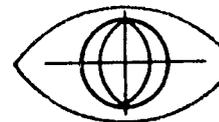


PD-ABG-763

1st 9/3/93



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

QUARTERLY PROGRESS REPORT #5
APRIL - JUNE, 1993

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

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JULY 1993

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I. PROJECT SUMMARY

The following is the sixth quarterly report for the IEF project "Vitamin A For Child Survival" in Chikwawa District, Lower Shire Valley, Malawi, Cooperative Agreement No. PDC-0284-A-00-1123-00. The reporting period covers April 1st through June 30th, 1993.

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. SIXTH PROGRESS REPORT, APRIL - JUNE, 1992

A. Administrative

* All IEF vehicles (Peugeot, Toyota Corolla, Toyota Cressida, Isuzu pick-up, and Toyota 4x4) are in good working order. The Toyota 4x4 was finally repaired in June by Montfort Hospital garage at a fraction of the labor costs of other garages.

* Although renovations on the Nchalo office are in-complete, the new office is being occupied. The new address in Nchalo is P.O. Box 142, Nchalo, Telephone 428-295.

* The Malawi Kwacha is currently 4.2 MK = \$US 1. There is a severe shortage of foreign exchange in Malawi resulting in the absence of spare parts in the country.

* Problems with the Fax and telephone lines continues to be unresolved.

- Mr. Kalavina, IEF HSA for Dolo, was promoted to be an HSA supervisor for the northern half of Chikwawa District

B. Monitoring and Evaluation

* The project information system is under review to a) refine data needed by indicator, b) assess the quality of data gathered, c) assess the schedule for gathering and reporting data, and d) determine training needs of staff and volunteers.

- The first Health Information System review was conducted in April and May and reported in June. The assessment reviewed 230 village health volunteer registers for information on vitamin A coverage and diarrheal disease. Data from the review is used as a training exercise and reporting exercise. See Attached report.

- The next review will assess nutrition, AIDS, and family planning.

C. Project Activities

1. Training/Supervision

* Village Health Volunteers (1989-1991): VHV's in Nsange District continue to be provided VACs by IEF and are supervised when possible.

* Village Health Volunteers (1992-1995): The training of village health volunteers in the second phase Health Center Catchment Sites (HCCS) of Maperera, Ngabu, and Ndakwera, is complete. Despite delays, 217 out of 226 VHV's (96% of goal) were trained. HSAs have experienced increasing difficulties in organizing village health committees due to the political

climate. VHV training was suspended from June 7-11 and 14-18 due to the political referendum. See constraints.

* VHVs from the new HCCS are being interviewed, along with another women chosen as a control, to determine what characteristics identify women selected to be VHVs. This information will serve as a baseline to determine what factors lead to a successful VHV and to drop-out rates among VHVs. These initial interviews were completed in May.

* Health Surveillance Assistants: HSAs continue to provide training to 344 VHVs and the Village health committees in AIDS control activities. These training were conducted in coordination with MOH HSAs.

- IEF HSAs and MOH HSAs are being paired together for AIDS control activities. IEF HSAs are identifying traditional healers in their areas to begin AIDS control activities.

- Interviews for new HSA trainees for the third phase Health Center Catchment Sites (HCCS) of Chikwawa, Chapananga, Gaga, and Kakoma will be held in July. Training will commence in mid-July.

* Village health committees: Training of VHCs in the new HCCSs was completed in April. There have been increasing difficulties in organizing VHCs due to the current political problems. IEF has been confused as a political pressure group ("International Eye Front") and local people don't attend meetings called by the village headmen because village headmen, representing the Malawi Congress Party, are distrusted.

- VHCs are being provided training in AIDS control activities.

* Montfort Hospital:

- IEF, Montfort hospital and the MOH are continuing discussions on development of an AIDS control and family planning center at Montfort hospital.

- Nsua Island now has HSAs supervising VHVs and are now part of the routine health delivery system.

- IEF is working with Montfort to include vitamin A and ORT activities to their programming.

2. Vitamin A/ORT

* IEF is working with ADRA in the northern half of Nsange district. ADRA has achieved 87% coverage with VACs during their last distribution cycle.

- IEF has provided ADRA with an additional 10,000 vitamin A capsules for their next campaign.

- A presentation was made to the MOH/south by Dr. Courtright on the success and failures of the national vitamin A capsule distribution program in June.

* IEF is working with the MOH/South to modify the Hoffmann-LaRoche, Inc., Task Force "Sight and Life" Vitamin A Poster. The poster has not been printed to date.

* Coverage with VACs among children 6 months to 6 years of age in the district, measured during a nutritional assessment review, currently averages 45% (baseline survey was 13.9%); a significant increase. Higher coverage rates are expected in the first phase HCCSs.

3. Drought Relief

- IEF helped to develop and coordinate a Health and Drought Seminar in May 31-June 2 in Blantyre. The purpose of the seminar, attended by 113 representatives of the MOH (regional and district), health NGOs, and others, was to discuss the abilities, successes and failures of the health system during the 1992/93 drought and to develop recommendations for the future. A report is in preparation.

- Data from all nutritional assessments (25,000 children) conducted in the southern region by NGOs and UNICEF during 1992/93 is being used to prepare a report on the nutritional status of Malawian children.

- A proposal is under development by IEF and any other interested PVO/NGO, to conduct semi-annual nutritional assessments.

- A manuscript is under preparation describing the distribution of kwashiorkor found in the southern region of Malawi during 1992/93.

- IEF is assisting in the preparation of a special issue of the Malawi Medical Journal highlighting drought and health.

4. Breastfeeding

* Investigations into the prevalence of exclusive breastfeeding and diarrheal disease was conducted in each district of the southern region. The results are being tabulated at the Regional Health Office and will be analyzed in July.

- Project Hope has now taken the initiative to assist the MOH in the training of nurse tutors in July.

5. AIDS Education

* A proposal to undertake AIDS control activities in Nchalo was submitted to Action Aid. Funding from AIDSCAP is also under investigation.

- IEF conducted a baseline survey and a series of focus groups in the Nchalo HCCS in preparation for AIDS control activities with traditional healers.

- IEF met with the General Manager of SUCOMA, (Sugar Company of Malawi) to discuss management acceptance of an AIDS control activity at the company estates.

- Two IEF staff were accepted to attend the AID/JHU CSSP sponsored AIDS workshop in Uganda planned for July.

- IEF received training in community based contraceptive distribution from the MOH. HSAs have identified and trained 1-2 male motivators in each of their villages during June.

6. Investigations

a. Vitamin A Deficiency and Measles

* There were no measles cases admitted during the reporting period.

b. Vitamin A Deficiency and Cerebral Malaria

* Enrollment of cases ended in June. A report on the first years' work was published in the Ophthalmology. See attached.

- The Malaria laboratory at QECH, in collaboration with the Liverpool School of Tropical Medicine, will receive training support in the analysis of serum retinol by HPLC. This will provide the only capacity in Malawi to conduct retinol analysis.

c. Village Health Volunteers

* Enrollment of village health volunteers into the IEF/ADRA/SCF-UK study of village health volunteers continues.

D. Problems and Constraints

* Reports of gunfire in Chikwawa District continue and are presumed to be armed RENAMO fighters from Mozambique.

* There were delays in community organizing and training activities due to the uncertainty created by the National referendum held on June 14. 63% of the voting population cast a "yes" vote for multi-party democracy.

E. Sustainability

* IEF continues to follow its plan for supporting the MOH through health centers and training. In addition, increased efforts are being made to strengthen activities between IEF activities and the Christian Hospital Association of Malawi (CHAM) health centers.

F. Other Meetings/Collaboration/Presentations

1. Meetings

- The National Prevention of Blindness meeting was held April 5th.
- The Chikwawa District Drought Relief meeting was held April 21.
- Mr. M'Manga attended the USAID-sponsored Child Survival meeting in Senegal in early April.
- A meeting was held with UNCHR to discuss NGO involvement in safe water supply in April.
- A meeting with Dr. Ann Bauer, seconded to the MOH and in charge of standardizing HSA training, was held June 10.
- The IEF Program Advisory Committee meet in May.
- The last meeting of the Chikwawa District Drought Relief met in May.
- IEF met with the MOH to discuss ways that MOH personnel can be involved in VAC distribution in June.
- IEF PCV attended the DRCU workshop "Technical Forum on Disaster-Related Information Systems" in June.

G. Collaboration

- * PCV Ms. Laura Porter:
- continues to provide support in developing AIDS control activities in conjunction with the MOH and Montfort hospital.

- continues to coordinate the construction of two community constructed Under-Five clinics at Thendo and Nyasa villages using Ambassador self-help Funds.

* PCV Mr. Jon Mauzyski:

- continues to provide support in drought relief and nutritional assessment activities.
- Mr. Mauzyski will complete his PCV service in July 15th.

* PCV Ms. Kelly Quinn:

- currently working in another district, will begin working with IEF in December and assist Ms. Porter in AIDS control.

* PCV Mr. Mark Thompson:

- currently working in Lesotho, will begin working with IEF in September and will concentrate efforts in nutritional improvement/consumption of vitamin A rich foods.

H. Ophthalmologic Situation

* Dr. Lewallen continues to explore the possibility for training a Malawian Physician graduated from the Malawi Medical College in ophthalmology. No suitable candidate has been found to date.

- IEF and Sight Savers conducted a workshop for Ophthalmic Medical Assistants in Malawi in June. The purpose of the workshop was to develop plans to a) integrate primary eye care into primary health care, b) initiate collaboration with traditional healers, and c) improve cataract surgery coverage.

III. APPENDIX

Monthly Reports April, May, June

Seminar on Integrating Eye Care into Health Care

Article on Attitudes and Practices Regarding Child Spacing in Chikwawa District

Report on 4th nutritional Assessment (including VAC coverage data)

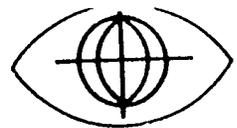
Report on Nsua Island Health Program

Report on 1st HIS Review

Report on Traditional Healers and AIDS control

Proposal on Nchalo AIDS Family Health Education and Counseling Center

file number 10000001
monthly reports



MONTHLY REPORT **APRIL 1993**

Administrative Issues & Personnel

4 of the 5 IEF vehicles (Peugeot 305, Toyota Corolla, Toyota Cressida, and Isuzu 4x4) are in working order. Our Toyota 4x4 is still not in working order; it is at Montfort Garage for repairs.

At last breath, renovations of the IEF/Nchalo office are, as yet, incomplete.

At the end of March the Malawi kwacha stood at 4.2 MK = \$US 1.

We are still having problems with our FAX line; requests to repair the line have not been fulfilled. The Blantyre phone is also in need of repair.

Meetings

Dr. Courtright attended a meeting at UNHCR on 1 April to discuss the use of paid workers or volunteers to chlorinate water supplies at the refugee camps.

Mr. Mmanga attended the USAID-sponsored Child Survival meeting in Senegal, returning on 6 April.

Mr. Chikhosi and Mr. Mmanga attended the Chikwawa District Drought Relief meeting on 21 April. The last meeting of this group will be on 12 May.

Drs. Lewallen, Johnston (IEF/Malamulo), Witte (IEF/Bethesda), and Courtright attended a meeting of the National Prevention of Blindness Committee in Lilongwe on April 5.

Ministry of Health/Chikwawa & IEF Collaboration

Training of village health committees in the three new areas (Maperera, Ngabu, and Ndakwera) were completed in April except for one village in the Ndakwera area. HSAs have noted increasing difficulties in organizing the establishment of village health committees in all areas because of the political climate. IEF is often confused with pressure groups ("International Eye Front"??) and it is taking about twice as long to get these new areas organized. People allege that because village headmen are members of the MCP they (the villagers) cannot attend any meeting summoned by them. HSAs are concerned that they will not be able to keep to their planned target dates for training and provision of services. This will have to be monitored closely and the HSAs have been asked to document the problems on an on-going basis.

The poster on vitamin A supplementation, prepared in February, has still not been printed yet. If UNICEF/Lilongwe has not been able to print the poster by mid-May, the RHO/South and IEF will have it printed in Blantyre.

ADRA/IEF Collaboration & Montfort Hospital/IEF Collaboration

Operational plans for Nsua Island have been formalized and activities are well underway. It is with sadness that Mr. Koleka (Senior Clinical Officer) has left Montfort Hospital for Mwanza. Mr. Koleka was a strong leader in Montfort's community-based work and he will be sorely missed.

IEF is working with Montfort Hospital to integrate additional activities within their community based health volunteer structure. In particular, the

provision of vitamin A capsules and diarrhoeal disease control (provision of ORS) will be added over the next few months. IEF will assume responsibility for some of the training and costs; Montfort will assume all responsibility for supervision.

IEF is pleased to note that the Nsanje District ADRA project has achieved 87% coverage of vitamin A in its last distribution. IEF continues to assist ADRA with training and vitamin A capsules.

Village Health Promoters (1989-1991)

IEF continues to monitor these volunteers providing vitamin A every six months and ORS when available.

Village Health Volunteers (1992-1995)

There has been no change in the situation at Dolo Health Centre and we have not been able to send IEF staff back to live in this area. Incidents involving shooting have continued to increase throughout Chikwawa District.

After selection and prior to training all VHVs in the three new catchment areas are being interviewed. The interview covers topics related to health knowledge, demography, village characteristics, etc. A control woman in each village is also being interviewed. The purpose of this exercise is to determine what characteristics identify a woman selected to become a VHV. The information will also serve as a baseline set of indices about the VHVs so we can assess characteristics of the VHVs that lead to both good working experience and volunteer drop-out. These interviews will be completed by 21 May.

IEF HSA Trainees

Mr. Makata has set up a well-organized system for motorcycle repair and operation. Every pay-day time is set aside for further training and follow up. A local mechanic has been identified for routine maintenance.

In April Mr. Chikhosi and Dr. Courtright met with John Niewoehner, water engineer from American Refugee Committee. The ARC and IEF are starting collaborative efforts in water and sanitation with a training of HSAs set for 17-18 May. Following the workshop, ARC and IEF will assess the ways that this collaboration can best be expanded.

Ophthalmologic Situation at QECH

Dr. Lewallen continues to explore possibilities for support for additional training in ophthalmology for a College of Medicine-trained Malawian physician.

IEF and Sight Savers are planning to conduct a seminar for all ophthalmic medical assistants throughout Malawi in early June, the goal being to equip them with the skills to integrate primary eye care activities into various general health care activities in Malawi. The proposed list of goals and objectives is given as an appendix.

Under-Five Clinic & Health Education Centre

Ms. Porter continues to make arrangements for the construction of Under-5 Clinic/Health Centres in Thendo and Nyasa. Supplies have been delivered to the villages and construction will begin soon.

Exclusive Breast Feeding: Developing an Effective Programme

Results from the MoH/South investigation into the prevalence of exclusive breast feeding and diarrheal disease are beginning to come into the Regional Health Office. Project HOPE and IEF will assist the RHO in the analysis of this data. In May Project HOPE will assist the Northern Region to carry out a similar assessment; the Central Region will handle its own investigation. Funds to carry out these activities have been received by the IEF from the DRCU.

In April IEF submitted a manuscript authored by Dr. Courtright, Ms. Duke, and Dr. Jacka detailing the magnitude of the problem of early supplementation and diarrhea in Chikwawa District

AIDS Control/Family Planning

Readers should note that "family planning" has been added to this subheading. The MoH/Chikwawa and Southern Region as well as the medical officer at Montfort feel that these activities can be carried out under the same umbrella; IEF is in agreement with this addition. Ms. Porter joined a Regional Health Office meeting on 20 April on community-based distribution of contraceptives (CBD) and she will include CBD into the proposal under preparation. We had hoped that the proposal would be completed by end-April but, for a variety of reasons, this was not possible. The structure of the work will have to be adjusted due to the continuing resistance of the Catholic church to contraception and the need for creating a programme that can be sustained beyond the grant period.

A copy of a manuscript on *Attitudes and practices regarding child spacing in Chikwawa District* appearing in a recent Malawi Medical Journal is included as an appendix.

PCV Activities

Mr. Mauzyscki continued as the coordinator of IEF's nutrition assessment activities. He conducted the final Chikwawa assessment on 4-10 April. A summary report is attached. Mr. Mauzyscki will use his remaining time in Malawi to finalize IEF (and regional) activities in nutrition assessment. He will be completing his service on 15 July.

Ms. Porter has devoted most of her time to AIDS control programme development, focus group discussions with traditional healers and planning for workshops of IEF staff. She has also strived to finalize plans and activities for Nsua Island. A report of Nsua Island activities is attached.

Peace Corps has identified Mr. Mark Thompson, an agriculturalist currently stationed in Lesotho, as a third year extender into IEF's programme. Mr. Thompson will join IEF in September. His project will focus on improving the consumption of indigenous vitamin A rich foods.

Drought & Impending Famine: Nutritional Assessment

IEF completed its last nutritional assessments in April. The summary report is attached; a copy of the full report can be obtained from IEF/Blantyre. It should be noted that this assessment showed little deterioration in nutritional status compared to the three previous surveys. Mr. Joe Canner, biostatistician from the Johns Hopkins Project is assisting IEF in the analysis of all four data sets to construct the progression of malnutrition from August 1992 to April 1993. Information to be incorporated in the analysis includes age, sex, area (TA) of residence, and stunting (all

individual level) and distance to health centre, water source and distance, and livestock (all community level).

As described in the February report Chikwawa survey children who were malnourished (December 1992) were given a referral form to take to the nearest MoH/CHAM health centre for supplemental feeding. These children and a matched control were visited in February. We will be repeating this exercise for the last nutritional assessment in April and combine the two data sets. We hope to have the basic analysis completed by the end of May.

At present we have kwashiorkor maps for Chikwawa, Blantyre, Mulanje, Chiradzulu, Nsanje, and Machinga. Maps for the remaining districts (Zomba, Mangochi, Mwanza, and Thyolo) have not been received yet.

Vitamin A Supplementation

As stated earlier we are awaiting printing of the vitamin A supplementation posters.

As noted in the attached health summary to IEF's recent nutrition assessment in Chikwawa District vitamin A supplementation is currently 45%, considerably improved from our baseline survey. Health staff providing supplemental foods need to be encouraged to check under five cards and give vitamin A supplements to all indicated children. It is felt that, although a number of workshops have been held with health centre staff, there is still a lack of knowledge of vitamin A, impeding the growth of coverage. The IEF and MoH/Chikwawa will explore ways to overcome this deficiency.

Traditional Practices for Eye Disease in Malawi

Interviews of traditional healers will be completed in early May. At present over 100 healers have been interviewed. The National Herbarium in Zomba has completed the first round of plant identifications.

Investigation of Vitamin A Deficiency and Other Disorders in Measles

Enrollment of cases was concluded on 1 March giving us a 12 month period of QECH measles admissions. A shortened form has been introduced to keep track of cases in 1993. As yet there have been no measles in-patients.

IEF still awaits a response by the HSRC to our letter regarding our proposal *Response to measles vaccine with and without vitamin A supplementation*. The HSRC met on 19 February. Communication from the HSRC remains non-existent.

Vitamin A Deficiency and Cerebral Malaria

Enrollment of cases is proceeding well. Dr. Lewallen has received a grant from WHO TDR to investigate retinal findings in malaria and encephalopathies.

Barriers to the Acceptance of Cataract Surgery

Detailed data analysis and report writing is underway.

Prevalence Survey of Onchocerciasis in Mwanza District.

A summary report of findings and IEF's programme is attached.

Plans for May

Distribution of ORS and vitamin A will continue as needed.

The next IEF Programme Advisory Committee (PAC) meeting is scheduled for 7 May.

Drs. Courtright and Lewallen will be presenting the 18 May QECH Clinical Session on Onchocerciasis. Dr. Courtright will give the QECH Journal Club talk on 24 May and Dr. Lewallen will give the talk on 31 May.

A training session on water and sanitation for IEF HSAs is planned for 17-18 May followed by a session on AIDS on 19-21 May.

Representatives from the MoH/South, IEF, ARC, and Project HOPE will continue to prepare the plans for the May 31-June 2 Drought & Health Seminar.

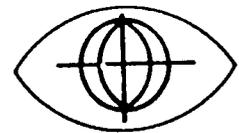
Training of village health volunteers will continue in May.

The first round of the VHV health information system will be completed in May. It will assess coverage of vitamin A supplementation and diarrhoeal disease control.

Mr. Chikhosi, Mmanga, and Mauszycki will attend the last Chikwawa District Drought Meeting on 12 May.

Financial Report

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



MONTHLY REPORT MAY 1993

Administrative Issues & Personnel

4 of the 5 IEF vehicles (Peugeot 305, Toyota Corolla, Toyota Cressida, and Isuzu 4x4) are in working order. Our Toyota 4x4 is still not in working order, remaining at Montfort Garage for repairs.

At last breath, renovations of the IEF/Nchalo office are, as yet, incomplete.

At the end of May the Malawi kwacha stood at 4.2 MK = \$US 1.

We are still having problems with our FAX line; requests to repair the line have not been fulfilled. The Blantyre phone is also in need of repair.

IEF is promoting Mr. Kalavina, IEF HSA for Dolo, to be an HSA supervisor for the northern half of Chikwawa District. Mr. Kalavina will spend three weeks in Nchalo learning more about supervision and management from 21 June before being posted to Chikwawa (boma). Mr. Navaya (Chipwalla) will be transferred to Dolo Health Centre.

IEF's Ivermectin (Onchocerciasis) Project Director, Dr. Kathleen Johnston, departed Malawi on 29 May. She will be replaced in late June by Mr. Garrett Mehl. In the meantime, field activities will be supervised by Mr. Fedson Nkoma.

The HSRC arranged a Research Dissemination Seminar (Lilongwe) for 28 May, notifying Dr. Courtright only 3 days in advance that he was expected to attend. The meeting was canceled on the 27th although we were not notified of the cancellation.

Drs. Lewallen and Courtright gave the 18 May QECH/College of Medicine Clinical Lecture on Onchocerciasis in Malawi. Dr. Courtright gave the 24 May and Dr. Lewallen gave the 31 May QECH Journal Club on a mix of public health and ophthalmology topics.

Meetings

On 10 and 31 May Mr. Mauszycki and Dr. Courtright met with doctoral student Shannon Gradowski and her advisor Dr. Roslyn Gibson regarding their study of nutritional factors (specifically micronutrients--zinc, iodine, vitamin A, and iron) in pregnancy related to low birth weight. We have encouraged them to expand the follow up period of study to include the infant's first year of life. This may facilitate a better understanding of the poor nutritional status of Malawian infants very early in life.

IEF held its Programme Advisory Committee (PAC) meeting on 7 May. Discussion focussed on the planned AIDS control and family planning programme and the drought relief activities.

Messrs. Chikhosi, Mmanga, and Mauszycki attended the last Chikwawa District Drought Relief meeting on 12 May. We are recommending that, although the drought is over, periodic meetings be called by the district commissioner to coordinate activities of government departments and NGOs working in Chikwawa District. Additional meetings were held with district health staff to outline issues for the 31 May-2 June Drought/Health Seminar.

Mr. Chikhosi and Mr. Mmanga met with Mr. John Niewoehner of ARC at Kunyinda

refugee camp on 13 May to finalize arrangements for the HSA seminar on water and sanitation, scheduled for 18 May.

Ministry of Health/Chikwawa & IEF Collaboration

Training of the last village health committee was completed in Ndakwera. Mr. Mmanga has had a meeting with the facilitators of the Chikwawa breast feeding seminar and has scheduled a second seminar on 7 July in Ngabu. This will be the last district seminar assisted by IEF.

Mr. Mmanga met with Mr. Gobede, District MCH coordinator, to work out details for the proposed vitamin A supplementation orientation sessions for MoH health centre staff. The first sessions are planned for Gaga, Chapananga, Kakoma health centres, catchment areas that IEF is currently not working.

The poster on vitamin A supplementation, prepared in February, has still not been printed yet. It appears that agreement has been reached with MoH/Lilongwe and UNICEF on the pictures and wording and the poster should be ready in July.

ADRA/IEF Collaboration & Montfort Hospital/IEF Collaboration

Plans are still underway to collaborate with Montfort Hospital in the proposed AIDS control and family planning activities. IEF and Montfort will also combine efforts in the training of village health volunteers on Nsua Island. Integrating additional activities (vitamin A and ORS provision) within Montfort's community based health volunteer structure has been slow, primarily due to staff changes at Montfort.

IEF will work with the Nsanje District ADRA child survival project to conduct exclusive breast feeding seminars in August.

Village Health Promoters (1989-1991)

IEF continues to monitor these volunteers providing vitamin A every six months and ORS when available although we recognize that we have been able to maintain support of those in Chikwawa District and the northern half of Nsanje District.

Village Health Volunteers (1992-1995)

IEF is relieved that the tense situation at Dolo Health Centre has resolved and IEF staff have been able to move back to the area. Shooting incidents continue in Chikwawa District, particularly in and near the refugee camps.

HSAs in the Dolo, Chipwaila, and Makhwira catchment areas have completed a review of VHV activity; this is given as an appendix.

All VHV (and a "control" woman) in the three new catchment areas have been interviewed except for VHV in 3 villages in Ndakwera and 9 villages in Ngabu. The interview, covering topics related to health knowledge, demography, village characteristics, etc. will be coded and analyzed in June and July to determine what characteristics identify a woman selected to become a VHV.

VHV training will be suspended for the weeks of 7-11 and 14-18 June due to difficulties in organizing the training of VHV around the referendum. The year plan will have to be adjusted to account for this change; the two weeks will be used to work with existing VHV on AIDS messages.

15

The training of VHVs includes:

	Total	Completed (to date)
Ngabu catchment area	107 VHVs	33
Ndakwera catchment area	69 VHVs	30
Maperera catchment area	54 VHVs	16
Assistants	30	
✓ Total	260	79

IEF HSA Trainees

On 18 May the ARC conducted a training for IEF HSAs at Kunyinda refugee camp on water and sanitation issues. Due to illness of Mr. Neiwoehner (ARC) the training did not go smoothly and was inadequate. Additional training will have to be scheduled. IEF HSAs are expected to work with the village health committees on maintenance of existing water sources and protection of shallow wells. A plan of action will have to be developed with the district health office, ARC, and IEF.

On 19-21 May the AIDS Secretariat and Project HOPE with assistance from the Regional Health Office (South) conducted a training on AIDS control with IEF HSAs. Everyone, facilitators and trainees, felt that the workshop was a huge success, stimulating considerable discussion. For the two weeks following the workshop Ms. Porter worked with the HSAs to improve their teaching skills and the HSAs have already starting working with their VHVs. We were very impressed with the quality of the workshop.

Ophthalmologic Situation at QECH

Dr. Lewallen continues to explore possibilities for support for additional training in ophthalmology for a College of Medicine-trained Malawian physician.

IEF and Sight Savers are planning to conduct a seminar for ophthalmic medical assistants throughout Malawi on June 4-6, the goal being to develop plans for a) integrating primary eye care in primary health care in the district, b) initiating collaboration with traditional healers, and c) improving cataract surgical coverage.

Under-Five Clinic & Health Education Centre

Construction of the Under 5 Clinic/Health Education Centres in Thendo and Nyasa have started. This project, funded by US Peace Corps, should be completed at the end of July.

Exclusive Breast Feeding: Developing an Effective Programme

✓ Results from the MoH/South investigation into the prevalence of exclusive breast feeding and diarrheal disease are being tabulated at the Regional Health Office. Project HOPE and IEF will assist the RHO in the analysis of this data. Project HOPE assisted the Northern Region to carry out their assessment in May. The Central Region assessment will be conducted in June.

✓ Mr. Mmanga and Miss Washa (IEF HSA) are establishing a pilot programme in some key villages to identify pregnant women and use the VHV to offer one-on-one encouragement for exclusive breast feeding throughout the first four months of life. We will assess the programme in the fall.

AIDS Control/Family Planning

The impact of the AIDS epidemic continues to increase; the Johns Hopkins/MoH project reports that HIV sero-prevalence of antenatal women in Blantyre in the first four months of 1993 has increased to 30%. The failure of national leaders to recognize the crisis and take action has resulted in an ever-increasing national tragedy.

Ms. Porter has joined the Regional Health CBD Group. The USAID-funded AIDSCAP programme will not have developed its funding mechanism until early July. In order not to delay implementation of project activities, IEF has developed a start-up grant and is circulating this to all collaborative groups; start-up funding is being sought from Action Aid. Support from SUCOMA is also being pursued.

The HSAs have noted that an HSA "buddy" system has been very helpful for AIDS control talks (and condom use demonstration) in the villages. If one HSA becomes nervous his "buddy" can come to his aid. The HSAs have noted that women (and men) in some areas, in particular Maperera, Makhwira, and Nsua Island, have been more resistant to talking about AIDS than in other areas. The HSAs will be working with the village health committee to identify one (to two) men as a male motivator and channel AIDS control activities through these people.

PCV Activities

Mr. Mauzyski continued as the coordinator of IEF's nutrition assessment activities. Mr. Mauszycki supervised the follow up of malnourished children by HSA. All nutritional assessments have drawn to a close and Mr. Mauszycki will use his remaining time in Malawi to finalize IEF (and regional) activities in nutrition assessment. He will be completing his service on 15 July.

Ms. Porter has devoted most of her time to AIDS control programme development, focus group discussions with traditional healers and planning for workshops of IEF staff. She has also organized the construction of the health education centres in Nyasa and Thendo.

Kelly Quinn, a PCV currently working in fisheries in Mangochi District, will join IEF in December. She will assist Ms. Porter with AIDS control and family planning activities, assuming responsibility of the project after Ms. Porter's completion of service.

Drought & Impending Famine: Nutritional Assessment

IEF helped coordinate the May 31 - June 2 Health & Drought Seminar, conducted in Blantyre. The seminar, attended by approximately 150 representatives from the MoH (region and district), from the health NGOs, and others, will be reviewed in the June report.

IEF and Mr. Joe Canner, biostatistician from the Johns Hopkins Project, have compiled data from all of the NGO and CSR/UNICEF nutritional assessments in the Southern Region. This information will be presented at the Health & Drought Seminar and, upon inclusion of the last data set (Zomba District), will be used to prepare a report outlining a) the change in nutritional indices throughout the Southern Region during the drought, b) the factors associated with malnutrition district by district, and c) the profile of nutrition in the various districts. This information, while not used to target groups during the drought, has been very useful in nutrition planning. IEF will be developing a proposal to undertake periodic (semi-annual) nutritional assessments to help track changes in nutritional status, identify groups at particular risk of wasting

and stunting, and monitor success (or failure) of nutrition education programmes.

As described in the February report Chikwawa survey children who were malnourished (December 1992) were given a referral form to take to the nearest MoH/CHAM health centre for supplemental feeding. These children and a matched control were visited in February. This process was repeated in April (for the last nutritional assessment) and children were traced in May. A summary report of the findings is given as an appendix. *(to be in June)*

We have completed the kwashiorkor map for the Southern Region which is given an appendix. It should be noted that kwashiorkor is *not* randomly distributed throughout the Southern Region, clustering in Mangochi, Machinga, Zomba and the northern part of Blantyre district. With the high mortality associated with kwashiorkor (50-100%) we encourage investigation of this phenomenon as soon as possible. *(to be in June)*

Vitamin A Supplementation

As stated earlier we are awaiting printing of the vitamin A supplementation posters. Trimester Vitamin A supplementation and ORS use is being tabulated for the catchment areas of Dolo, Chipwaila, and Makhwira. This will be included in the June report.

Traditional Practices for Eye Disease in Malawi

A traditional healer in Migano village was videotaped in late May. Data collection has been completed (106 healers) for this project and data is being entered on computer in Blantyre. Plans for a programme in primary eye care will be developed at the 4-6 June ophthalmic medical assistant seminar.

Investigation of Vitamin A Deficiency and Other Disorders in Measles

There have been no measles in-patients.

✓ VEF has abandoned hope of receiving a response from the HSRC regarding our proposal *Response to measles vaccine with and without vitamin A supplementation*. With sadness, we have informed Johns Hopkins University that this valuable research will not move forward and funding is being diverted to another country.

Vitamin A Deficiency and Cerebral Malaria

Enrollment of cases is proceeding well.

Barriers to the Acceptance of Cataract Surgery

Detailed data analysis has been completed and report writing is still underway.

Plans for June

The Drought & Health Seminar is scheduled for 31 May - 2 June. Editing of the seminar report will be completed by 17 June.

The IEF/Sight Savers OMA workshop is scheduled for 4-6 June.

A meeting with Dr. Ann Bauer, USAID consultant to the MoH on the development of the HSA training programme, is scheduled for 10 June.

Village health volunteer training will continue during the month, to be completed in mid-July.

June 14 (Referendum Day) will be a holiday for IEF staff.

Drs. Lewallen and Courtright will conduct follow up ocular assessments of Thyolo onchocerciasis starting on 13 June.

Distribution of ORS and vitamin A will continue as needed.

The first round of the VHV health information system will be completed in June, two weeks behind schedule. It will assess coverage of vitamin A supplementation and diarrhoeal disease control.

Mr. George Mekisini (Information Coordinator) and Mr. Mathews Alifnali (Assistant Training & Supervision Coordinator) will travel to Uganda on 1 July for a 10 day workshop on AIDS and child survival.

Financial Report

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

MONTHLY REPORT JUNE 1993

Administrative Issues & Personnel

All 5 IEF vehicles (Peugeot 305, Toyota Corolla, Toyota Cressida, Toyota 4x4, and Isuzu 4x4) are in working order. Work on the Toyota 4x4 was completed in June. Montfort Garage did an impressive job and charged us a fraction of the labor costs of other garages.

At last breath, renovations of the IEF/Nchalo office are, as yet, incomplete. Legal proceedings are being considered.

At the end of June the Malawi kwacha stood at 4.2 MK = \$US 1. The inability to obtain foreign exchange in Malawi has led to an absence of spare parts in the country. Ordering spare parts from South Africa is both time-consuming and expensive.

We are still having problems with our FAX line; requests to repair the line have not been fulfilled. The Blantyre phone is also in need of repair.

Mr. Kalavina, IEF HSA, assumed the position of HSA supervisor for northern Chikwawa District in June. Mr. Navaya (Chipwaila) was transferred to Dolo Health Centre to take over Mr. Kalavina's VHV programme.

Meetings

Mr. Chikhosi met with Dr. Chirambo on 4 June to explore ways of involving MoH personnel in distribution of vitamin A capsules to increase coverage. Dr. Chirambo promised to discuss the issue with Dr. Chimimba.

On 10 June Dr. Courtright met with other NGO representatives and Dr. Ann Bauer regarding supervision of HSAs. It was decided that the multitude of issues regarding HSA training, supervision, and accreditation could not be covered within a short period; a separate sub-committee of the NGO/MoH Health Committee has been established to address these issues. IEF will be represented by Mr. Rene Berger, IEF Programme Assistant. Mr. Berger will start work for IEF in mid-July.

Mr. Mauszycki participated in the DRCU workshop in Lilongwe "Technical Forum on Disaster-Related Information systems" from 29-30 June.

Ministry of Health/Chikwawa & IEF Collaboration

The poster on vitamin A supplementation, prepared in February, has still not been printed yet.

Mr. Chikhosi met with Mr. Luhanga regarding MoH involvement in selection of IEF HSA trainees; Mr. Chimwaza MoH health inspector (Nchalo) will assist in the selection.

Mr. Allinall met with Mr. Gobede regarding a briefing IEF will hold with MoH staff in the Chapananga area regarding vitamin A and the upcoming project activities in this area.

ADRA/IEF Collaboration & Montfort Hospital/IEF Collaboration

Plans are still underway to collaborate with Montfort Hospital and the MoH in

the proposed AIDS control and family planning activities. (see section on AIDS control/family planning) There is concern that the staff changes at Montfort have led to an unwillingness by professional staff to make decisions.

IEF has provided ADRA with 10,000 vitamin A capsules for their next distribution campaign.

Village Health Volunteers (1992-1995)

VHV training was suspended for the weeks of 7-11 and 14-18 June due to difficulties in organizing the training of VHVs around the referendum. The year plan will have to be adjusted to account for this change; the two weeks will be used to work with existing VHVs on AIDS messages.

Our first Health Information System exercise was conducted in April and May with results tabulated in June. The exercise covered the topics of vitamin A capsule coverage and diarrhoeal disease. The report is given as an Appendix. We see this as a training exercise as well as a reporting exercise and Mr. Mmanga will use the next staff meeting to address questions raised by this data. The next H.I.S. will cover the topics of nutrition, AIDS, and family planning. A copy of the English questionnaire is given as an appendix. The H.I.S. will cover all areas currently covered by IEF.

The training of VHVs includes:

	Total	Completed (to date)
Ngabu catchment area	103 VHVs	96
Ndakwera catchment area	69 VHVs	67
Maperera catchment area	54 VHVs	54
Assistants	30	0
	<hr/>	<hr/>
Total	256	204

IEF HSA Trainees

The HSAs have continued to devote time to AIDS control. During the two week hiatus in new VHV trainings in June the HSAs conducted additional AIDS trainings with the VHVs. (Chipwaila: 78 VHVs and VHCs, Makhwira: 170, Dolo: 96) In some areas the IEF HSAs worked with the MoH HSAs on these AIDS control activities--this was the first time that most MoH HSAs have conducted AIDS control activities in the villages. We will continue to pair up IEF and MoH HSAs for AIDS control activities. IEF HSAs are identifying traditional healers in their areas. Special AIDS control activities will be set up with these healers. Ms. Porter continues to work with the HSAs to improve their teaching skills.

The interviews for new IEF HSA trainees (Chikwawa, Chapananga, Gaga, and Kakoma health centre catchment areas) will be held in early July. Their training will commence in mid-July.

Ophthalmologic Situation at QECH

Dr. Lewallen continues to explore possibilities for support for additional training in ophthalmology for a College of Medicine-trained Malawian physician. Although we are confident that a training location can be found in southern Africa there is, at present no intern or final year student appropriate for training.

IEF and Sight Savers conducted a seminar for ophthalmic medical assistants

throughout Malawi on June 4-6. Plans were developed to a) integrate primary eye care in primary health care in the district, b) initiate collaboration with traditional healers, and c) improve cataract surgical coverage. The seminar was a success and the recommendations are given as an Appendix. Plans for developing collaboration with traditional healers in Chikwawa and Mulanje Districts are underway. A trial to try to increase cataract coverage in Chikwawa will also start soon. Details of these activities will be included in a future report.

Drs. Lewallen and Courtright will be attending the 14th International Leprosy Congress in Florida in August. Arrangements have been made to have a well-trained volunteer ophthalmologist (Dutch) provide coverage at QECH during her absence.

Under-Five Clinic & Health Education Centre

Construction of the Under 5 Clinic/Health Education Centres in Thendo and Nyasa are progressing well and should be completed at the end of July.

Exclusive Breast Feeding: Developing an Effective Programme

Results from the MoH/South investigation into the prevalence of exclusive breast feeding and diarrheal disease are still being tabulated at the Regional Health Office. Analysis of this data should start in July. IEF is very pleased that Project HOPE has taken this initiative and will conduct a training of nurse tutors in July.

AIDS Control/Family Planning

Because of the delay in AIDSCAP funding mechanism development we have submitted a pre-proposal (1 year) for AIDS control activities in Nchalo to Action Aid. A decision should be made in July. When the AIDSCAP funding mechanism is fully developed we will submit a full proposal for more long-term support.

In order not to delay implementation of project activities, IEF is preparing a baseline survey of the Nchalo catchment community. In preparation for more activities with traditional healers we have conducted a baseline survey and conducted a series of focus group discussions of traditional healers. Results are given as an appendix. Orientation of traditional healers will start in July.

Ms. Porter met with Mr. A.J. Vaudin, General Manager, SUCOMA, on June 25 regarding potential SUCOMA involvement in AIDS control activities being developed. Mr. Vaudin expressed his willingness to have SUCOMA medical personnel assist with AIDS activities IEF has planned as well as the provision of land and other support services (transport of medical, laboratory, and construction supplies).

Mr. Mekisini and Mr. Alifinali will be attending a workshop in Uganda (1-10 July) on AIDS control at the community level. They will each do a presentation, time permitting.

Mr. Mmanga was trained as a trainer in community based distribution of contraceptives from 21 June to 2 July in Lilwonde. Follow up activities await start-up of the regional programme.

The HSAs identified and trained one (to two) men as male motivators in each of their villages in June.

PCV Activities

Mr. Mauzyski continued as the coordinator of IEF's nutrition assessment activities. Mr. Mauszycki spent a considerable amount of time preparing the report of the 31 May - 2 June drought/health meeting. Mr. Mauszycki will use his remaining time in Malawi to finalize IEF (and regional) activities in nutrition assessment. He will be completing his service on 15 July.

Ms. Porter has devoted most of her time to AIDS control and family planning activities. She has joined a regional committee on the development and implementation of community based distribution of contraceptives. She has also organized the construction of the health education centres in Nyasa and Thendo.

Drought & Impending Famine: Nutritional Assessment

IEF helped coordinate the May 31 - June 2 Health & Drought Seminar, conducted in Blantyre. The seminar, attended by 113 representatives from the MoH (region and district), from the health NGOs, and others, was intense. The report, to be available in early July, serves to highlight some of the successes and failures of the health system to deal with the drought (and health care in general) and gives recommendations that should help guide health programme improvement.

Data from all of the NGO and CSR/UNICEF nutritional assessments (includes over 25,000 children) in the Southern Region is being used to prepare a report of nutritional status of Malawian children. The report will be a joint effort by Mr. Canner, Mr. McGurk (UNICEF/CSR), and Dr. Courtright. IEF will be developing a proposal with other interested groups to undertake periodic (semi-annual) nutritional assessments.

We are preparing a manuscript describing the distribution of kwashiorkor throughout the Southern Region of Malawi.

A special issue of Malawi Medical Journal will be published on drought and health. Dr. Courtright will help in the preparation of the issue; contributors should send manuscripts and a diskette to Dr. Courtright by end-August.

Vitamin A Supplementation

Dr. Courtright gave a presentation to the Southern Region DHO on 18 June on the success and failure of the national vitamin A capsule distribution programme. The talk highlighted some of the barriers to greater vitamin A capsule coverage.

Traditional Practices for Eye Disease in Malawi

Plans for a programme in primary eye care were developed at the 4-6 June ophthalmic medical assistant seminar and implementation will start in July.

Investigation of Vitamin A Deficiency and Other Disorders in Measles

There have been no measles in-patients.

Vitamin A Deficiency and Cerebral Malaria

Enrollment of cases ended on 30 June. Results from the first year's work were recently published in Ophthalmology. The first page is given as an appendix; those interested in receiving a reprint should contact IEF/Blantyre.

On 17 & 24 June Dr. Courtright met with Dr. Malcolm Molyneux, Liverpool School of Tropical Medicine regarding HPLC assessment of vitamin A. Dr. Molyneux has

agreed to have the Malaria Project laboratory technician learn vitamin A HPLC in Liverpool this coming Fall. He will provide the first, and only, capacity for vitamin A HPLC assessment in Malawi.

Barriers to the Acceptance of Cataract Surgery

A report of the findings from this investigation will be appended to the July report. An intervention project (to improve cataract surgical coverage) will start in July.

Plans for July

Village health volunteer training will continue during the month, to be completed in mid-July.

Distribution of ORS and vitamin A will continue as needed.

The second round of the VHV health information system will be completed in July. It will assess nutrition, supplemental feeding, AIDS, and family planning.

Mr. Kalavina, HSA supervisor, will move to Chikwawa boma on 12 July.

Mr. Chikhosi will meet with Mr. John Niewoehner (ARC water engineer) regarding the establishment of areas of collaboration between ARC and IEF.

Selection of new HSA trainees will be held on 8 July; training should begin 19 July.

Mr. George Mekisini (Information Coordinator) and Mr. Mathews Alifinali (Assistant Training & Supervision Coordinator) will travel to Uganda on 1 July for a 10 day workshop on AIDS and child survival.

Mr. Rene Berger will start work for IEF on 12 July.

The next Prevention of Blindness meeting is planned for 12 July.

Financial Report

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

INTERNATIONAL EYE FOUNDATION / SIGHT SAVERS

Seminar on

Integrating Eye Care Activities into Health Care in Malawi

4-6 June, 1993
Blantyre

Primary Goal:

Develop ways to integrate primary eye care activities into general health care in Malawi.

Specific Objectives:

Past Experiences

1. Review the success and failures of current activities of OMAs working with various government and CHAM health staff, village health volunteers, and community rehabilitation officers in primary eye care.
2. Discuss the contribution of traditional healers and TBAs to eye care in Malawi.
3. Discuss some of the barriers to the acceptance of cataract surgery and general eye care by the rural population.

Developing Plans

1. Identify the most appropriate health staff for the introduction of specific eye care activities (conjunctivitis of the newborn, identification of cataract blind, active trachoma and trachomatous trichiasis, and conjunctivitis). Develop plans to institute eye care activities at these levels. [Facilitator: Dr. Chirambo]
2. Determine the feasibility of establishing a revolving drug fund for village health volunteers, TBAs, and/or traditional healers for tetracycline eye ointment. Develop plans to institute a pilot project for a revolving drug fund. [Facilitator: Dr. Blignaut]
3. Develop plans to collaborate with traditional healers. [Facilitator: Dr. Courtright]
4. Determine the feasibility of extending cataract surgical services in the districts. Develop a community-based educational programme for promoting the acceptance of cataract surgery. [Facilitator: Dr. Lewallen]

a CBD training curriculum; supervision and monitoring mechanisms to assure monthly supervision of CBD agents; a quality assurance action plan for facilitating informed choice, medical monitoring and infection control; and a management information system to monitor service delivery activity and to enable timely planning and decision making.

In 1991 we had the birth of the CBD Programme, in which the community is very much involved. The programme involves men as well as women. These are the male motivators. The impact of the programme is increased because the women and men volunteers are chosen by the community. The community has so far done very well with this programme as they are more free to talk to the CBD's agents than us at the Hospital; male motivators by talking to their male counterparts help them to accept that their wives should start using child spacing methods. Men may be a stumbling block to their wives using child spacing. Even if the wife has been motivated, she will usually first seek consent from her husband. The door-to-door nature of CBD services is appreciated as it allows for more privacy.

The CBD Project has increased the number of new users. There have been 442 new users in the first 6 months. This project looks as if CBD will be very helpful in controlling the rapid population increase and we feel that our goal of increased child spacing may be achieved through CBD. It must be emphasised that frequent supervision and refresher courses are needed to consolidate this CBD programme.

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 CBD Project Manageress
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 Ekwendeni
 Malawi

Attitudes and Practices Regarding Child Spacing in Chikwawa District

Dr. P. Courtright, Mr. R. M'manga

Introduction

The recent adoption of new child spacing policies and contraceptive guidelines by the Government of Malawi affirms the belief that child spacing and family planning are important factors in the health and welfare of mothers and children in Malawi. Non-governmental organizations (NGOs) who have child survival projects in Malawi welcome the adoption of the new guidelines; they will be used to formulate plans for the introduction of child spacing activities in the areas where some NGOs have child survival projects. The International Eye Foundation (IEF), an NGO with a long history of work in eye care and child survival in Malawi, had not included child spacing as a project activity until recently; IEF's 1992-1995 USAID supported child survival project in Chikwawa District has included child spacing as a project activity starting in 1993. Village health volunteers (VIIVs) are the backbone for the delivery of IEF's child survival activities and, over the next year, child spacing activities appropriate for female VIIVs will be developed with the Ministry of Health.

As required by USAID, and essential to the establishment of project targets, IEF conducted a baseline survey in April 1992 in Chikwawa District. This survey covered a range of child survival topics, including child spacing. Results from this survey are being used to guide the development of IEF's goals and programme over

survey will be conducted to measure to what extent IEF has been able to achieve its stated targets. A copy of the child survival survey report can be obtained from IEF/Blantyre.

Materials and Methods

A questionnaire was developed and tested prior to the survey. Census data was used to create a sampling frame of the district and a 5% probability proportional to size sample was taken to represent children in the district. In each of the 70 clusters 50 children < 72 months of age were randomly selected. Mothers of these children were interviewed. Our results are not representative of all women in Chikwawa District as women without a child < 72 months of age were not included. Women who gave birth to a child that subsequently died would not be included unless there was a live child < 72 months of age. Our results are therefore representative of mothers with children under 6 years of age.

Interviews were conducted by IEF and Ministry of Health health surveillance assistants (HSAs); some of these HSAs were women but most were men. In a few cases (estimated to be about 5%) the husband of the interviewee was present during the interview.

Results

There were 2,173 women interviewed, 15% of whom were literate.

Most women were between the ages of 20 to 29 and only 13% were over 40 years of age. Overall, 31% of women reported that they desired no additional children. This proportion increased as the age of the mother increased (Figure 1). We have no data on the parity of these mothers although it is likely that older mothers will have had more successful births than younger mothers.

Desire for No Additional Children
 % of mothers who report that they desire no additional children

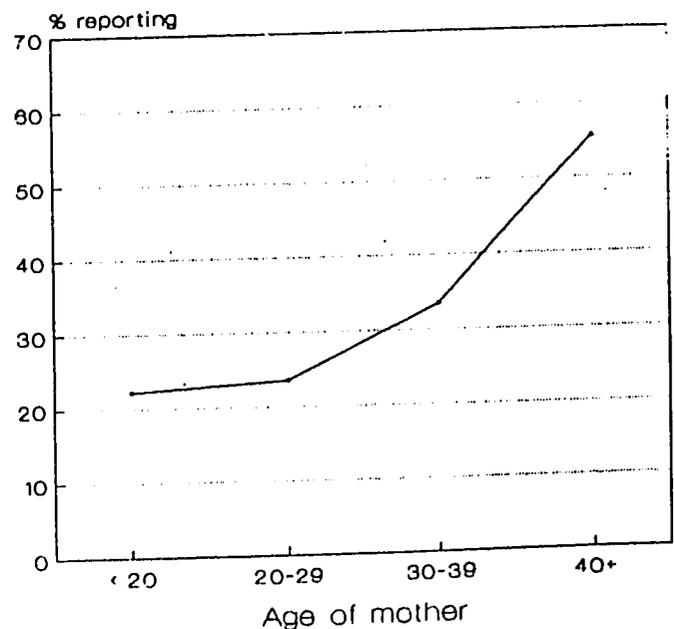


FIGURE 1

Overall, only 19% of the women who desired no additional children had ever sought clinic-based child spacing services. There is significant variation in the use of clinic based child

spacing services between traditional authorities (TA) (Figure 2). It is the authors' impression that the differences in the traditional authorities reflect the level of interest in child spacing activities by the health personnel. In particular, efforts made in TA Chapanangu, a rural isolated TA, have been impressive.

Use of Child Spacing Services
% of women not desiring more children who have used child spacing services

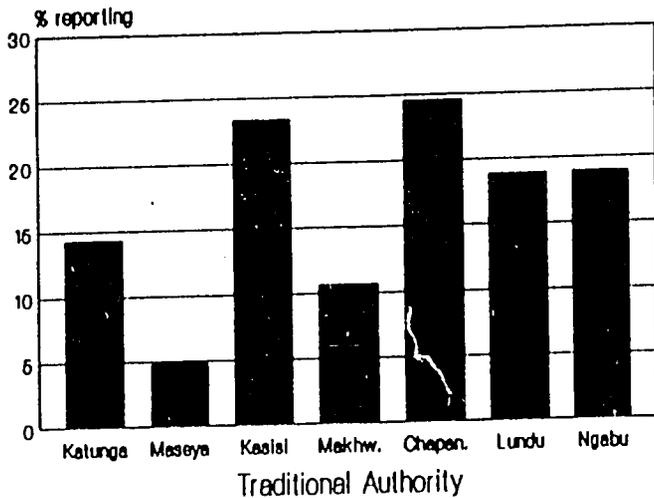


FIGURE 2

The use of clinic based child spacing services also increased with age (Figure 3). These women all state that they want no additional children. It is likely that, although younger women may not desire additional children, their husbands still do. In the previous child spacing policy the approval of the husband was required before women could receive these services. This probably explains why so few young women, reporting that they desire no additional children, have sought child spacing services.

As found in most developing countries literacy is a major contributor to the use of clinic-based child spacing services. In Chikwawa literate mothers were twice as likely to seek child spacing services as illiterate mothers (Table 1).

Table 1 Association between Literacy & Use of Child Spacing Services among Mothers who Desired no Additional Children

Literacy status	Used child spacing services	Did not use child spacing services
Literate	32 (31.1%)	71 (68.9%)
Illiterate	95 (16.9%)	465 (83.0%)

Odds ratio = 2.2 (95% CI 1.3, 3.64) $p < 0.001$

There was no correlation between births in the last year and the lack of desire for additional children; 46% of women who wanted no additional children had a birth in the last year while 42% of women who stated they wanted additional children had a birth in the last year. There is no statistical difference between these two proportions.

Women were not asked as to the type of child spacing

Use of Child Spacing Services by Age
% of women desiring no additional children who have used services

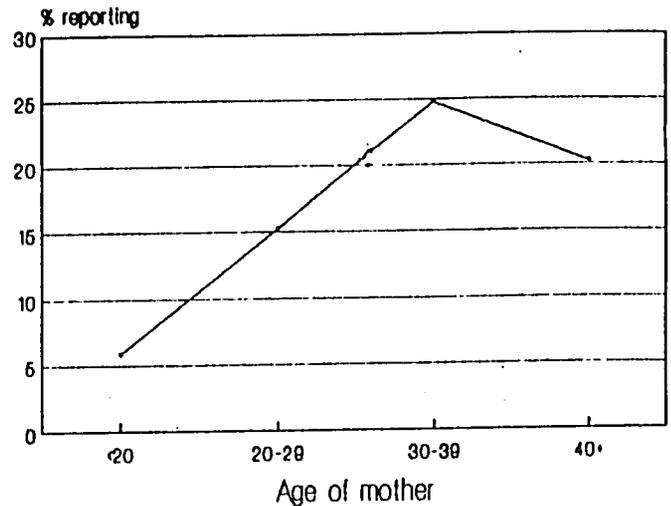
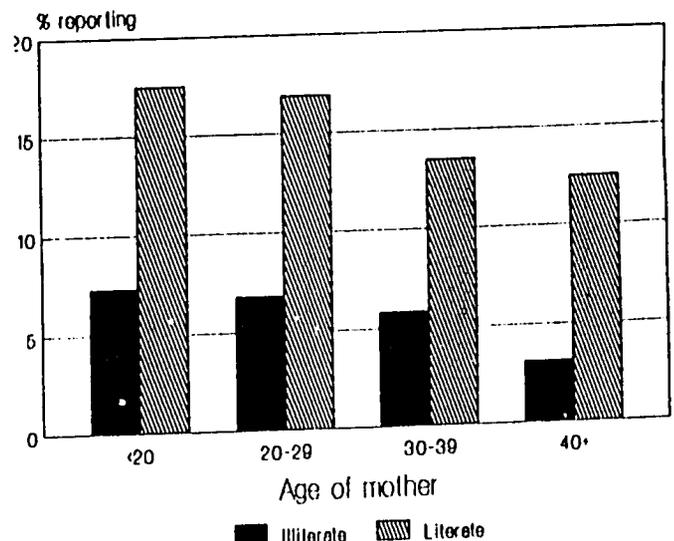


FIGURE 3

the development of AIDS control activities). Overall, only 7% of women reported that their husbands had used a condom in the past year. Condom use was infrequently reported in the rural TAs, especially TA Makhwira and TA Ngabu. Literate women were three times as likely to report condom use than illiterate women (Figure 4).

Condom Use by Age & Literacy
% of women reporting condom use in the last year



Discussion

Our results show that while many women report that they desire no additional children, few have used the clinic-based child spacing services. There are many factors responsible for the disparity between the desire for no additional children and the utilization of available services. We can only hypothesize the relative contribution of these factors in our population.

Literacy appears to be a major contributor and our data confirms findings elsewhere suggesting that as female literacy increases there are subsequent rises in the use of child spacing services.

It is encouraging that health workers in some settings have been particularly successful in their promotion of child spacing activities. It may be helpful to identify what characteristics of their work has contributed to their success. While distance to clinic is likely to be a factor in women's use of services the results from our study suggest that long distance is not a significant barrier to improving the proportion of women using services.

The lack of association between women's desire for no additional children and births in the past year is discouraging. This suggests that there are pressures (desire of the partner, lack of empowerment, and expectations of the extended family) that restrict the use of services by women who would otherwise use them.

Based on these findings the following recommendations have been developed:

1. Female literacy programmes should be expanded and special efforts should be made to ensure that all girls have access to educational opportunities.
2. Health personnel who have been particularly successful in promoting child spacing services should be commended for their work. This will help motivate all health staff to improve child spacing services.
3. Child spacing programmes directed only at women will fail. Programmes must be developed to educate men on the benefits of child spacing and family planning.

Acknowledgement

The IEF would like to thank the MOH/Chikwawa and MOH/Southern Region for their assistance in this survey.

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Attitudes to Child Spacing Amongst Rural Malawian Women

Dr. L. Phiri

Introduction

Child spacing is the principle that people should space their children by allowing a time interval of at least two years between live births. Repeated close-spaced pregnancies and heavy family loads put a great strain on a mother's nutritional and physical body resources. The quality of the women's children is also greatly reduced. Child spacing would therefore greatly improve the health of women by enabling them to have children when they are best prepared to have them¹.

The Malawi Government policy is to raise the level of the health of all Malawians via an efficient and relevant health service. To achieve this, the Malawi Government has set out to increase the access of people to modern health services. The emphasis is on the survival of children under 4 years². There is a link between the health and mortality of children and the level of child spacing. High levels of child

mortality: 320/1000 live births³. Better child spacing is positively associated with reduced mortality⁴. The health of children is a crucial part of national health and it is apparent that with adequate spacing, children would be able to live a fuller life¹.

Child spacing services are widely available in rural areas at hospital and health centre level. What will determine the use and effectiveness of the clinics are the beneficiaries themselves and their attitudes towards child spacing and child spacing services. An attitude can be defined as an opinion that has an evaluative and emotional component⁵ and is very influential in a person's subsequent behaviour. The aim of this study is to examine the currently prevailing attitudes towards child spacing among village women in one District in Southern Malawi (Mangochi).

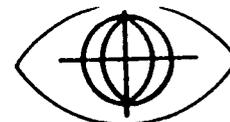
During preliminary investigation work for this paper⁶, a few informal discussions with women visiting some clinics made it clear that there was a lack of correlation between what people said they would/should do and what they actually did in practice. The vast majority of women spoken to at Monkey Bay and Nankumba Clinics knew what child spacing was, its advantages and even some of the methods. They had been constantly exposed to messages by radio and at various health meetings. Yet, despite this knowledge, they all admitted that they were not using child spacing methods themselves. Further more, there appeared to have been high drop out rates of child spacing methods at St. Martin's Hospital in Malindi on the shore of Lake Malawi. Between 1988 and October 1991, 101 women, who had begun receiving child spacing services at the hospital, had dropped out. Only 44 had remained active. By October 1991, the drop-out rate had reduced significantly, but still existed. The widespread failure rate of child spacing campaigns in rural society can be attributed in large part to insufficient awareness by programme administrators of the way of life and traditional attitudes - particularly attitudes to children - of the community involved. The preliminary investigation by Bandawe described above, served to fuel the need for a survey of attitudes towards child spacing amongst rural people.

Methods

Well established methodologies already exist for assessing needs, values, attitudes and other aspects of subjective experience. The pictorial projective technique was chosen as the form of assessment strategy. Liggett⁷ argues that this strategy can make a significant contribution to many of the developmental problems of the Developing World. The projective technique has been used in Sri Lanka, India, Malaysia and Indonesia and was used for the present study in Malawi. It is argued very strongly by Liggett⁷ that the technique uses wide ranging, open ended instruments to catch in a broad sweep the most salient attitudes, motivations and preoccupations of the particular community. It also provides the opportunity for insights into aspects not thought of by the researcher, thus avoiding investigators' preconceptions which might be exhibited in a questionnaire. The pictures can hold the attention of the respondent. Since there is no pressure to give the correct answer, a rich crop of ideas can emerge. Hence projective techniques facilitate "the free expression of ideas, speculations, doubts, and difficulties in terms which are familiar and significant to the respondent." Respondents do not feel threatened by intrusion into their private lives since the disclosures made are given in regard to the subject in the picture. It is the nature of these personal feelings which the study is trying to discover.

Results

The study was carried out in Mangochi District in various child spacing clinics. Mangochi was chosen because it is representative of most rural living patterns in Malawi, has low average age at marriage (16.5 years), high total fertility (7.1) and strong traditional beliefs



Report on Nutrition Assessment conducted in Chikwawa District April 5-10, 1993

SUMMARY REPORT

A fourth nutritional assessment was conducted in Chikwawa District from April 5-10, by IEF. 3.5% of the children were moderately to severely malnourished.

<u>Survey Date</u>	<u>Moderately - Severely Malnourished</u>	
	<u>< 80% WFH</u>	<u>(95% CI)</u>
August 1992	3.2	
October 1992	2.0	(1.5-2.5%)
December 1992	1.8	(1.1-2.5%)
April 1993	3.5	(2.4-5.0%)

The April malnutrition rate was not significantly different than the three previous nutrition assessments when comparing % weight for height, however, malnutrition was *significantly* higher in April than the previous (December 1992) assessment when comparing Z-scores, which accounts for standard deviation.

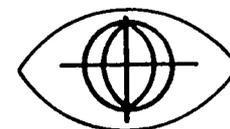
Food distributions have been well-orchestrated in the district and most villages received between three and five free maize distributions. Distribution was based on 1 tin (1 tin = 9kg) per person, with the exception of 1 tin for every 2 children in some areas. By April, over 50% of the people had access to a protected water source (borehole, protected shallow well or piped water). The improvement in water availability is due to repair and construction of new boreholes, especially in TA's Ngabu and Chapananga.

Although bloody diarrhea seems to be on the decline throughout the district, diarrhea is still prevalent, affecting 16% of the children surveyed. Children under 3 years had the highest rates of malnutrition and the highest prevalence of diarrhea.

Vitamin A supplementation has reached 44% of the children within the last 6 months in Chikwawa District. It was disturbing to note that children receiving supplemental food at health facilities were not receiving vitamin A at the time of distribution. Overall, 12% of the children had received supplemental foods in the past month. Access to supplemental feeding was not equal throughout the district; children surveyed in TA Ngabu had the lowest access rate (4.0%) while children surveyed in TA Maseya had the highest access rate (45%).

Recommendations

1. Discuss with all relevant drought relief agencies, the lessons learned from the past drought and how they can be best utilized to avert acute malnutrition if another drought should happen.
2. Investigate further the health factors associated with malnutrition specific to Chikwawa District.
3. There is not equal access to supplemental feeding. This needs to be investigated and it is recommended that supplemental feeding programmes in TA's Ngabu and Chapananga be strengthened.
4. Investigate a possible measles outbreak in TA Lundu and Nsua Island and increase the number of children immunized on Nsua Island.
5. Vitamin A capsule supplementation should be integrated into the supplemental feeding program.

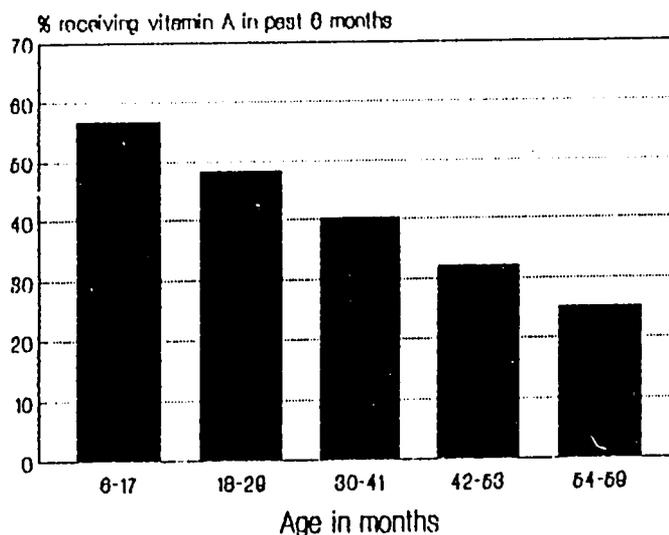


Supplement to 4th Chikwawa Nutrition Assessment

Vitamin A Supplementation in Chikwawa District

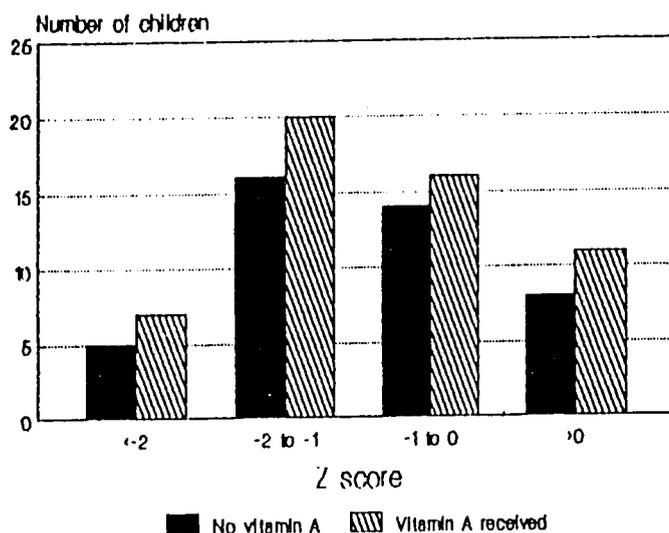
Vitamin A deficiency is a common finding in drought situations and supplementation with vitamin A capsules to all children under 6 years of age has been recommended in Chikwawa District and throughout Malawi. In the past six months 44.4% of children in Chikwawa District have received at least one dose of vitamin A. Coverage was highest among the youngest age group.

**Vitamin A Supplementation Coverage
Chikwawa District (April 1993)**



Malnourished children who have received supplemental foods at a health facility in the past month were only slightly more likely to have received vitamin A compared to the general vitamin A capsule distribution programme. Of the 97 possible opportunities to provide vitamin A with supplemental feeding, vitamin A was not provided to 43 children (44.3%). This suggests that health staff, when providing supplemental foods, are failing to recognize the importance of vitamin A to the health of this high risk group.

Vitamin A Missed Opportunities Number of children not receiving Vitamin A when receiving supplemental foods



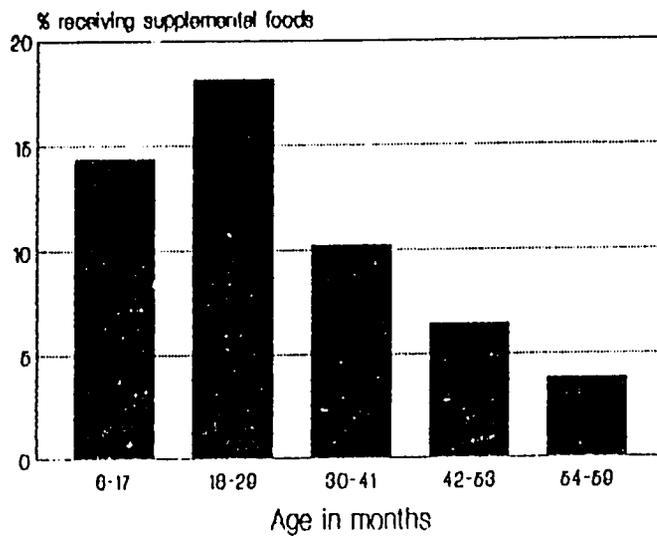
Chronic Poor Nutrition as a Risk for Acute Malnutrition

Chronic poor nutrition leads to stunting, as measured by height for age. In Chikwawa District 63.9% of children are moderately to severely stunted (≤ -2 z scores). Chronic malnutrition starts in the first few months of life; by 6 months of age most children are stunted; 67.4% of the children 6-17 months of age are stunted. Stunting is slightly more common in boys than girls. We also find that stunted children are more likely to be acutely malnourished (weight for height). The odds of being acutely malnourished if a child is stunted is 1.74 times the odds of being acutely malnourished if a child is not stunted.

Supplemental Feeding

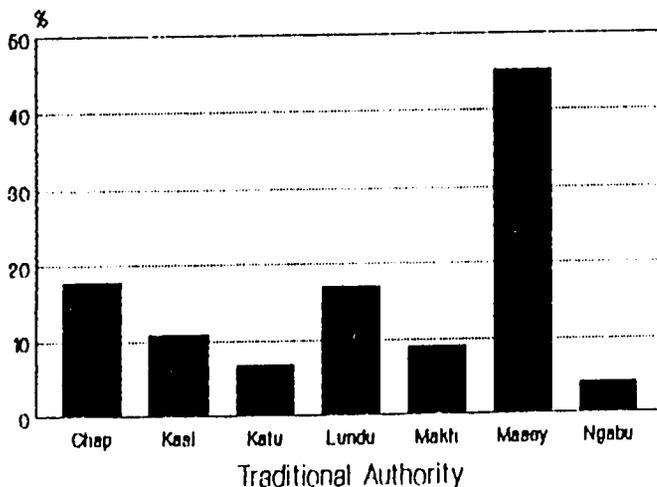
Supplemental feeding was provided to 11.6% of the children in Chikwawa District in the one month period prior to this survey. Supplemental foods are most likely to have been given to the age group 18-29 months.

Supplemental Food Received in Last Month Chikwawa District (April 1993)



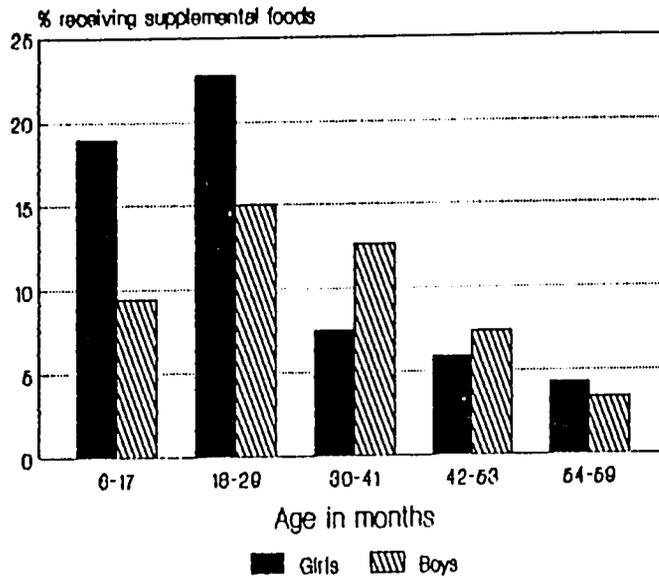
It was disturbing to note that supplementary feeding was not necessarily available to the most needy children. In 5 villages (4 in Ngabu TA and one in Makhwira TA) no survey child had received supplementary foods while in one village in Maseya TA 14 (45%) of the survey children had received supplementary foods. Children in TA Ngabu had the lowest supplementary food rate (4.0%) followed by TA Makhwira (9.1%).

Food Supplements by TA: Is Access Equal? % of survey children who received food supplements in the past month



Interestingly, girls were 1.3 times as likely to receive supplemental foods compared to boys. This association was most pronounced amongst children 6-17 months (2.24 times) and 18-29 months (1.67 times).

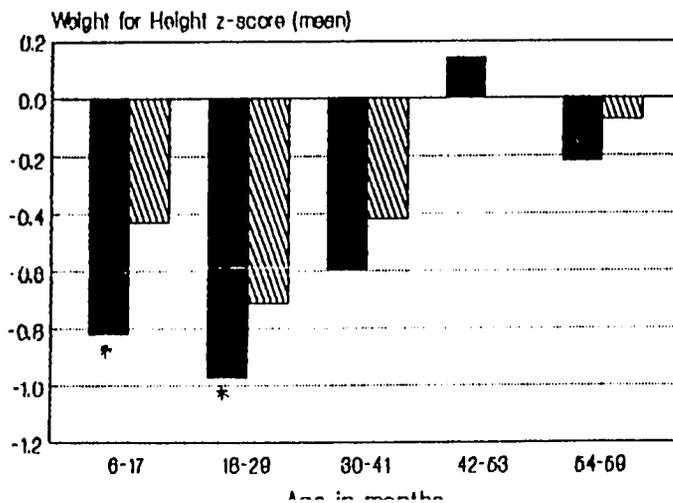
Supplemental Foods by Sex Chikwawa District (April 1993)



Malaria

Malaria was reported in all age groups and equally in boys and girls with an overall prevalence of 45.6%. This is likely to be an overestimate of the true prevalence of malaria in Chikwawa District. Children, in whom malaria was reported by the mother, had lower weight for height z-scores. The differences were most striking in the youngest age groups. There was no association between recent malarial episodes and stunting (~~weight~~^{height} for ~~weight~~^{age}) although it should be recognized that sequential analysis would be necessary to determine the contribution of malaria to chronic malnutrition.

Weight for Height by Reported Malaria Chikwawa District (April 1993)



RECOMMENDATIONS

Vitamin A Supplementation

Vitamin A supplements are reaching less than half of the children in the district.

1. It is recommended that community and church leaders and health personnel step up efforts to encourage mothers to bring their children to under-five clinics for vitamin A supplementation every 6 months.
2. Health workers need to be encouraged to provide vitamin A supplementation to any child receiving supplemental food.

Supplemental Feeding

Supplemental feeding programmes may not be reaching the children at greatest need.

1. It is recommended that the apparent maldistribution of supplemental feeding be investigated to determine why there is a disparity in access in the different traditional authorities; information should be used to ensure that those children eligible for supplemental feeding actually receive it.
2. Since it has never been documented that supplemental feeding actually improves the nutritional status of children in Malawi, it is recommended that a proper study of the contribution of supplemental feeding programmes to child health be instigated.

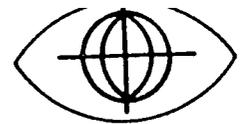
Malaria

The interesting association between reported malaria and acute malnutrition, especially in young children, deserves further investigation.

It is recommended that, as part of on-going malaria research in Malawi, children with symptomatic and asymptomatic parasitology be followed to assess the contribution of parasite load to acute malnutrition.

Further Nutritional Analyses

There are a number of data sets from NGO nutritional assessments, some of which are sequential "snap-shots" over the period of the drought. It is recommended that these data sets be analyzed in greater detail to generate a better understanding of the factors that contribute to malnutrition in Malawian children.



NSUA ISLAND HEALTH PROGRAMME

Summary of Activities

Background

Nsua Island, a large alluvial island (also known as Elephant Marsh) in the middle of the Shire River, is home to over 10,000 Malawians. There has never been an accessible health care infrastructure for the residents of this island; all residents had to cross the Shire River to either Montfort Hospital, the closest facility, or to Makhwira Health Centre, which has the administrative jurisdiction for the island. With financial support from the Drought Response Coordination Unit and USAID and administrative support from Montfort Hospital IEF is establishing a permanent health infrastructure on the island.

Current Status

In January 1993 IEF hired and IEF, Montfort Hospital, and the MoH trained an Nsua Islander, Mr. Friday Lewis, as a health surveillance assistant. Training was completed in early March. Leaders were advised that each village should form a village health committee (VHC) and choose a village health volunteer (VHV). Mr. Lewis arranged dates on which he would visit some villages in order to oversee the election of VHC members. Responsibilities of the HSA, VHCs, and VHVs were explained as was Mr. Lewis' affiliation with IEF, Montfort and MoH. As of early April all VHCs had been elected and all VHVs chosen.

Potential Problems/Limitations

As part of Montfort Hospital's community programme growth monitoring volunteers (GMVs) are trained. The activities these volunteers undertake is similar to that undertaken by IEF village health volunteers (VHVs) with a couple of exceptions. GMVs do not provide vitamin A while VHVs do. VHVs do not do growth monitoring although GMVs do. These discrepancies will have to be addressed in order to permit a smooth absorption of IEF VHVs into Montfort's programme. There is concern that GMVs/VHVs may become too overloaded. Supervision of both the North Island and South Island by Mr. Lewis could be problematic. Supervision of the South Island will prove to be more difficult than originally envisioned. It has been suggested that the 3 southernmost villages be assigned to HSAs from Ngabu Rural Hospital to supervise.

Operational Decisions

1. Because of the location of and access to the villages, Nsua Island will be divided into the North Island and South Island for purposes of supervision and communication.
2. A monthly meeting for local leaders and representatives of VHCs and VHVs should be held in both the North and the South to facilitate communication and attend to any problems.
3. IEF and Montfort personnel should meet together with Mr. Lewis once every two weeks, especially in the first 4-6 months after VHVs have been trained, to be sure that things are running smoothly.
4. Mr. Lewis should spend at least one week per month in the South to supervise VHVs and address any problems.
5. In the event of an outbreak or other serious problem, the North will report to Mr. Lewis, who will then contact IEF and Montfort whereas the South will report directly to Montfort with a letter or verbal message to be sent to Mr. Lewis.
6. A monthly mobile under-five clinic should be reinstated on the island. A

point should be chosen which is relatively easily accessed by health personnel from Nchalo and is relatively equidistant to the North and South. This needs to be agreed upon with Montfort. Another alternative would be to hold one under-five clinic on the North Island and one in Jumbo. Women from the North Island and the South Island have, at present, no choice but to attend an under-five clinic at Montfort in Nchalo.

Upcoming Activities

All VHVs will receive a baseline interview to help us understand what characteristics define volunteers selected by the community. Training of VHCs has already started. Training of VHVs will begin in May. Mr. Lewis will take part in a two day training in water and sanitation followed by a 3 day training in AIDS control in May.

Health Information System
Results of 1st Assessment (May/June 1993)

Vitamin A Coverage & Diarrhoeal Disease

Introduction

HSAs in the three catchment areas conducted their first health information system review in May and June. Questions focused on vitamin A coverage and diarrheal disease. 230 VHVs were interviewed and their roster books checked.

The purpose of the exercise was to:

1. Assess vitamin A coverage throughout the project area, for each HSA, and for each VHV.
2. Identify HSAs and VHVs with the best coverage in order to reward them for their efforts and identify HSAs and VHVs with poor coverage so they can re-double their efforts.
3. Establish a tool to teach IEF staff basic statistical computation and interpretation of data
4. Identify problem areas (with poor vitamin A coverage, poor ORS coverage, and high diarrhoea-associated mortality rates) and encourage staff to critically assess the reasons for the differences.

Vitamin A Capsule Coverage

The average vitamin A capsule coverage for the 230 VHVs was 72%; there was a tremendous range, from no capsules distributed by a couple VHVs to 100% of children receiving capsules. (Table 1). Because of the large range of values, the median capsule coverage, 76%, is more reflective of the overall capsule distribution. Among the 230 VHVs 9 (3.9%) distributed vitamin A to less than 25% of their target population and 37 (16.1%) distributed to less than 50% of their target population. These VHVs (Table 2) will require considerably more follow up by the HSAs. VHVs with >90% coverage (Table 3) deserve commendation for their efforts.

Table 1

Vitamin A Capsule Coverage of Population Served

Area HSA Name	No. (%) of VHVs with <50% coverage	Mean Coverage	Mean No. of Children per VHV
<i>Chipwaila</i>	9 (14.5%)	76%	57.9
<i>Navaya</i>	2 (8.7%)	84%	59.3
<i>Kupheka</i>	5 (27.8%)	69%	60.4
<i>Masansa</i>	2 (9.5%)	72%	54.3
<i>Dolo</i>	8 (14.0%)	71%	63.8
<i>Kalavina</i>	8 (18.2%)	68%	64.7
<i>Washa</i>	0	84%	60.6
<i>Makhwira</i>	21 (18.9%)	71%	53.2
<i>Chiwanda</i>	1 (3.8%)	86%	61.3
<i>Zintula</i>	14 (20.9%)	67%	49.0
<i>Moyo</i>	5 (27.8%)	62%	56.9

Table 2

Village Health Volunteers with Poor Vitamin A Coverage

Coverage	VHV Name	Village	HSA (Area)
42%	Margret Jasten		Kupheka (C)
38%	Chrissy Aonenji		Kupheka (C)
50%	Esinati		Kupheka (C)
50%	Alfred Chakudnamaso		Navaya (C)
50%	Yusita Raphu		Navaya (C)
39%	Lucy Loyd		Masansa (C)
21%	Lenaissi Tenson		Masansa (C)
50%	Monika Aiven		Kupheka (C)
45%	Kerita Nsingano		Kupheka (C)
3%	Mary Chiphawau		Kalavina (D)
50%	Unesi Macfield		Kalavina (D)
9%	Ndinenenji Tinasoni		Kalavina (D)
0%	Gladys Ganamba		Kalavina (D)
7%	Maujani Dyanjona		Kalavina (D)
30%	Akesi Pitolosi		Kalavina (D)
38%	Aliyanesi Christopher		Kalavina (D)
45%	Patricia Thenesi		Kalavina (D)
9%	Alike Khulumula		Moyo (M)
48%	Estere Dauya		Moyo (M)
42%	Dola Matiyasi		Zintula (M)
32%	Funny Maiteni		Zintula (M)
7%	Grace Frank		Zintula (M)
36%	Rodge Banda		Zintula (M)
44%	Mary Manjomo		Zintula (M)
47%	Elizabeth John		Zintula (M)
50%	Dester Masauko		Zintula (M)
24%	Rose Matiasi		Zintula (M)
42%	Mary Kadzuwa		Zintula (M)
15%	Beatrice Kunje		Zintula (M)
49%	Elesi Chipe		Zintula (M)
35%	Beatrice Laston		Zintula (M)
34%	Ruth Judge		Zintula (M)
33%	Genti		Moyo (M)
41%	Polina Chamanga		Moyo (M)
41%	Modester Saumu		Moyo (M)
36%	Ainess Botoman		Zintula (M)

Table 3

Village Health Volunteers with Excellent Vitamin A Coverage

Coverage	VHV Name	Village	HSA (Area)
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Interpretation

1. The average coverage of the three areas are not significantly different from one another. The average coverage of the 8 HSAs are significantly different (F value = 5.22, $p < 0.001$) The best coverage was in the areas of HSA Navaya, Washa, and Chiwanda. There was no correlation between coverage and number of children managed by each VHV.
2. The average number of children per VHV among the HSAs was significantly different (F value = 2.77, $p = 0.009$). The average number of children per VHV among the three areas was also significantly different (F value = 5.12, $p = 0.007$)

Deaths Associated with Diarrhoea in the Past 3 Months

There were a total of 231 deaths in which diarrhoea was reported prior to death in the three catchment areas. There were deaths of children under 6 in all areas. Deaths were evenly divided between males and females. 11.5% of deaths occurred in children <6 months of age and 43.8% of deaths were in children under the age of 12 months. 28.6% of deaths were in the second year of life.

Table 4

Mortality Associated with Diarrhoea

HSA Name	No. (%) of VHVs reporting one or more deaths	Deaths/Population (Mortality Rate/1000)
Chipwaila	35 (56.5%)	77/3592 (21.4)
Navaya	17 (73.9%)	42/1363 (30.8)
Kupheka	7 (38.9%)	13/1088 (11.9)
Masansa	11 (52.4%)	22/1141 (19.3)
Dolo	18 (31.6%)	41/3635 (11.3)
Kalavina	14 (31.8%)	31/2847 (10.9)
Washa	4 (30.8%)	10/ 788 (12.7)
Makhwira	43 (38.7%)	99/5910 (16.8)
Chiwanda	18 (69.2%)	41/1593 (25.7)
Zintula	16 (23.8%)	31/3292 (9.4)
Moyo	9 (50.0%)	27/1025 (26.3)

Interpretation

1. Overall, 96 (41.7%) of VHVs reported one or more death. There were significantly more deaths associated with diarrhoea reported by VHVs in the Chipwaila area compared to the other areas (chi-square = 8.35, df=2, p=0.015). The number of deaths reported by VHVs were also significantly different among the HSA catchment areas (chi-square = 30.6, df=7, p<0.001).
2. Mortality rates reflect a 4 month period only. Mortality rates were significantly different among the 8 HSAs.

ORS Treatment Prior to Death

ORS was provided by the VHV to only 30.1% of these children prior to death. Boys were slightly more likely to receive ORS (34.5%) compared to girls (25.2%).

Hospitalization Prior to Death

51.2% of the children went to a health centre, 32.5% went to a hospital, and only 16.3% did not go to either of these facilities prior to death. Boys who later died were more likely to go to a hospital (35.6%) than girls who later died (29.3%); girls were more likely to not be taken to either a hospital or health centre (19.2%) compared to boys (13.5%).

Children who died without being taken to the hospital were older (21.7 mo) than children taken to the health centre (15.2 mo) or children taken to neither the hospital or health centre (19.0 months). (F value = 4.0, p=0.019)

Table 4

ORS Coverage & Hospital & Health Centre Use Prior to Death

Area HSA Name	ORS coverage among children who died (%)	ORS Coverage *	H.C. prior to death	Neither HC nor hospital prior to death
Chipwaila	21/76 (27.6%)		18.9%	35.1%
Navaya	13/42 (31.0%)	2.6	17.1%	14.6%
Kupheka	0/12	2.9	36.4%	54.5%
Masansa	8/22 (36.4%)	2.3	13.6%	63.6%
Dolo	8/41 (19.5%)		75.8%	0%
Kalavina	5/31 (16.1%)	2.7	79.2%	0%
Washa	3/10 (30.0%)	1.5	66.7%	0%
Makhwira	36/99 (36.4%)		67.7%	7.3%
Chiwanda	13/41 (31.7%)	1.4	63.4%	14.6%
Zintula	15/31 (48.4%)	2.1	57.1%	3.6%
Moyo	8/27 (29.6%)	2.0	85.2%	0

* ORS coverage is the number of ORS packets given by the VHV per diarrhoeal disease episode.

Interpretation

1. Hospital and health centre use varied by area; in Chipwaila only 18.9% of children were taken to the health centre while in Dolo 75.8% of children were taken to the health centre and in Makhwira 67.7% of children were taken to the health centre. (Chi-square = 56.8, df=4, p<0.001). Over one-third of the children who died in Chipwaila (35.1%) went to no health facility as compared to only 7.3% in Makhwira and no children in Dolo.
2. ORS coverage among children who died was different among the 8 HSAs. (Chi-square = 13.5, df=7, p=0.06)
3. Hospitalization and health centre patterns varied by HSAs (Chi-square = 104.4, df=14, p<0.001) although, by and large, it reflected the catchment area.

Vitamin A Capsule Coverage

Overall, vitamin A capsules were received by only 47.2% of the children who died (compared to 72% of children who were alive). Coverage varied by area; in Makhwira 61.2% of children who died had received vitamin A compared to only 39.0% of children in Dolo and 28.6% of children in Chipwaila. (Chi-square = 19.4, df=2,

p<0.001)

Of the children who died, boys were slightly more likely to receive vitamin A (50.0%) compared to girls (40.2%). Children who were taken to a health centre were more likely to have received vitamin A (49.5%) compared to children taken to the hospital (43.9%) or children taken to neither place (33.3%).

Table 5

Vitamin A Capsule Coverage in Children Who Died

Area HSA Name	Average Vitamin A Coverage (live)	Average Vitamin A Coverage (died)
Chipwaila	76%	25.3%
Navaya	84%	33.3%
Kupheka	69%	0%
Masansa	72%	36.4%
Dolo	71%	39.0%
Kalavina	68%	35.5%
Washa	84%	50.0%
Makhwira	71%	61.2%
Chiwanda	86%	63.4%
Zintula	67%	56.7%
Moyo	62%	62.9%

Interpretation

1. Overall, the average vitamin A capsule coverage was higher in the children who were alive than in the children who had died, although there was great variation by HSA area. (Chi square = 25.6, df=7, p<0.001)

Current Pregnancies

The average number of current pregnancies in each of the VHV catchment populations was 3.9 and varied little by supervising HSA or by area.

POINTS OF DISCUSSION & APPLICATION

1. Why was vitamin A coverage better in some areas compared to others? How can vitamin A coverage be improved? How much extra supervision will be needed?
2. Why was diarrhoeal disease associated mortality highest in Chipwaila? What can be done to reduce this?
3. Why is mortality low for HSA Zintula and much higher for HSA Chiwanda and HSA Moyo when they are all in the Makhwira area?
4. Why did ORS coverage among children who died vary? (coverage high in Makhwira, low in Dolo)
5. Why did so few children go to the health centre in Chipwaila before death? Why did so many of these children not go to any health facility?
6. Why is vitamin A coverage of children who died so much lower than in the children alive?
7. Why is vitamin A coverage in children who died so much higher in Makhwira compared to either Dolo or Chipwaila?
8. Why wasn't vitamin A coverage of children taken to the hospital or health centre prior to death any higher than in the children who did not die? What can be done to correct this?
9. What is an appropriate "reward" for VHVs who had excellent (>90%) coverage? What kind of role can the village health committee play?

TRADITIONAL HEALERS AND AIDS IN CHIKWAWA DISTRICT, MALAWI
PRESENTED BY:

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Traditional Healers in Malawi

Traditional healers are commonly used by rural Malawians for all types of health care needs. They are well-regarded by the community and their services are often sought before those of the Ministry of Health. The Traditional Healers Association of Malawi is weak in most districts with a few notable exceptions (Mchinji District) and weak nationwide. Traditional healers can be roughly divided into a number of groups although there is considerable overlap. 'Sing'anga' is the broad term that covers village and market herbalists, doctor-diviners, and in some cases traditional birth attendants. As elsewhere in Africa, there is no developed theory of natural causation among traditional healers in Malawi; symptoms are treated rather than biomedical conditions.

To investigate knowledge, attitudes and practices regarding AIDS in the district, a survey of AIDS and healers was conducted in conjunction with an on-going project on eye care and traditional eye medicines. In addition, IEF staff have been conducting in-depth discussions with traditional healers active in the care and counselling of villagers in many illnesses, including sexually transmitted diseases.

Survey

A population proportionate to size sample of villages (10%) was selected in Chikwawa District (population 350,000) and all healers resident in these villages interviewed regarding their knowledge of AIDS. A total of 88 healers were interviewed regarding AIDS. In Chikwawa District there is one healer per 350 people. The average age of the healers was 60 years, 53% were male, and 76% were illiterate. All healers were familiar with AIDS although only 46% reported meeting someone suspected of having AIDS. Healers who were literate, younger, and living close to a health centre were more likely to report meeting someone with AIDS.

All healers reported that sexual intercourse was the main transmission pathway for AIDS although 81% also reported razor blades and 76% reported injections as major pathways to AIDS. Only one person each reported mosquito bites and witchcraft as a major pathway to AIDS. 84% of healers said AIDS could be prevented; female healers were more likely to report this compared to male healers. Three healers (3.4%) reported that AIDS could be cured; these same healers all reported that they could cure AIDS through use of special plant products. These three healers, two men and one woman, lived close to health centres and next to a main road.

Only three healers (3.4%) reported counselling patients or family members and only 12% of the remaining 85 healers said they are willing to counsel patients or family members. Those willing to counsel live near a main road and the main health facility in Chikwawa. Most healers (91%) said they are willing to work with the MoH to help fight AIDS and most healers (89%) also said they are willing to hold meetings with their community to help educate people about AIDS.

Focus Group Discussions

Small in-depth group discussions, usually with 3 or 4 traditional healers and lasting about 2 hours, were held in villages where healers lived and worked to gain a better understanding of the beliefs regarding AIDS and other STDs, condom use and factors influencing sexual behavior.

1. AIDS

Some healers attended seminars on AIDS control sponsored by the MoH, but most healers had little education about AIDS and did not know the cause of AIDS. Because healers did not understand the nature of the virus that causes AIDS, they did not believe that a person could be asymptotically infected with HIV and able to transmit the virus to others. Most held the belief that a 'person with AIDS' was emaciated like a skeleton and had a severe cough, ulcers all over the body, and persistent diarrhea. They knew only the symptomatic stage that has been categorized by modern medicine as 'AIDS', but did not understand initial infection and the asymptomatic stage, so they maintained that someone could not 'look strong', yet have and transmit the virus. The healers who had been educated by MoH, however, understood the progression from HIV infection to AIDS and therefore the dangers inherent in the asymptomatic stage; for this reason, we are optimistic that educational efforts aimed at prevention will prove successful in clarifying this misconception.

It was widely believed among healers that AIDS resembles '*tsempho*', a traditional disease which has characteristics similar to kwashiorkor, and is caused by violation of the abstinence customary in the post-funeral mourning period. The healers, however, quickly distinguished between *tsempho* and AIDS. *Tsempho* is a very old disease arising from the violation of traditional customs; the healers can identify *tsempho* through the 'spirits' and are able to cure it. AIDS, on the contrary, is a very new disease, also arising from bad behavior, but not violation of traditional customs. And, unlike *tsempho*, AIDS resists treatment. One or two healers thought that they could cure AIDS, while a couple of others thought they might be able to given adequate opportunity to try when presented with an AIDS case.

All traditional healers said that AIDS was spread through sexual intercourse and most said that AIDS could be transmitted through blood-to-blood contact by reusing razors, needles, and pins. Unfortunately many also held the belief that AIDS could be spread through mosquitoes, coughing, eating from the same plate, sharing clothing, toothbrushes, and combs, and by stepping on a place where someone had urinated or defecated. These misconceptions are dangerous because they imply that HIV is much more infectious than it is and that, therefore, a person with AIDS needs to be isolated or quarantined from the community; some healers even suggested that persons with AIDS should be isolated from the community. When these misconceptions were clarified by explaining the reasons for the transmission pathways, healers seemed to gain a better understanding of the virus causing AIDS and why the virus could not be transmitted in ways they had thought before. For this reason we are also optimistic that future educational efforts will prove successful.

2. Other Sexually Transmitted Diseases

We discussed extensively the treatment of STDs to gain a better understanding of the prevalence of STDs and the risk of the population for HIV infection. As expected, we found a much higher prevalence of STDs in the villages immediately surrounding large trading centres than in the more rural areas (based on the number of patients reporting to traditional healers for STDs). Traditional healers generally identified 3 STDs - those causing genital discharge ('*chinzono*'), those causing genital sores ('*chindoko*') and those causing large

pus-filled blisters around the genital area ('mabomu'); there are some other less common STDs recognized by healers and usually caused by violation of traditional customs (e.g., having sexual intercourse with a menstruating woman or a woman who has had a recent spontaneous abortion). The healers felt that they could effectively treat all STDs though many did admit that chizonono (probably gonorrhoea) was very stubborn to treatment and its symptoms often recurred. Patients were considered to be healed when, upon their own report, symptoms such as genital sores or discharge went away, though many healers said that often women could have a disease and not have symptoms.

Most people reporting to traditional healers with STDs were young adults, men and women, approximately 18 - 28 years; women reporting with STD symptoms often were younger than the men reporting. Many healers charged higher rates for the treatment of STDs as a way of punishing patients for having acquired the disease through 'bad' and intentional behavior. Healers encouraged simultaneous treatment of sexual contacts, though they admitted that distant contacts and 'illicit', single-encounter contacts often were not told or treated.

Most healers could not immediately associate the occurrence of STDs with increased risk of HIV infection. When asked, however, who had a higher chance of HIV infection - one with ulcers, or one without - most reasoned that the one with ulcers would more likely be infected due to the break in skin caused by the ulcer and the resulting exposure of 'blood' with semen or vaginal secretions.

3. Knowledge and Use of Condoms

All healers could identify the protective nature of condoms with respect to AIDS and other STDs, but few had ever seen, used or recommended to their patients use of condoms. Most were unable to demonstrate proper use of a condom, but we found it encouraging that all were eager to learn and thought it important they do so in order to teach their patients and their communities. The few healers who could demonstrate proper condom use were taught by health professionals at seminars; two of these healers worked in a large trading centre where they regularly demonstrated condom use to patients and distributed condoms to patients free of charge.

4. Factors Influencing Sexual Behavior

Most healers attributed the high prevalence of STDs and AIDS to the breakdown of traditional customs and beliefs among the younger generation. They felt that the youth do not truly believe that AIDS exists, do not feel themselves to be at risk, and do not heed advice despite repeated warnings and even repeated occurrences of STDs. They also felt that peer pressure plays a large role in determining behavior particularly with regard to alcohol consumption.

We found the widespread belief that since sexual urges are 'natural', they simply cannot be controlled or disciplined. Moreover, healers felt that young women are unable to negotiate condom use or refuse sexual advances, particularly if money is offered. We found that in the areas immediately surrounding trading centres, young women regularly traded sexual favors for money; while older, dependent family members claimed such behavior to be reproachable, they commonly 'looked the other way' if the women provided a source of income for the family.

Discussion

There are few intrinsic differences (age, sex, years in practice, literacy, member of healers association, etc) between healers regarding their knowledge and willingness to tackle the AIDS problem in Malawi. The major differences found in the survey are in proximity to health facilities or main roads which suggests

that AIDS messages have only been successful in reaching those within easy access to health facilities or training programmes. In the group discussions, we found that only the healers who had attended 3-day AIDS control seminars sponsored by MoH did not hold dangerous misconceptions about transmission - both during the asymptomatic stage and by pathways other than those known.

Proposed AIDS Prevention Activities with Traditional Healers

In Chikwawa District there have been a few very focused, very effective efforts on the part of some local health professionals and the MoH to educate a few healers about AIDS. Most healers, however, have not been educated about AIDS and the ones who have been educated are not encouraged to initiate public education. The educated healers are not being utilized as the community resource they are, despite the fact that almost all healers express interest in learning from and cooperating with the MoH in the fight against AIDS.

IEF, in coordination with MoH, is strongly encouraging the traditional healers already trained in AIDS control to become community educators, and with the assistance of village leaders to choose community AIDS education volunteers. We will, in the coming months, sponsor AIDS control seminars for the healers who have not yet been formally educated. Education of healers must focus on:

- ▶the lack of a cure and the dangers of suggesting a 'cure',
- ▶the importance of prevention and behavior change necessary to prevent HIV transmission,
- ▶community education in coordination with local MoH personnel including village health volunteers, health surveillance assistants and other community AIDS control volunteers,
- ▶the importance of counselling and supporting persons with AIDS, not isolating them, and
- ▶the importance of counselling STD patients in the increased risk of HIV infection.

THE INTERNATIONAL EYE FOUNDATION and AIDS PREVENTION
IN CHIKWAWA DISTRICT, MALAWI

MR. MATHEWS D. ALIFINALI,
INTERNATIONAL EYE FOUNDATION,
BOX 142,
NCHALO, MALAWI.

The International Eye Foundation and Child Survival

The International Eye Foundation (IEF) promotes child survival activities in the Lower Shire Valley under a three-year grant from USAID. IEF has developed and supports a network that includes IEF-trained health surveillance assistants (HSAs) posted to health clinics as well as village health volunteers (VHVs) who are responsible for monitoring maternal and child health, educating mothers about basic health care issues, distributing Vitamin A and Oral Rehydration Solution and reporting any serious problems to the Ministry of Health (MoH) or IEF. As the AIDS epidemic is expected to cause a significant increase in infant mortality, one objective of IEF is to incorporate AIDS education and prevention into its child survival activities.

Baseline Survey - Methodology and Results

In order to develop effective child survival activities and to demonstrate that these activities have led to some change over the three-year span of the child survival project, IEF conducted a baseline survey in Chikwawa District in March and April of 1992. Interviews were conducted with 2173 mothers of children under 6 years of age in 68 villages. Included in the interview were questions about knowledge of AIDS and condom use.

Almost all women (96.5%) had heard of AIDS. Just over half (58.3%) of the women felt that condoms could protect against AIDS. Only 158 women (7.3%) reported that their husbands had used a condom in the past year. Most women (82%) whose husbands used condoms understood the protective nature of condoms while only 56% of women whose husbands did not use a condom understood the protection that condoms offer. Condom use was most commonly reported by younger women. This is likely a function of literacy, as literate women were 2.9 times more likely to report condom use than illiterate women. It is encouraging that most women (84%) understood that sexual intercourse is a transmission pathway for AIDS. Less encouraging is the high proportion of women reporting other (generally minor, or incorrect) transmission pathways for the disease. The belief that mosquitoes can transmit AIDS is found mostly among older women and is likely a function of early widespread beliefs. All age groups report sex as a transmission pathway for AIDS. Unfortunately, all age groups equally report witchcraft as a cause of AIDS. The proportion of women who think that AIDS can be transmitted through witchcraft may be an underestimate, because many women would answer this question ambivalently, e.g., with a shrug of the shoulders and, when pressed, would finally respond 'no'. It is unclear whether women who consider injections as a transmission pathway are less likely to take their children for immunization. A review of our data indicates that this is not the case. The proportion of women with this belief whose children were not immunized (25.8) is similar to the

proportion of women without this belief whose children were not immunized (22.9%). . Razor blades are thought to be a pathway by older women and less frequently by younger women.

IEF Activities in AIDS Prevention

Rural seroprevalence in Malawi remains unclear; blood donor studies suggest that rural seroprevalence presently ranges from 6-10%. Most women have heard of AIDS and a surprisingly high number understand the protective nature of condoms. Unfortunately, the use of condoms is reported to be very low. Given the baseline results, IEF project objectives have been to:

- ▶investigate further women's and men's knowledge and attitudes towards AIDS control and condoms,
- ▶investigate mothers' beliefs that injections are a common transmission pathway and the impact it may have on an EPI programme, and
- ▶develop and implement an AIDS control programme for village women to be implemented by (rural) female village health volunteers.

In May, 1993, IEF sponsored a training seminar facilitated by the National AIDS Control Programme for all IEF staff and health surveillance assistants and other health personnel in Chikwawa District. At this seminar, the group learned the facts about AIDS and other sexually transmitted diseases, discussed rumors and misconceptions prevalent in the district, practiced teaching others about AIDS, learned and demonstrated proper condom use, and formulated work plans for their respective health clinics and catchment areas. Health surveillance assistants have just completed training of the female villages health volunteers as well as male members of village health committees in their catchment areas in STD and AIDS prevention and condom use. These volunteers, upon return to their villages, will educate the village women and men of all ages about STDs, AIDS and condom use; the volunteers are encouraged to use small gender-separate groups to educate their communities in order to encourage open discussion, to answer 'sensitive' questions, and to clarify misconceptions.

To investigate further knowledge, attitudes and practices in the district, IEF staff also have conducted in-depth discussions with traditional healers active in the care and counselling of villagers in many illnesses, including sexually transmitted diseases. In coordination with the local hospital and businesses, IEF soon will begin intensive STD and AIDS education and control activities in Nchalo, the largest trading centre in Chikwawa District and where HIV seroprevalence is thought be above 20%.

A Proposal to Collaborate with Traditional Healers
in Primary Eye Care Activities

Pilot Project Areas: Mulanje & Chikwawa District
Project Period: July 1993 - July 1994
Supporting Agencies: Project ORBIS
 International Eye Foundation

Introduction

Traditional healers and traditional birth attendants (TBAs) are widely used for eye care in Malawi. Some practices are harmful and need to be discouraged while other practices are acceptable. (See attached abstract for more details). Healers and TBAs could contribute to the prevention of blindness in Malawi.

Goal

The overall goal of the programme is to improve collaboration with traditional healers and TBAs in the prevention of blindness.

Objectives

1. Meetings with traditional healers/TBAs will be conducted quarterly over the entire project period to improve collaboration for the prevention of blindness.
2. Within a one year period 25% of healers in the catchment areas will understand and promote the importance of face-washing as a preventive measure for eye disease.
3. Among corneal ulcer patients recognized at the district hospital the average time between onset of symptoms and referral to OMA will be reduced (from the current 48 days to 40 days).
4. Within a one year period 30% of healers will be able to:
 - a) identify a blind eye/person, and
 - b) know where these patients can be referred.
5. Within the project period the number of patients with corneal ulcer who report traditional eye medicine use will be reduced (from the current 50% to 40%).
6. Ophthalmia neonatorum will be recognized and treated more effectively.
 - a) A proportion (10%) of TBAs and healers will understand that there is no relationship between foods consumed during pregnancy and ophthalmia neonatorum
 - b) The number of days between onset and presentation of children with ophthalmia neonatorum presenting to the OMA will be reduced.

1. The OMAs will arrange an orientation with chiefs and quarterly meetings with traditional healers and TBAs.
2. HSAs (and community nurses, where appropriate) will conduct training of traditional healers and TBAs on face washing and general hygiene.
3. OMAs will conduct training of traditional healers and TBAs on early referral of problem cases and on the recognition of blindness and referral.
4. OMAs will conduct training of traditional healers/TBAs on the dangers of traditional compounds instilled directly into the eye and the lack of danger of other methods. HSAs will conduct training of village health volunteers and village health committees on the danger of these traditional "eye drops".
5. Nurses will conduct training of TBAs and during antenatal clinic on the safety of spicy foods during pregnancy, the need for prophylaxis at birth, and early referral of ophthalmia neonatorum.

Coordination

HSA training of village health volunteers will be conducted within existing programmes. Interaction with healers will be included within the existing HSA training curriculum.

Among antenatal clinic mothers information regarding ophthalmia neonatorum needs to be strengthened. Workshops with traditional healers should be done with other health sectors (particularly AIDS control).

Pilot Testing

Mulanje and Chikwawa Districts will be the pilot programme areas; if a reduction in eye disease associated with traditional eye medicine use is recognized, the programme will be promoted elsewhere.

To assess the success of the programme, complete and accurate records will need to be kept over the next year. Baseline data exists at both districts from which we can measure changes. Similar information will need to be collected starting in November 1993

1. Corneal ulcer patients presenting at both hospitals will be interviewed regarding traditional eye medicine use.
2. Parents of all ophthalmia neonatorum patients will be interviewed upon presentation to the OMA (starting July 1993)
3. A sample of healers will be interviewed after one year to assess any changes in knowledge of eye diseases

Collaboration

will receive appropriate training. IEF village health volunteers will also receive education regarding traditional eye medicines.

Limitations

For pilot work in Chikwawa and Mulanje existing personnel will be able to handle the work. If the project expands elsewhere, a project coordinator will be needed. Financial support is needed for training, transportation, and record keeping. It is unclear if these activities can be managed within the OMAs' current work schedule; time constraints will have to be assessed during the pilot project.

Training

Initial orientation with traditional healers and TBAs will take two to three hours each. Training of VHV's will be included in the next series of training programmes (August) to be conducted by the HSAs. Training should take about 3-4 hours.

Training of traditional healers will take a considerable amount of time and need to be divided into a number of sessions. Select healers (who demonstrate an interest in eye care and a willingness to adapt) will be chosen for more in-depth training and requested to serve as trainers.

Dissemination of Information

The Traditional Healers Association in Chikwawa and Mulanje Districts are relatively weak and is not expected to feature prominently in the programme. Nevertheless, the national association will be notified of activities. Healer associations in other districts who express an interest would be prioritized for expansion of activities.

Information will also be submitted to the Ministry of Health (national, regional, district) to encourage more collaboration with healers.

Evaluation

Success will be determined by achievement of specific objectives.

Supervision

After initial orientation and training the OMA will need to meet with healers quarterly to ensure that interest in primary eye care continues. OMAs will need to meet with HSAs twice per year to ensure continuity.

Financial Needs

Transport
Teaching materials
Office supplies
Lunch allowances

INTERNATIONAL EYE FOUNDATION
P.O. BOX 142, NCHALO
P.O. BOX 138, CHIKWAWA

8 June, 1993

Mr. A.J. Vaudin,
General Manager,
Sugar Corporation of Malawi, Ltd.,
Private Bag 50,
Blantyre.

RE: PROPOSAL FOR NCHALO FAMILY HEALTH EDUCATION AND COUNSELLING CENTRE

Enclosed please find a summary of the proposal for the Nchalo Family Health Education and Counselling Centre. The purpose of the centre is to prevent and control AIDS and other sexually transmitted diseases (STDs) and to promote family planning in the Nchalo area. I write to inform you about the proposal and to invite you to become involved in the establishment and activities of the centre.

Why the proposal?

The proposal has arisen from numerous discussions with health care professionals and villagers about the failure of the current health care system to address the problems of increasing HIV seroprevalence (particularly in Nchalo and other semi-urban areas of the district) and population growth. The current system simply does not allow health professionals to devote adequate time and effort to the priority areas of AIDS Control and Family Planning.

AIDS prevention and control programmes, similar to the one proposed, have proved successful in other areas of Malawi including Dowa, Lilongwe and Mulanje, while similar family planning programmes have demonstrated success in Ekwendeni and Thyolo. As the two areas are inextricably related through responsible sexual behaviour, the current trend in Malawi is to combine resources of the two areas to maximize education and prevention efforts.

The proposal is a working document. It has been reviewed and commented on by health professionals at all levels, including Dr. Jacka - Regional Health Officer, Dr. Sok - Montfort Hospital, and Mr. Kachale - SUCOMA Senior Medical Officer.

The proposal is expected to be formally submitted for funding in June. Prospective donors have already been approached and have expressed interest in funding part or all of the proposal.

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How can SUCOMA benefit from the centre?

SUCOMA has its own system of health clinics and, with assistance from Project Hope, may soon have its own compound-based volunteer health surveillance network which will promote, among other things, AIDS control and family planning activities. SUCOMA employees, however, do not live independent of the rest of the Malawian population; they interact with the 'non-employees' in innumerable ways. One way is through frequent sexual contact, especially in the trading centre where HIV seroprevalence is widespread and where treatable STDs commonly go untreated.

SUCOMA cannot effectively treat its employees for STDs and prevent HIV transmission unless the non-employee trading centre population is simultaneously treated for STDs and educated - treating one partner alone is inadequate.

Moreover, since SUCOMA clinics depend on Montfort Hospital for referral, anything which burdens personnel and strains the resources of Montfort negatively impacts the quality of care available for SUCOMA referrals. We hope to lessen the impact of the AIDS epidemic on Montfort Hospital and SUCOMA clinics, by advocating prevention of HIV transmission now.

The activities of the centre will benefit everyone in the Nchalo trading centre area, including SUCOMA employees, by:

- promoting a standard of sexual responsibility (i.e., reducing number of sexual partners, using condoms) and accountability (i.e., ensuring all sexual contacts are treated for STDs) through risk awareness, peer counselling, condom distribution and STD treatment.

- reducing the prevalence of treatable STDs and therefore the risk of HIV transmission among the general population through free STD testing and treatment.

- reducing the prevalence of treatable STDs among specific high-risk populations such as bar-girls through education, peer counselling and free STD testing and treatment.

- reducing the number of future AIDS cases which burden personnel and strain resources at Montfort Hospital through prevention and counselling activities and HIV testing,

- reducing the number of AIDS cases which burden personnel and strain resources at Montfort Hospital through the teaching and promotion of home-based care for the terminally ill, and

- strengthening, through continuity and coordination, STD/AIDS control and Family Planning efforts among all organizations in the Nchalo area, including MOP, Montfort, SUCOMA, IEF, and Project Hope.

How can SUCOMA become involved?

We welcome any assistance you can offer; there are many ways in which SUCOMA can become involved. Mr. Kachale, who is very much in favour of the proposal, has suggested, for example, that nurses and other medical personnel from SUCOMA, including himself, devote some technical assistance on a voluntary basis to the centre each week.

Some other ways SUCOMA could demonstrate interest include, but are not limited to:

- assisting in area briefings about use of the centre and its activities,
- encouraging SUCOMA employees to use the educational and counselling services provided at the centre,
- encouraging SUCOMA employees treated for STDs to refer all 'non-employee' sexual contacts to the centre for treatment,
- transporting medical, laboratory, and contraceptive supplies from Blantyre to the centre and Montfort Hospital,
- providing land (in or near the trading centre) for the construction of the centre,
- providing labour for the construction of the centre,
- transporting materials from Blantyre for the construction of the centre,
- providing temporary housing for the facilitator, and
- assisting in the design and start-up of income-generating activities.

Dr. Courtright, IEF Country Director, and I would like to meet with you some time in the next few weeks to discuss the proposal. I can be contacted by telephone at 423-228 in Chikwawa; if I cannot be reached, please contact Dr. Courtright at 635-917 in Blantyre. Thank you for your time and attention in this matter. I look forward to meeting with you.

Sincerely,



Laura Porter
AIDS Programme Coordinator
International Eye Foundation

Dr. David Jacka, RHO-South
Dr. Paul Courtright, IEF Country Director
Dr. Elisha Venemans, DHO - Chikwawa
Mrs. Cathy Thompson, Project Hope Project Director
Mr. Kachale, SUCOMA Senior Medical Officer
Mr. Salamu, Administrator, Montfort Hospital

SUMMARY OF PROPOSAL FOR NCHALO FAMILY HEALTH EDUCATION AND COUNSELLING CENTRE

The International Eye Foundation

The International Eye Foundation (IEF) promotes child survival activities in the Lower Shire Valley. IEF has developed and supports a work that includes IEF-trained health surveillance assistants (HSAs) linked to health centres throughout the district and village health workers (VHVs) who live in the community and who are responsible for monitoring maternal and child health, educating mothers about basic health issues, distributing Vitamin A and Oral Rehydration Solution and reporting any serious problems to the Ministry of Health (MoH) or IEF. IEF has worked closely with the MoH and Montfort Hospital (Nchalo) in the pursuit of these activities.

As the AIDS epidemic is expected to cause a significant increase in infant mortality, one objective of IEF is to incorporate AIDS education and prevention into its child survival activities. In May IEF sponsored an AIDS Education Seminar facilitated by the National AIDS Control Programme for Malawi workers from IEF, Montfort Hospital and SUCOMA.

Another objective of IEF is to reduce infant and maternal mortality through the promotion of family planning activities. In the last month, IEF has been working closely with the regional and district health offices and other NGOs in Malawi to coordinate a district pilot programme for community-based distribution of contraceptives.

The Proposal

The IEF, in conjunction with Montfort Hospital and the Ministry of Health, proposes to establish a FAMILY HEALTH EDUCATION AND COUNSELLING CENTRE (FHECC) in the Nchalo boma near Montfort Hospital. The centre would have two sections: one to promote the prevention of sexually transmitted infections (STIs), including AIDS, and the other to promote family planning.

AIDS Control

Since the discovery of HIV and AIDS in Malawi in 1985 the disease has spread at an alarming rate:

- urban seroprevalence studies have reported up to 30% of antenatal women to be HIV-positive,
 - seroprevalence among bar-girls in urban areas who have been in the profession for more than 3 months has been reported at nearly 40%.
 - blood donor studies in rural areas suggest that rural seroprevalence actually ranges from 6-10%,
 - seroprevalence among blood donors at Montfort Hospital is 5%.
- 173.

The primary mode of transmission in Malawi is heterosexual intercourse. There is no vaccine and no effective treatment or cure for AIDS, HIV and it is preventable. As a consequence, efforts at controlling the AIDS epidemic have focused on education and preventive measures. Since the presence of genital ulcers caused by sexually transmitted diseases (STDs) greatly increases likelihood of HIV transmission, efforts at controlling the spread of AIDS must include STD prevention, as well as education about and treatment of STDs.

The centre would address the STD/AIDS problems by training community volunteers as educators and counsellors in STD/AIDS control and by the promotion and distribution of condoms. The centre will concentrate the majority of its education and prevention efforts within a 5-10 kilometer radius of the Nchalo area, targeting the high-risk populations in the Nchalo market area and the surrounding villages.

Family Planning

Contraceptive use in Chikwawa District is almost non-existent: fewer than 1% of women of reproductive age practice modern methods of family planning. At the few health centres where there are nurses trained as family spacing providers, the nurses have too many other responsibilities to make the promotion of family planning a priority. Families in the rural areas do not have easy access to family planning services and they do not receive the information and encouragement that would motivate them to seek family planning methods. Moreover, because men are not involved in family planning education they often discourage family planning.

IFP personnel, through focus-group discussions in rural areas, have found that there exists a large demand for family planning services: women would like to have fewer and healthier children, but they simply do not have access to family planning education and services.

The centre would promote family planning by training village-elected community-based female volunteers to be community-based educators, motivators and distributors (CBEDs) of family planning methods. The CBEDs are extensively trained in family planning education and counselling and are qualified to provide a method most appropriate for a woman and her family and to distribute birth control pills, condoms, and foaming tablets, if appropriate. The participation and recognition of men in family planning education and decision-making is essential to a successful CBED programme.

Role of the Centre

Since STD control and Family Planning are inextricably related through responsible sexual behaviour, by coordinating efforts of the sub-sections at a central location, resources can be combined to maximize efficiency and effectiveness in promoting safe and responsible sexual practices. The role of the centre would be:

- to provide centre-based education and counselling in STD/AIDS control and family planning,
- to provide outreach education and counselling through the training of community volunteers in STD/AIDS control and family planning.

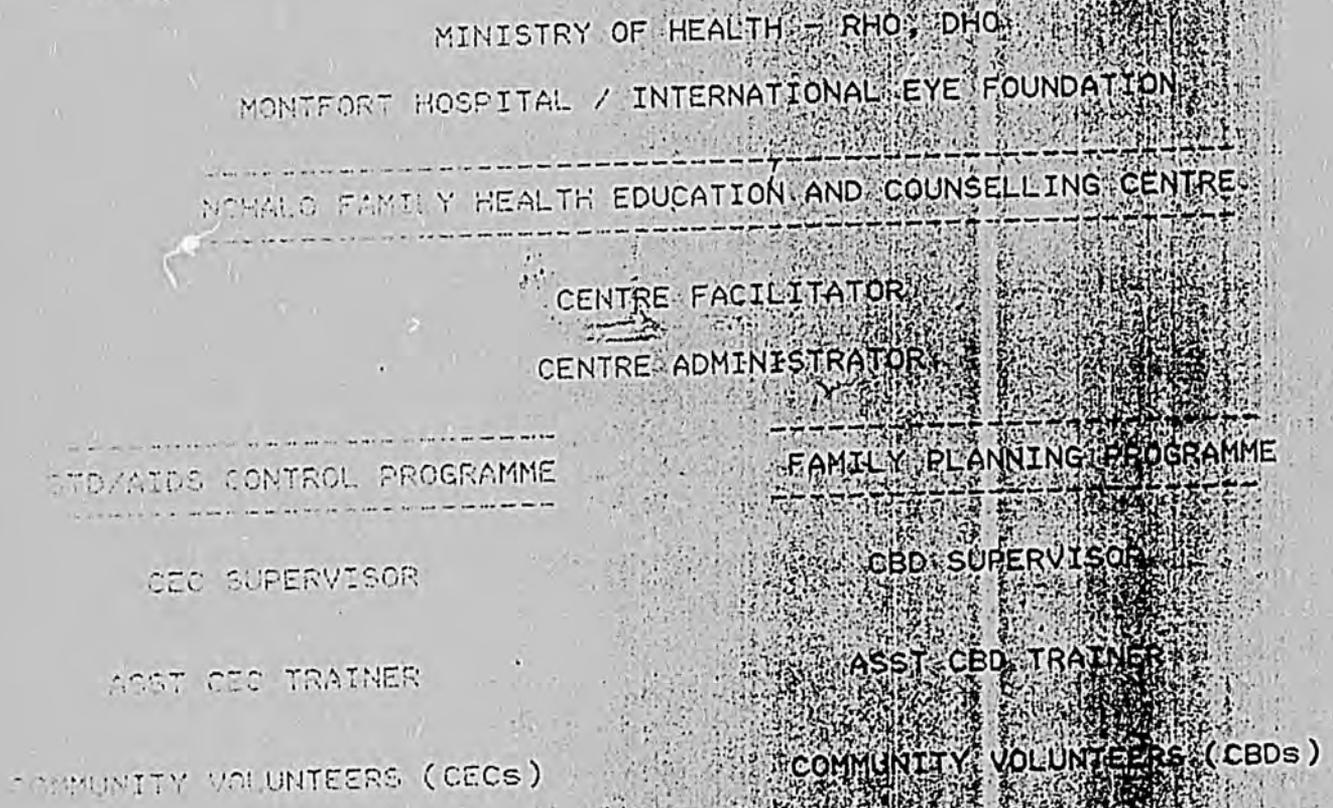
- to market and distribute condoms,
- to refer clients to hospital for laboratory and medical services,
- to coordinate, monitor and evaluate STD/AIDS control and family planning activities in the Nchalo area, and
- to develop appropriate educational messages for the different population groups to be served by the centre.

Location of the Centre and Staff Houses

The centre should be located in an area which makes it accessible to segments of the general population, and from which referral to the hospital would be simple. Three staff houses, one each for the Centre Administrator, the STD Control Supervisor and the Family Planning Supervisor, would be constructed on Montfort Hospital grounds.

Organizational Diagram

The following is a diagram of the organization of the centre within the current framework of health care providers and the structure of staffing at the centre.



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