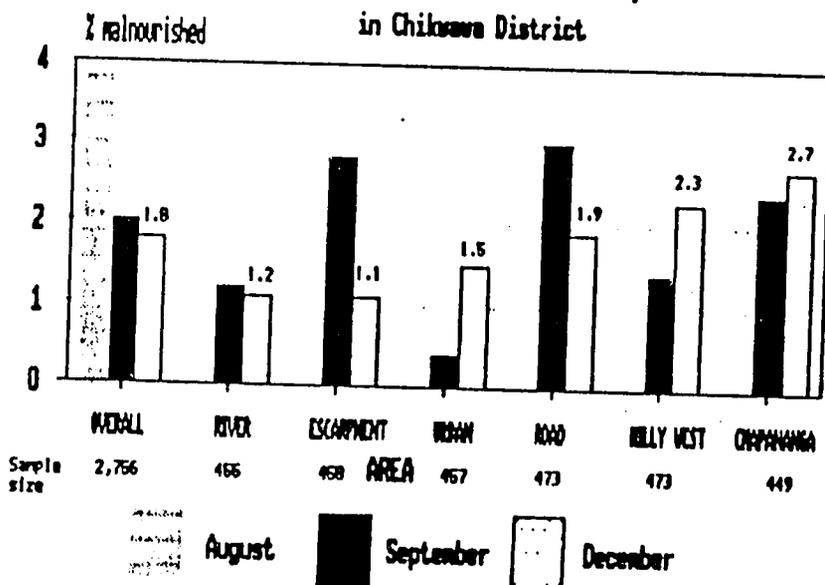
**SUMMARY**

A third nutritional assessment was conducted in Chikwawa District from Nov. 23- Dec. 3rd by MSF and IEF. Overall, 1.8% of the children under five-years were moderately to severely malnourished.

To allow for prioritizing areas at a sub-district level with limited resources, the same 6 areas have been surveyed for this assessment. (See attached map).

**Moderate & Severe Malnutrition**

(Less than 88% W/H + Oedema)



At present in Chikwawa District, there are no significant differences in nutritional status as compared to the surveys done in August and October, 1992. Also, there are no significant differences between the 6 geographic areas at the sub-district level, when looking at confidence intervals. However, from field observations and discussions with village chiefs and local health personnel in the district, it appears many people are able to cope with drought situations while others are not coping as well. In some areas, people have better access to food (ie. refugee camp food or harvested food), access to water, and/or access to an income. In other areas, people are facing a deterioration in food, water, livestock, and a significant increase in diarrhoeal disease

There have been three maize distributions in the district; in May/June, September, and October/November. In the latter, the ration was 9 kg. per person and most people in all areas of the district received the free maize.

Food stocks, livestock, and water conditions continued to deteriorate throughout the district. Diarrhoea is a chronic problem throughout the district (17.1% of children surveyed) but, with significantly higher rates



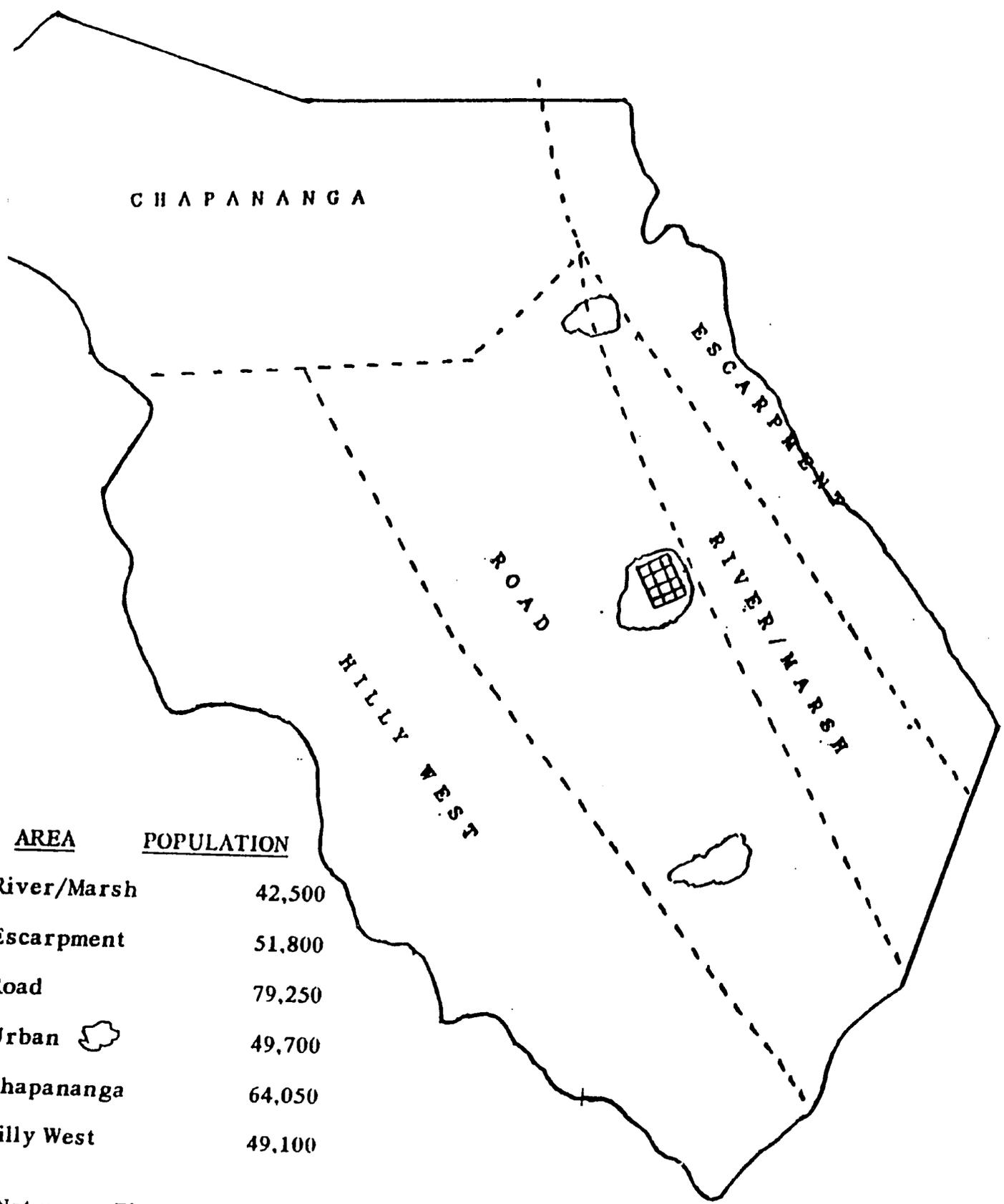
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found in Chapananga area. Bloody diarrhoea was present, but only at low levels (4.9 % for the district).

Based on these findings, we recommend:

1. Prioritize worst affected areas (Road, Hilly West, and Chapananga) for receiving general and complementary rations.
2. Diarrhoeal disease control activities should be strengthened throughout the district with first priority to Chapananga.
3. The areas of Chapananga and Escarpment should receive first priority for water improvement activities.
4. Based on key indicators, nutritional assessments should be continued at sub-district level.

# Chikwawa District



<u>AREA</u>	<u>POPULATION</u>
River/Marsh	42,500
Escarpment	51,800
Road	79,250
Urban 	49,700
Chapananga	64,050
Hilly West	49,100

Note: Figures are taken from 1987 Census, estimated to 1991.

Thursday, 21 January 1993

- 8 - 8:30            Opening and Introductions  
                  Dr. David Jacka, Regional Health Office  
                  Dr. Paul Courtright, International Eye Foundation
- 8:30 - 9:00        Purpose and Goals of Seminar  
                  Participant Pre-Test
- 9:00 - 10:00      Breast Feeding Myths (Discussion)
- 10:00 - 10:15     Tea Break
- 10:30 - 11:30     Results from Chikwawa, Thyolo and Nsanje Breast  
                  Feeding Investigations
- 11:30 - 12:30     Advantages of Exclusive Breast Feeding  
                  (Discussion)
- 12:30 - 2:00      Lunch
- 2:00 - 3:00        Physiology of Breast Feeding
- 3:00 - 4:00        Lactation Management
- 4:00 - 4:15        Tea Break
- 4:15 - 5:00        Composition of Breast Milk

Friday, 22 January 1993

- 8:00 - 8:30        Review of Day One
- 8:30 - 9:00        Mother's Nutritional Status and Breast Milk  
                  Production (Quality and Quantity)
- 9:00 - 10:00      Exclusive Breast Feeding During Drought  
                  (Discussion)
- 10:00 - 10:15     Tea Break
- 10:30 - 11:30     Dangers of Early Supplementation
- 11:30 - 12:30     Breast Feeding Advice for Pregnant/Lactating Women  
                  (Discussion)

Friday, 22 January 1993 (continued)

- 1:30 - 2:00 Lunch
- 2:00 - 2:30 Water and the Exclusively Breastfed Infant
- 2:30 - 2:45 The Baby Friendly Hospital Initiative
- 2:45 - 4:15 What Health Workers Can Do to Promote Exclusive Breast Feeding & The Importance of Community Involvement in the Promotion of Exclusive Breast Feeding (Discussion)
- 4:15 - 4:30 Tea Break and Seminar Evaluation
- 4:30 - 4:45 Participant Post-Test
- 4:45 - 5:00 Closing

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