

SAVE THE CHILDREN
MALAWI FIELD OFFICE
CHILIPA (MANGOCHI) IMPACT AREA
CHILD SURVIVAL 9
MIDTERM EVALUATION

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ACRONYMS

| | |
|----------------|--|
| AIDS | Acquired Immuno-Deficiency Syndrome |
| ANC | Antenatal care |
| ARI | Acute Respiratory Infections |
| BHR/PVC | Bureau of Humanitarian Response/Private and Voluntary Co-operation |
| CBA | [Women of] child bearing age |
| CHAM | Christian Health Association of Malawi |
| CHSU | Community Health Sciences Unit |
| c s v | Child Survival V |
| cs IX | Child Survival IX |
| DHI | District Health Inspector |
| DHMT | District Health Management Team |
| DHO | District Health Officer |
| DIP | Detailed Implementation Plan |
| DRF | Drug Revolving Fund |
| EPI | Expanded Programme of Immunization |
| HIS | Health Information System |
| HSA | Health Surveillance Assistant |
| KPC | Knowledge, Practice, and Coverage Survey |
| MOWCACS | Ministry of Women and Children Affairs and Community Services |
| MOH | Ministry of Health |
| NGO | Non-Governmental Organisation |
| ORS | Oral Rehydration Salts |
| ORT | Oral Rehydration Therapy |
| PVO | Private Voluntary Organisation |
| SCF | Save the Children Federation/USA |
| TBA | Traditional Birth Attendant |
| TTV | Tetanus Toxoid vaccination |
| USAID | United States Agency for International Development |
| u5 | Under Five (card, clinic) |
| VHC | Village Health Committee |
| VHP | Village Health Promoter |

EXECUTIVE SUMMARY

Save the Children (US) has completed one half of their 3 year CS IX project in the Chillipa **area in Mangochi** District in Malawi, covering a population of 40,000. Save the Children's project strategy is community-based: trained volunteer village health promoters, supported by village health committees and health surveillance assistants. SC is using a phased approach and has currently implemented the following interventions: management of **diarrheal** diseases, immunizations, growth monitoring and nutrition education, malaria control, and HIV/AIDS prevention. Antenatal care, management of acute respiratory infections, and child spacing will be implemented in the next few months.

The midterm evaluation took place May 22-June 2, 1995, and was conducted by a nine-person team: an independent consultant as team leader; the Regional Family Health Coordinator, the District MCH Coordinator, the Medical Assistant from one of the health centers in the Chilipa area, the Epidemiologist from Save the **Children/Westport**, the Regional Director from SC-Mali, the SC Health Program Manager, the SC Senior Health Trainer, and one of the SC field health supervisors. The team spent 3 days in the Chilipa area, where it conducted interviews with 7 village health promoters, 4 village health committees, community members in 4 communities, 3 literacy instructors, 8 Health Surveillance Assistants, staff from all 3 health centers, all three SC field supervisors, the District Health Management Team, and SC health management staff. The team also observed 4 health education sessions by village health promoters and 2 literacy class sessions. The cost of the midterm evaluation was about US\$ 7,200 for the team's work (including consultant costs and travel costs of all participants), and about US\$ 500 for the midterm KPC survey.

The data from the midterm KPC indicate that the CS IX project has already met its objectives for immunizations of children and women of childbearing age, treatment of diarrhea in children, and literacy. In many areas, the data are not available to directly assess progress towards objectives, The CS IX project is progressing according to the DIP, and is very likely to meet its objectives by the end of the grant. The knowledge levels of **HSAs** and **VHPs** are generally good, and communities appreciate the knowledge they have gained and the increased access to immunization and growth monitoring services. The roster system which lists all children under five and women of child bearing age under the responsibility of each **VHP** is a key element to the project and ensures equity in coverage, because it focuses on both who is receiving services and who is not.

One of the major lessons learned in this project so far has been the need to adjust interactions with the community to the new attitude in Malawi. This has manifested itself in difficulties in motivating **VHPs** and getting communities to take responsibility for their motivation.

Major recommendations include: improve use of the roster and use of data for decision-making; find ways to involve men in child survival activities; strengthen communication and alternative health education techniques of **VHPs** and **HSAs**; do not accept shortages of supplies as inevitable at any level; both temporary and long-term solutions need to be implemented to "remotivate" **VHPs** and lessons learned should be incorporated in preparing community responsibility in future projects; **clarify** the role of the village health committees and train them for this role; improve communications with health center staff and develop a transportation policy; provide an "orientation" to the SC approach to all health center staff and a training in management of community-based programs; work now with the district to ensure sustainability of child survival activities; strengthen the links between health and literacy by adding additional health messages in literacy classes and clarifying health and empowerment outcomes hoped for from literacy; evaluate the reasons for the high literacy class drop-out rates; and for future programming, SC should expand to another area about the size of **Chilipa**.

Evaluation results have already been discussed with SC staff, health center **staff**, and the District Health Management Team. This report was written by the Team Leader, Dr. **Lynne** France, based on conclusions and recommendations developed by the entire midterm evaluation team.

**SAVE THE CHILDREN/MALAWI
CHILD SURVIVAL IX PROJECT
MIDTERM EVALUATION REPORT**

I. TERMS OF REFERENCE

The midterm evaluation team was presented with the following terms of reference:

1. Assess progress and achievements in relation to stated objectives from the Detailed Implementation Plan (DIP).
2. Follow United States Agency for International Development (**USAID**) midterm guidelines.
3. Assess the appropriateness of the objectives and strategies being used by the project in relation to the reality in the field, with particular consideration to use of volunteers and the interface with the health centers.
4. Make recommendations with regards to planning for follow-on funding: consider the relative advantages of expanding population versus expanding and enhancing current interventions.
5. Make recommendations regarding reinforcement of health surveillance assistant (**HSA**) supervision, team building with and enhancement of health center **staff**, and support and motivation for health committees and volunteers.

This report will describe the project and its background, the methods used to conduct the evaluation, and then will present findings following the sequence in the midterm evaluation guidelines provided by Bureau of Humanitarian Response/Private and Voluntary Cooperation (**BHR/PVC**). Recommendations have been categorized as follows: health information system; design and interventions; training, supplies; community participation and ownership; relationships with health center counterparts; sustainability; literacy; and future health projects in Mangochi.

II. BACKGROUND AND DESCRIPTION OF THE PROJECT

Malawi is a small, densely populated, land-locked country in south-eastern Africa, which gained independence from Great Britain in 1964. Stretching over 500 miles north-south and SO- 100 miles east-west, it is bordered by Mozambique, Tanzania, and Zambia. The total population is 10 million inhabitants.

Malawi's economy is based on agriculture, with tobacco as the major export crop and maize as the major subsistence crop. Approximately 90% of the population can be found in the rural areas, living in small villages and working smallholder farms. Per capita income was estimated in 1993 at \$200, one of the world's lowest.

Infant mortality, while slowly declining, is still one of the highest in the world at 144 deaths **per 1000** live births (UNICEF, 1993). Fertility is high, at 6.7 (DHS, 1992), and the birth rate is 55 births a year per 1000 population (UNICEF, 1993). The leading causes of death in children under five include: malaria, diarrhea, malnutrition, pneumonia, and measles. Rates of under five malnutrition have historically been high and they have increased in recent years due to the drought.

The Ministry of Health (**MOH**) operates a system of district hospitals and rural health centers, supplemented by a number of private hospitals and clinics. The rural health centers are generally staffed by a medical assistant, a nurse, and sometimes a health assistant. Health centers also have health surveillance assistants who are the main outreach worker, and help mainly with the Expanded Programme of Immunizations (EPI) activities and environmental sanitation.

The Child Survival (CS) IX project, initiated in October 1993, operates in the Chilipa area of **Mangochi** District, in the Southern Region of Malawi. This area was chosen by the District Health Management Team (DHMT), due to limited access to health resources in this area. There are three health centers in the area serving 40,000 population: one Ministry of Health (MOH), one Christian Hospital Association of Malawi (CHAM), and one **MOH/local** government. Save the Children Federation's (SC) CS IX expands the community-based services in the area by increasing the number of **HSAs** from the 7 employed by the MOH to a total of 30. The 23 additional SC **HSAs** were trained by District health staff, using the standard MOH curriculum for HSA training (duration - 8 weeks). SC **HSAs** have similar responsibilities to those of MOH **HSAs**, except the SC **HSAs** focus more of their time on MCH activities, and have direct responsibility for supervision of village volunteers (see below).

SC has trained 134 volunteer village health promoters (VHP) in the 48 villages and revitalized the village health committees (VI-IC) that existed in the area. A VHP is responsible for keeping a roster of **all** the children under five and all the women of child bearing age (CBA) that are part of the approximately 60 families she is responsible for. The children's roster includes information about: immunization status; growth monitoring attendance and nutritional status; and information on training of mothers in such areas as diarrhea and malaria. New-boms are added to the roster and deaths are crossed out. The women's roster includes information on: immunization status (TTV); pregnancy; antenatal care; and delivery outcomes. Identified from the information in their roster, **VHPs** conduct home visits to malnourished children and immunization defaulters, In addition, each VHP is responsible for forming a mothers' group and conducting health education on a regular basis (1-4 times a month).

SC has also trained 20 literacy instructors for 10 days, following the National Literacy Programme literacy instructor curriculum (under the auspices of the Ministry of Women and Children **Affairs** and Community Services). Twenty 10 month adult literacy classes started in October 1994, and a second session will begin in October 1995.

SC's CS IX project focuses on management of diarrheal diseases, immunizations, growth monitoring and nutrition education, malaria control, management of acute respiratory infections (ARI), antenatal care, child spacing, HIV/AIDS prevention, and literacy. Other activities included village sanitation and home chlorination of water. In the next several months, SC will be initiating a drug revolving

fund @RF) in 30 of the 48 villages (those that are farther from the health centers). Because **USAID** does not allow Private Voluntary Organizations (PVO) to use Child Survival funds to purchase drugs, SC has sought and received funding from UNICEF for the initial drug stocks.

HI. METHODS OF EXECUTION OF THE MIDTERM EVALUATION

A. Team Composition

The midterm evaluation team was composed of a nine-person team with an independent consultant as team leader. Members included:

Dr. **Lynne Miller France**, Team Leader, Independent Consultant

Mrs. Jane **Mwafuilirwa**, Regional Family Health Coordinator, Southern Region

Mr. **Mangochi** Chiwamba, **Mangochi** District MCH Coordinator

Mr. Frank Manjoli, Medical Assistant and Officer in Charge, Chilipa Health Center

Dr. David Marsh, Epidemiologist, Save the Children **Headquarters/Westport**

Mr. Peter Laugham, Regional Director, Save the Children/Mali

Mr. Stanley Jere, Senior Health Trainer, Save the Children/Mango&i

Mrs. Rose Kaulimbo, Health Field Supervisor, Save the **Children/Chilipa**

Ms. Marcie Rubardt, Health Program Manager, Save the Children/Mango&i

B. Work Schedule

Except for the final preparation of this report, the entire evaluation was conducted as a team effort during the period of May 22-June 2, 1995. The team met for three days in **Mangochi** to review documents and prepare for data collection. The next three days were spent in Chilipa, gathering information from individual interviews, focus group discussions, and observation of health education talks and literacy classes. The team then spent two and half days in **Mangochi** compiling and interpreting the data, and developing findings and recommendations. A debriefing was held for the District Health Management Team (DHMT) on June 1, 1995, and for the SC Chilipa staff (including **HSAs** and literacy instructors) and health center staff on June 2, 1995.

C. Data Collection

A series of 14 questionnaires were employed to collect information for this evaluation (copies of these questionnaires can be found in Appendix A):

| Data Collection Instrument | Sample size |
|---|--------------------|
| Questionnaire for Village Health Promoters | 7 |
| Observation form for health education by VHPs | 4 |
| Discussion guide for village health committees | 4 |
| Discussion guide for community members | 4 |
| Discussion guide for Health Surveillance Assistants | 1 |
| Questionnaire for Health Surveillance Assistants | 8 |
| Questionnaire for Literacy instructors | 3 |
| Questionnaire for participants in literacy classes | 7 |
| Questionnaire for non-participants in literacy classes | 10 |
| Observation form for literacy classes | 2 |
| Questionnaire for health center staff | 3 |
| Questionnaire for District Health Management Team | 1 |
| Questionnaire for Save the Children field staff (Chilipa) | 3 |
| Questionnaire for Save the Children Mango&i staff | 2 |

A purposeful sampling methodology was used. Four villages were visited, selected by SC staff to represent 2 villages that were working well and 2 villages where things were not working well. In all 4 villages, VHPs and HSAs were interviewed, as well as the VHC, community members, the literacy instructor (if there was one), and non-literacy class participants. In addition, the VHP was observed giving a health talk. Two literacy classes were selected for observation and four women per class were asked to volunteer for interviews. The team visited all three health centers in the Chilipa area.

D. Midterm Evaluation Costs

The costs of the midterm evaluation include the KPC survey as well as the costs of the midterm evaluation team's costs. The costs of the midterm evaluation team's work was about US\$ 7,200. This cost included the consultant fees of the team leader, travel costs for the Field Office Director from Mali, and the lodging, food, and transport costs for all participants (except the home office representative) during the two weeks in **Mangochi**. The cost of the midterm KPC survey was about US\$ 500.

Iv. RESULTS

This section will follow the format of the 1995 **BHR/PVC** Child Survival Midterm Evaluation Guidelines.

A. Accomplishments

The Child Survival IX project has been operating for 19 months and is basically on schedule according to the DIP. SC has chosen a phased approach with initial emphasis on control of immunizations; diarrheal disease; growth monitoring and nutrition; AIDS; and literacy. ARI, maternal care, and family planning will be starting in the middle of the second year.

1. Inputs and Outputs

Personnel: SC organized and financed an 8 week training for 23 **HSAs**, using District trainers and the MOH curriculum. The training was divided into two sessions (3 weeks and 5 weeks). 134 Village Health Promoters received 5 days of training by SC staff. 42 village headmen received one day of orientation to the VHP's role. 20 literacy instructors were trained by the Literacy Field Supervisor for 10 days, following the Basic Course in Literacy Instruction curriculum **from** the Ministry of Women and Children Affairs and Community Services (MOWCACs).

Health Information System (HIS): The roster system for household tracking of children under five and women of child bearing age has been established, based on all relevant individuals counted during the census (May-June 1994). VHPs are responsible for updating for births and deaths.

Access: SC has established an additional 20 outreach sites for growth monitoring, 5 additional sites for immunizations, and 3 sites for antenatal care (some sites have all three services). The number of immunization sites is not the total anticipated, due to shortages of vaccines in the district, and difficulties getting one refrigerator converted to gas. Health education is now being provided by **VHPs** to mothers groups in all villages. Literacy classes have been established in 20 villages.

Supplies: It should be noted that SC uses MOH supplies for vaccinations (vaccines, syringes, needles, vaccine carriers, Under Five (US) cards, tetanus toxoid vaccination (TTV) cards), health education materials, oral rehydration salts (ORS), family planning, Vitamin **A**, and condoms.

Money for initial drug stocks for drug revolving funds has been obtained from UNICEF.

Midterm Assessment has been completed.

The Monthly Reporting system (based on information from the **VHP's** roster and other sources) provides information on the number of mothers trained in diarrhea, malaria, ARI, AIDS, nutrition, and measles. However, the data are not cumulative and the same mothers could be trained in more than one month. Over the last four months, a monthly average of 780 mothers were trained in malaria, 1050 in diarrhea, 200 in malnutrition, 250 in ARI, 300 in measles, 140 in AIDS, and 500 in family planning.

2. Outcomes

Table 1 provides a summary of the project objectives, baseline values and midterm values for outcomes. Differences in indicators from the project objectives to the survey data are shown in italics for the survey data. It should be noted that sample sizes do not allow statistical comparison between baseline and midterm results.

Table 1: Progress towards Project Objectives

| Project Objective | Baseline level | Midterm Level |
|--|---|--|
| 70% of children 0-11 months will be fully immunized | 53% of children 12-23 months were fully immunized | 80% of children 12-23 months were fully immunized |
| 60% of women of CBA will receive 2 or more TTV | 44% of women with child <2 had received >=2 TTV | 64% of women with child <2 had received >=2 TTV |
| 1 member in 60% of households will know how to prepare ORT | no data in baseline on ability to mix/prepare OR T | 92% of mothers with child <2 who were trained (77% of mothers) know to use 1 liter of water, and 51% of those trained mentioned correct administration (although the question asked only about mixing ORS) |
| 50% of cases of diarrhea in children < 2 in the previous 2 weeks will have been treated with ORT | 48% of children <2 with diarrhea in the previous 2 weeks received ORS, SSS, cereal based ORT, or other liquid infusions | 73% of children <2 with diarrhea in previous 2 weeks received ORS or increased fluids |
| 60% of infants will receive appropriate weaning foods at 4-6 months of age | 61% of children under 4 months had received semi-solidfoods | 83% of children aged 5-6 months are receiving likuni phala, bananas or other solidfoods |
| 60% of mothers with children <2 will know they should exclusively breastfeed for >= 4-6 months | 41% of women with children <2 knew they should start adding food to breastfeeding between 4-6 months | 39% of women with a child <2 knew they start adding fluids in addition to breast milk at 4-6 months; 65% of women with child <2 knew they should start giving soft foods in addition to breastfeeding between 4-6 months |
| 75% of children <3 will be weighed >= 4 times a year | 78% of children <2 have been weighed in the last four months | 45% of children <3 are attending growth monitoring in any one month (from monthly data form) |
| 60% of high risk children (growth faltering) will receive at least one home visit | no data in baseline on home visits for malnourished children | about 43% of growth faltering children are visited at home in any one month (from monthly data form) |
| 85% of children attending growth monitoring sessions in the last 3 months will have received the appropriate dose of vitamin A | no data in baseline on coverage with Vitamin A | 33% of all children <2 received Vitamin A in last six months |

Table 1: continued

| Project Objective | Baseline Level | Midterm Level |
|---|---|---|
| 50% of births will be attended by a trained TBA or midwife | 43% of women with a child <2 had the cord tied and cut by a health professional | no data in midterm survey (since TBAs not yet trained) |
| 50% of pregnant women will receive >=2 prenatal visits | 89% of women with a child <2 attended prenatal care | 70% of women with child <2 had an ANC card for that child |
| 20% of delivering women will receive a post partum check by a trained TBA or midwife | no data in baseline on post partum care | no data in midterm on postpartum care |
| 75% of women attending prenatal care will gain weight during pregnancy | added during the DIP review so not in baseline | no data in midterm on weight gain in pregnancy |
| 25% of mothers with children <2 who don't want to be pregnant within the next two years will be using a modern contraceptive method | 15% of women with child <2 who are not pregnant were using modern contraceptives | 7% of women with a child <2 who are not pregnant are using a modern contraceptive method |
| 90% of mothers with children <2 will seek appropriate treatment for children with ARI | 74% of mothers with child <2 who had ARI in last 2 weeks sought treatment at health center | no data in midterm survey |
| 60% of children <2 with fever in the last 2 weeks will have been treated according to MOH protocol | 22% of children <2 with fever in last 2 weeks were treated with fansidar (MOH protocol) | 50% of mothers with child <2 knew to take child to health center if has fever, vomiting and chills; 54% knew to take western medicine |
| 60% of mothers with children <2 will know at least 3 ways to prevent transmission of AIDS | no data on how many knew 3 ways to prevent AIDS; 19% mentioned condoms; 60% -- avoid bar girls; 17% -- stick to 1 partner; 22% -- avoid skin piercing instruments; 6% -- abstinence | 31% of mothers with child <2 knew three or more ways to prevent AIDS; 59% mentioned abstinence; 2% -- avoid bar girls; 26% -- condoms; 29% -- stick to 1 partner |
| 10% of illiterate women will become literate | 79% of women with a child <2 were not able to read a simple sentence [this was extrapolated to 6,724 women being illiterate] | 6% of illiterate women have become literate through literacy classes [372 women attending the first literacy class session (which is not complete) have been declared literate] and a total of 607 women were attending as of April 1995 - classes are to finish in July. |

In conclusion, interventions that have been stressed (EPI, some aspects of nutrition, diarrhea, and literacy) are having the desired effect. It is also interesting to note the differences in frequency with which individual methods of AIDS prevention were mentioned: bar girls (not relevant for mothers) was high in the baseline, while abstinence, condoms and 1 partner were more frequently mentioned in the midterm.

In those areas that have not been stressed there has not been much effect (maternal care, malaria, ARI), further supporting the idea that SC has made a difference where they have put efforts. Significant change in knowledge and behavior change has also been achieved in stressed areas, and a good knowledge link between water and diarrhea was noted during several interviews. The

communities perceive that health problems have been reduced (child deaths due to measles and diarrhea, for example).

B. Effectiveness

Based on the results from Table 1, SC has made excellent progress towards their objectives. The areas that have not seen much impact are those planned for the second phase which begins in the next several months: antenatal care, family planning, ARI. With their planned schedule, SC should be able to meet project objectives by the end of the grant, if they can motivate the **VHPs** to continue working (see Section G.2)

With regards to high risk groups, SC has established an effective system for identifying and following up high risk groups for immunizations (defaulters) and growth monitoring/nutrition (growth faltering). This system is based on the roster kept by the VHP. Knowledge about who is high risk and what should be done when they are identified is high for **HSAs** and VI-IF%, and there is evidence in the rosters that actions are being taken. Focus at village level has been particularly high risk groups for growth monitoring and EPI. The three outreach pre-natal clinics also emphasize high risk ID of pregnant women.

For other interventions, the high risk groups mentioned in the DIP include:

- Diarrhea: children under 1 (particularly those not breastfeeding), children with diarrhea more than 48 hours, and malnourished children. There is not much evidence that these children are being sought out in any specific manner, although VHPs and **HSAs** were taught that they were high risk.
- Nutrition: low birth weight babies. Currently, without **TBA**s, there is no information about birth weight upon which to identify such infants,
- Maternal Care: previous complications in pregnancy or delivery, anemia or malnutrition, and women under 18 or over 40. Maternal care interventions on a large scale will only be starting over the next few months. However, these high risk groups are identified during the three Antenatal Clinics SC runs.
- Malaria: pregnant women or children under three. There does not appear to be any real focus on any specific group for malaria education. The Drug Revolving Funds (@RF) may change this when fansidar is available at village level.

C. Relevance to Development

SC's approach to increasing communities' ability to participate and benefit from child survival services includes several strategies: increasing access to services, health education, and environmental sanitation; creating mothers' groups; forming village health committees; instituting the roster; and providing access to literacy.

Access to services has been increased by providing additional outreach for maternal and child health activities, SC has increased the number of sites for growth monitoring from 7 to 27, for EPI from 7 to 12, and for antenatal care from 0 to 3. Health education is now available in the villages through the VHP, who provides talks to mothers groups 1-4 times a month. Environmental sanitation activities are under the responsibility of the HSA with the **VHCs**. The SC **HSAs** can take an active role in sanitation because they are responsible for a specific catchment population and they are based in the villages. The MOH has only 7 **HSAs** and 1 health assistant to cover the entire Chilipa area. Now, there are 48 VHCs and an additional 23 **HSAs**.

Mothers' Groups have given women in the villages a regular forum for discussing health issues and for receiving new messages about how to care for their children. Interviews with community members revealed that women now feel that they are capable of treating their children at home first for diarrhea and malaria. This saves them the time and money they would have spent to seek care at the health center (2 of the 3 health centers in Chilipa charge for services).

Village Health Committees have been formed in all 48 villages, replacing the 16 moribund area health committees present before SC arrived. The VHCs still need to receive training, although village headmen have been oriented. These VHCs provide a structure for supporting the VHP, and for working with the HSA on village environmental activities, such as promoting latrines, baths, and dish racks, digging rubbish pits, and organizing activities for clearing the surroundings.

The Roster: Described in more detail in Section E., the roster is a population-based listing of children under five and women of child bearing age that helps the VHPs identify high risk individuals needing services, This system, because it registers everyone, encourages equity and participation of all community members, by seeking out of those who are not using services as well as those who do.

Access to Literacy has been increased by providing 20 literacy classes in the area (with an additional 20 planned to start late 1995). Although SC planned to train a total of 600 women altogether (2 sessions with 300 participants total in each), they have reached this level with the first class sessions. Demand for literacy was much higher than expected and originally over 1,700 individuals enrolled. With drop-outs, the number of participants is now about 600 (with two months **left** in the classes). Literacy helps women to better understand health messages, both because health messages are covered during the class, and because the women can read posters and pamphlets. Thus, literate women have more chance to benefit from CS services.

It should be noted, however, that the changes in the Malawian political system over the last year have had a large impact on developing community participation in health activities. Although the political changes have allowed communities to be more verbal about what they want and what they are not happy with, the fall of the one-party state has also given self-help a bad name. During the previous regime, self-help was often a cover-up for forced labor. There is now an attitude that one should be paid for whatever one does, even for one's own community, and it is more difficult to get communities to participate. There is also a feeling that now that the government has changed, people in the rural areas should be getting more things from government.

D. Design and Implementation

SC has made no changes in their target population or in their strategies from the DIP. In fact, their census confirmed their estimates of the Chilipa population.

E. Management and Use of Data

Several types of data are have been collected by the Child Survival Project: one-time data collection and routine data collection.

One-Time Data Collection: The project conducted a Knowledge, Practice and Coverage (KPC) baseline survey in December 1993, and a KPC midterm survey in May 1995. A census was conducted in May-June 1994 during which all residents in the Chilipa area were registered (and eventually entered into the computer). A maternal assessment was conducted in October 1994 by the SC Health Field Supervisor who is a Community Nurse.

Routine Data Collection: SC has established a population-based system of data collection, based on a roster kept by each VHP. These rosters contain a list of all children under five and women of child bearing age, identified during the census. Each VHP has a roster for the families under her responsibility (about 60 families per VHP). The roster is updated for births and deaths by the VHP. For each child, the roster contains the following information: birthday, immunization status, growth monitoring attendance, nutritional status, and information on training of mothers in important health topics (malaria, diarrhea, etc.). For each woman of child bearing age, the roster contains: age, TTV status, pregnancy status (estimated date of delivery), attendance at antenatal care, and pregnancy outcomes. VHPs interviewed knew how to read their roster and to use it to identify people needing interventions. As intensive as the roster system is, it appears within the grasp of many **VHPs**, and active promoters appear to understand the information they are supposed to collect. However, for some **VHPs** and their **HSAs**, there is still some misunderstandings about what the information is and where it needs to best be recorded: for example, many **VHPs** record growth monitoring attendance in a separate notebook which must then be transcribed into the roster before defaulters can be identified.

The information from the roster is then compiled by village (some villages have more than one VHP) by the **VHP(s)** and the HSA onto a monthly report form. The monthly report form includes information on immunization outputs and coverage, growth monitoring and Vitamin A outputs, number of children underweight/faltering, number of home visits made, number of pregnant women, antenatal coverage, TTV coverage, birth outcomes, child spacing outputs, and VHC meetings. It also includes a section on disease surveillance and drug stocks. The latter is not yet used, and the former will be more effective when the drug revolving funds are started.

The system of monthly reports is intended to be used for feedback and discussions at village level with the VHP, the **VHC**, and the community, and then aggregated for use at project level. The monthly reporting form has been in effect for about 6 months, but only in the last few months has SC begun to feel confident of the quality of the data reported. They are now producing computerized, aggregate reports which are being distributed to health center **staff** and to the district. Some **HSAs** and many

VHPs interviewed were not able to easily tell how they used the data, but some examples cited include:

- *“When we find a lot of diarrhea, we ask for more ORS and tell the VHPs to do more talks on diarrhea.” -- HSA*
- *“When we saw that women were not attending the Under Five clinics, we asked our HSA to help. She made home visits with me and then the women started to come.” -- VHP*

Project staff said they used the information to determine the monthly topic for health talks, and the information on current use of antenatal care has been used for planning the maternal care interventions. It appears that HSA and supervisory levels are not quite clear about what are the possible decision points from the data (conclusions from aggregated data).

The data in the monthly reports is checked by the field supervisors for consistency and quality and then sent to **Mangochi** for data entry, where there is a computer person who enters data and produces the reports. However, the computerized reporting is not necessary for providing feedback to **HSAs** and communities. SC staff have used the data during monthly meetings with **HSAs** to discuss particular problems with the data itself. Now that data quality is improving, the information can be discussed for what it says. There is some evidence of feedback and discussion with the **VHPs** and to a small extent to the communities.

F. Community Education and Social Promotion

A good proportion of SC efforts go to health promotion activities. **HSAs** spend about 25% of their time on health education, while **VHPs** probably spend close to 75% of their time on education of mothers, either in regular sessions with mothers' groups or doing home visits.

Routinely, health education is conducted during each Under Five Clinic (a total of 20 monthly outreach sessions), and during sessions with mothers' groups which are conducted by **VHPs** 1-4 times a month. These health education sessions follow the standard Malawi format of a “health talk” and generally use participatory methods to involve women during the talk. Songs and drama are also occasionally used.

The health education messages and materials used are based on MOH guidelines. All materials are from the MOH Health Education Unit (with many being developed under the Health Corn project in the late 1980's). Therefore SC has done no further testing, although SC did use the data from their baseline survey to refine certain messages, as well as data from the monthly reports changing emphasis. During the midterm evaluation, the team attempted to get community members to assess the usefulness of the IEC materials, and those that made comments said it helped to have a visual picture.

SC tries to ensure the consistency of messages to community members through regular supervision of **VHPs** by **HSAs** which often includes attendance at a health talk, and through regular supervision of **HSAs** by the SC field supervisors. The midterm KPC survey also allowed SC to assess the level of learning achieved by their health education.

G. Human Resources for Child Survival

1. Personnel Mix

The SC CS IX project employs the following: 1 Health Program Manager (shared with other health projects), 1 Senior Health Trainer, 3 Field Supervisors (2 for health and 1 for literacy), 23 HSAs, and administrative staff (1 data management officer, 1 accountant, 3 drivers, 1 administrative assistant, 1 cleaner and 4 watchmen). In addition, although not paid by the project, 134 VHPs and 48 VHCs contribute to implementation of project activities. The mix of personnel appears to be good, and there does not seem to be any unnecessary duplication of effort, within the project or with the 7 MOH HSAs.

2. Use of Community Volunteers

SC uses three types of community volunteers: village health promoters (VHP), village health committees (W-K), and soon SC will be training traditional birth attendants (TBA).

The Village Health Promoters have four main roles: maintenance of the roster; assistance at Under Five clinics; routine health education sessions with the mothers' group they each form; and home visits for immunization and growth monitoring defaulters, and growth faltering children. In 30 of the 48 villages, one VHP will be chosen to also dispense some simple drugs, when the drug revolving funds have been established over the next several months. 134 VHPs were originally trained for five days in EPI, diarrhea and oral rehydration therapy (ORT), food and nutrition, growth monitoring, home visiting, family planning promotion, malaria, AIDS, health education techniques, use of the roster for children under five and women of child bearing age, and monthly reporting forms. Knowledge levels of VHPs interviewed was generally quite good. These levels were achieved, despite the short training, due to ongoing training by their HSA supervisors.

VHPs spend anywhere from 2-9 days a month working on child survival activities. There are officially 124 VHPs still in place (a 7% drop-out rate), but many have expressed dissatisfaction because of lack of incentives. SC provides no ongoing incentives to the VHPs, following current MOH policy for growth monitoring volunteers. VHPs did receive 15 MK (= 1 USD) a day for lunch allowance during their 5 day training, and a SC bag. The issues around motivation seem to stem from two sources: the times in Malawi and the fact that volunteers in a neighboring area are receiving salt and soap. Since the move to multiparty democracy in the last year, the spirit of self-help has withered, as it was associated with forced labor under the old regime. Now, even village headmen sometimes are asking the VHPs why they are working for nothing. This demotivation poses a large problem for SC and the progress of the project which depends on the VHPs for almost all activities.

The Village Health Committees are generally formed with a chairman, secretary, treasurer, and members (including some women). Their role is to assist the VHP in her work (by helping round up women for mothers' groups if they are not well attended and by helping with defaulters), and by working with the HSA on environmental sanitation activities. When the drug revolving funds start in the 30 villages, the VHC will have additional tasks in management of the funds raised. There is,

however, some unclarity of roles between the VHP and the VHC in some villages. The VHCs have not yet received any formal training.

3. Training

The training provided to the **HSAs** and the literacy instructors followed the MOH and MOWCACS guidelines and curricula. This is very appropriate for sustainability, since this ensures that these staff are eligible for employment by the MOH or MOWCACS. SC did add some additional sections to the HSA training: health information system and reporting, and more focus on the maternal care interventions that SC stresses in their CS project. In addition, SC split the HSA training into two periods with about six months between them: one for three weeks and one for five weeks. This appears to have been a very effective and efficient way to train, because the **HSAs** had a chance to get some field experience before having to absorb new material. Trainings included theoretical and practical sessions. Practical sessions focused on: immunizations (technique, sterilization, cold chain), antenatal care, growth monitoring (weighing, plotting, counseling), home visiting for malnourished children, village assessment, village inspection, chlorine preparation, and ORS preparation. More effort and time could have been spent on the roster during HSA training, since several **VHPs** were not using the roster correctly. 21 of the 23 **HSAs** scored at least a combined 57% for the two sessions.

The training of the **VHPs** was only five days. It appears that this was too short for the number of different interventions **VHPs** are to cover. In some ways, this duration was compensated by the on-the-job training provided by **HSAs**: for example, one **VHP** interviewed who did poorly in training, performed well in her interview -- her knowledge levels and mastery of the material had improved tremendously. In addition, all **VHPs** observed giving health talks had a good grasp of the material they were presenting. **VHP** training covered the role of the **VHP** and **VHC**, **EPI**, diarrhea, health education techniques, nutrition and growth monitoring, home visits for malnourished children, and one and half days on the roster. However, the roster was still a weak area for many **VHPs**. They understood the information they are to collect, but they do not always fill it in correctly, with the consequence that the information is not fully available for its intended use.

SC did not make any changes in program content or methodology for training. The HSA training was done in direct collaboration with the District HSA trainers. The training of **VHPs** was done exclusively by SC staff. The content of the training for each intervention and level of worker can be found in Appendix 2.

SC will be using the MOH TBA training curriculum for the training of their **TBA**s. SC was not able to obtain a copy in **Mangochi** at the time of this report, but the curriculum will follow.

H. Supplies and Materials for Local Staff

Table 2 shows the list of supplies deemed necessary for each level to carry out their tasks (**VHP**, **HSA**, and health center staff).

Table 2: List of Essential Supplies for Each Intervention and Worker

| INTERVENTION | Health Center | HSA | VHP |
|--|---|---|--|
| Immunization | refrigerator, gas, vaccine carrier, vaccines, sterilizer, stove, syringes, needles, TTV cards, US cards, | vaccine carrier, vaccines, U5 cards, TTV cards, tally sheets, sterilizer, syringes, needles | U5 roster, Women of child bearing age roster, pencil |
| Control of Diarrhea | basins, cups, spoon, ORS, register book, mixing container, 1 liter measure, diarrhea assessment chart, weighing scale, chloride of lime | chloride of lime, ORS, mixing container, fanta bottle, spoon, cup, notebook, pencil | ORS, mixing container, fanta bottle, spoon, cup, notebook, pencil, 1% stock solution |
| Malaria | Fansidar, panadol, quinine, aspirin, malaria treatment guide | malaria treatment guide, malaria booklets | malaria booklets, fansidar, panadol |
| Growth Monitoring and Nutrition | weighing scale, U5 card, nutrition posters, register of malnourished children, supplementary food (likuni phala), ferrous/folic acid , vitamin A | weighing scale, U5 cards, record books, nutrition posters, pen | U5 roster, pencil |
| Maternal Care and Family Planning | examination couch, weighing scale, blood pressure machine, speculum, light, clean water, plastic basin, gloves, contraceptives, ANC cards, fetalscope, ferrous/folic acid | educational posters, family planning booklets | educational posters, family planning booklets |
| ARI | Bactrim, panadol, ARI assessment and treatment charts | | Bactrim, panadol |
| AIDS | AIDS posters, AIDS pamphlets, condoms | AIDS posters, AIDS pamphlets, condoms | AIDS posters, AIDS pamphlets, condoms |

Assessment of supplies during the midterm evaluation showed that there were shortages of supplies at all levels. However, most shortages were found at the health center level: vaccines, Under 5 cards, TTV cards, drugs such as bactrim and aspirin, supplies for preparing ORS at the health center, and supplies needed for family planning.

At HSA level, there were a few shortages of ORS, condoms and health education materials. For condoms, this appears to be due to lack of demand on the part of the **HSAs** (or infrequent checking of stocks by supervisors). For ORS shortages, this was due to a perceived inadequacy of ORS stocks by the health center **staff** who distribute to **HSAs** as well.

VHPs had shortages of ORS and health education materials. Although SC had intended **VHPs** to distribute condoms in the villages, the team found no **VHPs** with condoms. During their training, the **VHPs** said that they did not think their husbands would allow them to distribute condoms.

It appears that supplies are appropriate to the type of health worker, and when available are being used properly.

Because the midterm evaluation team included representatives from the Regional, District, and health center level, it was possible to do some problem solving on supply issues. It was discovered that many of the shortages were due to lack of communication of needs between the various levels. Mechanisms for ensuring adequate supplies for at least EPI materials were developed by the team. Difficulties with drug supplies were not addressed, as the problems reside at the level of Central Medical Stores, and are not subject to effect by team members.

I. Quality

SC did not explicitly identify and document the specific knowledge and skills essential for implementing each intervention. Much of the training carried out by SC used national curricula (e.g., HSA and literacy instructors). The national HSA training curriculum already has specific competency objectives. For additional areas of the HSA training and for the VHP training, the approach was competency-based.

SC has evaluated the levels of essential knowledge and skills for the various levels in the following manner:

- Mothers: through a midterm KPC survey
- VHPs and HSAs: through routine supervision which includes observation of workers performing their activities, and through pre/post-tests during training
- Literacy Instructors: through observation of literacy classes during supervision visits, and through a post test during training
- The midterm evaluation team assessed the level of knowledge of **HSAs** and **VHPs**, and assessed teaching skills of **VHPs** (observation of a health talk) and literacy instructors (observation of a literacy class). For **HSAs**, knowledge was tested on:

EPI: the six diseases prevented by immunizations, and the immunization schedule

- Diarrhea disease control: preparation of chloride of lime solution, three signs of dehydration
- Malaria: four signs and symptoms of malaria, drug of choice and dosage for a child < 4
- Family planning: benefits to the child of family planning, five modern methods of family planning
- ARI: signs and symptoms of pneumonia, drug of choice for pneumonia
- AIDS: ways AIDS is transmitted, difference between HIV and AIDS.

Knowledge levels of the 8 **HSAs** interviewed were excellent on all areas, except ARI and water chlorination, where many **HSAs** were not able to adequately cite the signs and symptoms of pneumonia (fast or difficult breathing) or how to mix chloride of lime to make 1% stock solution.

VHPs were also asked their knowledge in these same areas:

- EPI: the six diseases prevented by immunizations, and age for measles immunization
- Diarrhea disease control: signs and symptoms of dehydration, advice to a mother whose child has signs of diarrhea (ORS or more fluids)
- Malaria: cause of malaria, advice to mothers whose child has fever (reduce temperature, and either give fansidar or take to health center)
- Family planning: three benefits of family planning, three modern methods of family planning
- ARde signs and symptoms of pneumonia, advice to mother whose child has signs and symptoms of pneumonia (keep warm and take to health center)

For **VHPs**, knowledge levels were generally good for all areas, except advice to mother of child with fever (only one mentioned both home care and treatment), signs and symptoms of pneumonia, and naming all six EPI diseases. The health talks observed (**n=4**) were generally well presented, and the VHPs were obviously knowledgeable about the topics they chose (malaria = 2, diarrhea = 2). The talks were participatory, although no VHP stated the objectives of the talk at the beginning and none praised the women who responded correctly to her questions.

Literacy instructors (**n=2**) used active, participatory techniques in the classroom. However, one instructor used group methods for participation, allowing little chance for assessment of individual performance.

J. Supervision and Monitoring

The SC approach to supervision is frequent visits to supervisees which include observation (sometimes) and problem-solving.

- Village Health Promoters: VHPs are supervised by **HSAs** about 4 times a month. **HSAs** come to the **VHP's** village, and generally stay about an hour with their **VHPs**: they observe a health talk if one is being given, they discuss problems and issues, supply ORS, and check the roster. Many **HSAs** provide on-the-job refresher training for their **VHPs** to strengthen their knowledge in topics that were not adequately covered during VHP training.
- HSAs: are supervised by SC Field Supervisors. There are two health supervisors for 23 **HSAs**. Supervisors supervise **HSAs** during Under Five Clinics and during their work in the villages. **HSAs** prepare a monthly workplan which shows where they will be during the month. Supervisors visit them in the field 1-3 times a month. Supervisors mentioned that they tried to focus on those **HSAs** who were having more problems, but most **HSAs** are seen 1-3 times a month. Supervisors stay an average of about an hour. Supervisors also meet monthly with all **HSAs** to discuss larger issues.
- Literacy Instructors: The 20 literacy instructors are supervised by one Literacy Field Supervisor, who visits them 1-3 times a month. The supervisor tests participant's skills, observes classroom activities, and looks over the register.

From the supervisee's perspective, **HSAs** and **VHPs** feel adequately supported. There are supervisory checklists for **VHPs** and **HSAs** which cover the activities a supervisor should carry out. The **VHP** checklist was developed in collaboration with the **HSAs** during their training (second phase). Although these checklists do not include performance criteria for assessment of quality, there is evidence that **HSAs** are informally assessing and providing training for areas where **VHPs** are weak. Supervisory checklists also do not cover assessment of community participation.

K. Regional and Headquarters Support

The administrative support provided from **Westport** has been adequate from an administrative side, and responses have been timely. However, support focuses more on compliance to regulations than on development of good programming. Support from the field office director has been excellent.

L. PVO's Use of Technical Support

SC staff in Mangochi are well prepared to handle most of the technical needs of the project. Technical assistance was sought and obtained during the planning phases of the **HIS**, where informal assistance was obtained from the MOH Community Health Sciences Unit Epidemiologist. Assistance **from** Headquarters was provided during the preparation of the **DIP**, and to install **ProMIS** (the software for the **HIS**) and train local staff in its use. There are no identifiable needs for technical assistance over the next six months, that cannot be handled through the informal networks in Malawi.

M. Assessment of Counterpart Relations

There are two main counterparts to SC in this project: the District Health Management Team (**DHMT**) and the health center staff in the Chilipa area.

1. Relations with the DHMT

Relations with the **DHMT** are good, and many collaborative activities have taken place, even beyond the bounds of the **CS** project. Such activities include developing a drought monitoring system for the district, and training and provision of chloride of lime for both **MOH** and **SC HSAs**. These joint activities have made the **DHMT** feel more capable of taking quick and effective action on health problems facing the district.

There is an exchange of materials from the district to **SC**, either directly from district stores or through the health centers in the Chilipa area: vaccines, immunization supplies (needles, syringes, immunization cards, etc.), **ORS**, condoms, and family planning methods. It should also be noted that one of the **SC** health supervisors is on loan from the **MOH** (starting with the **SC's CS V** project). **SC**, on its part, has provided one refrigerator (from **CS V**) to the Chilipa area, 3 bicycles for health center use, and arranged for increased supplies of chloride of lime for water purification during the diarrhea season (with supplies not being limited only to the Chilipa area).

At district level, the **DHMT** is probably capable of taking over responsibility from **SC** for district-level monitoring of community-based activities.

2. Relations with Health Center Staff in-the Chilipa Area

The midterm evaluation team found some difficulties in the relations between SC and the staff at the three health centers in Chilipa. Although the relationship started very collaboratively in the early phases of the project, for a variety of reasons, inadequate communication has led to some discord between SC and the health center staff. There is a perception among some health center staff that SC only comes to take from them (e.g., vaccination supplies), but that SC does not involve them enough or help them out when they need it. SC has recently started to hold monthly meetings with health center staff to update them on what is happening, and during the midterm evaluation exercise, a number of practical recommendations were made that won support from the DHMT (who were aware of the problems) and from the health center staff during the debriefings.

At this stage, health center staff would not be capable of taking over responsibility of the community-based activities that SC has initiated, because they do not really understand what SC is doing, and they do not have the practical experience with the SC community-based activities. Their perception of SC activities is often limited to Under Five and Antenatal Clinics. They have not been involved in training of VHPs and are not familiar with the VHPs' job description or the SC approach to community-based work.

Health center staff relations with the community were difficult to assess, but during interviews, many respondents said they were satisfactorily treated when going to the health center.

N. Referral Relationships

The referral sites for HSAs and VHPs are firstly the health centers in the area, and then the District Hospital in Mangochi. Responses from the health center staff indicate that there are occasional inappropriate referrals from HSAs or VHPs, which fell into two categories : those that were ill and had been told what their problem was and what they should receive at the health center (which did not correspond with the medical assistant's assessment); and children referred to the nutrition clinic who did not meet the criteria for malnutrition. Because the evaluation team included a representative from the health center, it was possible to resolve this problem on the spot by increasing communication between the health center staff and SC when these problems arise. The health center staff also noted that there were no referral slips for patients coming from the HSA or VHP.

SC has neither planned to nor has taken any steps to strengthen the services provided by the referral sites, but they have increase community assess by increasing community knowledge of when to seek care at the health centers (and what steps they can take at home).

0. PVO/NGO Networking

SC regularly meets at the Regional Health Office with other non-governmental organizations (NGO) and PVOs who have health projects in the region. These meetings are used to update each other on activities and to discuss areas of mutual interest, such as HSA supervision, and information systems. SC has gained knowledge about the experiences of others which they have incorporated into their own activities, such as the idea of the monthly priority health message.

In **Mangochi** District itself, SC participates in the District Health Planning and Coordinating Committee with other actors in the District: e.g., the Medical School Department of Community Medicine and Manneheim Foundation. There are no other **NGOs/PVOs** working in the Chilipa area and there is no overlap even with efforts at the district level.

P. Budget Management

Project expenditures are currently below the project budget, due to the devaluation of the Malawi kwacha (from MK 4 = USD 1 in 1993 to **MK 15** = USD 1 in 1995). However, it is expected that inflation will catch up with the devaluation over the next year or so. In addition, SC plans to use any extra money to enhance health center capacity to take over responsibility for community-based activities and for additional training activities. SC should be able to meet project objectives with the money remaining.

There has been one major shift in projected expenditures: the printing of literacy primers was not necessary because they were obtained from the MOWCACS. This money was then spread over other activities.

The pipeline analysis can be found in Appendix 3.

R Sustainability

The three sustainability objectives outlined in the DIP are covered in Table 3 on the following page. However, it should be noted that these indicators do not cover the range of issues involved in making the community-based activities sustainable in Chilipa: ownership, skills, and resources.

Table 3: Progress Towards Sustainability Objectives

| GOAL | End of Project Objectives | Steps Taken to Date | Mid-term Measure | Steps Needed |
|---|--|---|--|--|
| A) 50% of cases of diarrhea in children under two during past two weeks will be treated with ORT | 50% of diarrhea cases in children <2 in the last 2 weeks will be treated with ORT | Health education of mothers about treatment of diarrhea and preparation of ORT | 73% of cases of diarrhea in children <2 in last two weeks received either ORS or increased fluids | Continue health education to maintain levels of practice and improve supply of ORS in the villages |
| B) 50% of drug revolving funds established will be working independently | <ol style="list-style-type: none"> 1. Establish drug revolving funds in 30 villages 2. Select and train VHPs in drug distribution 3. Train VHCs to manage funds 4. Provide drugs to villages 5. Work with district/health centers to ensure resupply of drugs | 1. selection of 30 villages | Funds for drugs have been obtained; other activities are scheduled for July 1995 | see project objectives |
| 3) 12 (60%) of HSAs will be absorbed by the MOH at the end of the project | <ol style="list-style-type: none"> 1. Provide HSAs with standard MOH HSA curriculum 2. Ensure that HSAs have MOH training certificates at the end of the course | <ol style="list-style-type: none"> 1. HSAs were recruited jointly with the District Health Inspector and trained by district staff in the MOH HSA curriculum 2. HSAs received MOH training certificates from the National HSA Coordinator | 1. DHMT expressed concern that co-ordination will be needed to ensure that the district has not already met their quota for HSA recruitment for that year when SC leaves | <ol style="list-style-type: none"> 1. Discuss with National HSA Coordinator to ensure availability of slots for Mangochi 2. Update District Health Inspector regularly on plans 3. Provide refresher training to SC HSAs on those areas not emphasized in the CS project: e.g., sanitation, well protection |

Ownership: There are two major areas where ownership of activities is not yet sufficient: at community level and at health center level. The midterm evaluation team found that some communities resisted the idea that they should be responsible for motivating their VHP. This indicates that communities have not fully appreciated the activities the VHPs are doing for them. It should be noted, as mentioned before, that it is now a difficult time to carry out community-based activities in Malawi, due to changes in attitudes at village level. SC has been caught in the middle of this change. However, strategies for increasing community ownership must be developed **over the next several months so that** they have **time to take hold** before project end. It should also be noted that SC is not addressing (due to USAID grant constraints) one of the major community felt needs -- improving safe water supply. This need was mentioned in almost all villages visited (without prompting from the team). In addition, SC has formed VHCs at village level, but these have not yet been trained.

Health center ownership of SC activities was non-existent at the time of the midterm evaluation, since they feel that SC only takes from them and does not assist (although this impression is not completely accurate). In addition, health center staff are not very familiar with SC activities at village level.

Skills of health center staff in supervision of community-based activities, community problem solving, and support to drug revolving funds are not adequate at this time.

Resources: The health centers do not currently have the transport necessary to provide supervision to the 23 additional **HSAs**. SC currently uses a motorcycle or a 4 wheel drive vehicle to do its supervision. The health centers have at most a working push bicycle.

S. Literacy

A special section is devoted here to literacy, because this is one area that does not neatly fall into the guidelines provided by **BHR/PVC**. SC's literacy program follows the National Literacy Program guidelines, using their training of literacy instructors and their primers. SC has trained 20 literacy instructors who have each established a literacy class in their village. Originally, interest and enrollment was overwhelming, with total enrollment of over 1,700 and class sizes ranging from 52 to 337. Drop-out levels have been high, and now classes have stabilized at 14 to 56 participants, with a total of about 600 participants as of April 1995. In fact, drop-outs were used as the solution to too-large classes.

The inputs into the literacy program are solid, with a good primer that includes some health messages. In addition, **HSAs** participate in teaching some sessions on health to the literacy classes. The attempt to integrate literacy into a health program has raised the awareness of health professionals about the importance of the relation of literacy to health. However, it appears that the literacy instructors are not emphasizing health messages to participants and helping the participants themselves to see how literacy can help them have healthier children..

The training techniques appear adequate, as well as the supervision by the SC Literacy Field Supervisor.

Interviews with participants and non-participants showed the role literacy can play in improving the health of their families is not totally clear to them. However, participants appeared to have much more self-confidence than non-participants.

V. RECOMMENDATIONS

From the previous section, it can be concluded that SC is doing a good job in their implementation of CS IX, and that they have addressed issues arising in a thoughtful and careful manner. This section will focus on the improvement that SC can make over the next 17 months of their CS IX project.

A. Recommendations related to the Health Information System

Improve Use of *the Roster*: The roster is a very important part of the SC approach to community-based services, because it forces health workers to consider all those targeted for services, not just those that come of their own volition. It is an essential element of ensuring equity and coverage. However, some weaknesses in its implementation were noted, and should be strengthened. SC should start by collecting the rosters (or looking at all rosters in the villages) to make up a list of problems with the roster. This list should then form the basis for developing the content for a refresher training. This training should first be a formal one, to ensure consistency of the messages, and should include as participants all VHPs and HSAs, as well as observers from the surrounding health centers. This formal training should then be followed up with on-the-job training during routine supervision.

Improve Use of Data for Decision Making: The data available in the project provides a wealth of information that can and should be used by all levels in assessing progress and making decisions on improvements. SC should outline the possible decision points, the approach to analysis, and possible responses indicated by each component of the routinely collected data, and then communicate these to field supervisors, HSAs, and VHPs. Systems for communicating data results and conclusions from one level to the next (VI-P, HSA, supervisor, management, and District) and vice versa need to be established and routinized. Routine supervision should include discussion of data and what it means.

Use Data as Opportunities for Working with Health Center Staff: Not only should VHP/HSA data be discussed with health center staff to keep them informed, but other opportunities for looking at data together should be sought, such as including them in all investigations of maternal deaths.

B. Recommendations regarding Project Design and Interventions

Make the DIP more Usable for Project Management: In areas where DIP objectives do not correspond to services objectives, consider changing the DIP objectives. In addition, develop a table of service objectives that can be distributed to all staff. This table should serve as the basis for all discussions on project progress.

Look for Ways to Provide Family Planning Services Right Away: Even though the MOH has not finalized its training program for family planning providers, SC should conduct a short training to health center staff and HSAs in the use of the community-based distributor (CBD) checklists for distribution of contraceptives, such as the pill, condoms, and foam. This will allow access to contraceptives in the project area to meet the demand being generated through VHP and HSA health education sessions. During this training, it will be important to include how the contraceptives work so that HSAs can feel confident about answering questions from potential acceptors.

Find Ways to Involve Men in Child Survival Activities: SC's current strategies focus almost exclusively on women as the target of health education. Yet, there are many areas where knowledge of men is important for making changes: family planning, AIDS, caring for sick children, and nutrition (for malnourished children and pregnant women). VHP health education is currently given solely to mothers groups and to mothers during home visits. SC needs to develop strategies to reach men and get them more involved. One possible start would be to recruit the VHPs' husbands or other male

volunteers to receive training and supplies of condoms for distribution at village level. Other possible strategies include having a men's group for health education, using male **HSAs** to provide health talks in the villages, and training male members of the VHC in health education (man-to-man).

SC Should Look for Ways to Address the Problems of Water Supply: Water is a major concern for most villages in the area. SC is constrained by the limits of child survival funding from addressing water supply issues. However, SC should advocate on behalf of communities for safe water supply, with the Ministry of Works, with other donors who do address water issues, and with **USAID** to sensitize them of the need to integrate water supply into child survival activities.

SC should Include More Alternative Health Education Techniques: Many of the messages being transmitted are culturally sensitive and require a variety of techniques to ensure comprehension and absorption. SC should explore possible alternative, non-traditional methods.

C. Recommendations regarding Training

Strengthen the Communication Techniques of HSAs and VHPs: Health talks observed were generally good, but there were a few gaps in technique that could impede participation of mothers and retention of messages: outlining the objectives of the talk at the beginning, and praising mothers on correct answers. This could easily be incorporated into the VI-P and HSA refresher trainings, which should be due soon. The training should include many opportunities to practice giving health talks, so that gaps can be perceived and corrected.

Anticipate the Problems that VHPs will Encounter in Prescribing Drugs when the DRFs are in Place: One of the biggest difficulties of placing drugs (especially antibiotics) at village level is to restrict their use only to cases where they are indicated. It can be expected that community members will often demand more from the VHP than she is supposed to give. In order to mitigate this situation, SC should:

- focus on the assessment phase of the patient encounter during VI-IP training to encourage appropriate management of patients. This means concentrating on the such things as the differential “diagnosis” of various levels of severity of respiratory infections, and distinguishing between malaria and fever associated with other infections.
- provide the **VHPs**, during training, with responses they can give to patients on why the treatment given is appropriate, especially when confronted with requests for medications beyond the illness.
- use SC Field Supervisors to educate communities, before introduction of **DRFs**, about what communities can expect in terms of treatment.

D. Recommendations regarding Supplies

Do not Accept Shortages of Supplies as Inevitable at any Level: Discussions among members of the midterm evaluation team indicated that some of the shortages experienced were not the result of shortages on a national or regional level, but rather a problem of communication. SC should review

the needs for MCH/U5/EPI activities with the health center staff on a monthly basis and these needs should be communicated to the District MCH Coordinator. The District MCH Coordinator should then communicate monthly with the Regional Family Health Coordinator about district needs and how they can be obtained in a timely manner.

Shortages of Condoms at HSA Level should not be Accepted: Although there are no shortages of condoms in Mangochi, some of the HSAs interviewed had no condoms in stock. Given the level of HIV infection in Malawi, it is important to have condoms available at village level. Field Supervisors need to push condoms to HSAs without waiting for requests, perhaps by distributing condoms on each pay day. In addition, supervisors need to ask specifically about condom distribution during all supervisory visits. If problems are encountered, they should be discussed and resolved. Also, SC should look for alternatives to the VHP for condom distribution at village level, such as the VHP's husband or other male volunteers.

E. Recommendations regarding Community Participation and Ownership

SC should Develop and Use Indicators for Community Mobilization/Participation: SC's experience in Mbalachanda in developing collaborative relationships with communities has helped them considerably in Mangochi. However, the current climate in Malawi has made community involvement more difficult than before. It is important now to make a more concerted effort to involve the community and to monitor the levels of involvement. SC should develop or adapt indicators of community involvement that HSAs and field supervisors can use when visiting villages. SC/Mali has a set of indicators for participation in village schools that could be adapted to health and the Malawian context.

Temporary and Long-term Solutions need to be Implemented to "Remotivate" the Village Health Promoters: Again, due to the change in perception of "self-help" and community activities, SC is encountering unexpected problems with VHP demotivation. Experiences in Mbalachanda did not prepare them for such a problem. A two-pronged approach is needed to "remotivate" the VHPs: a short-term approach and a longer-term approach. Given that the project is only 18 months old and the VHPs have been in place less than a year, the communities may not yet recognize the importance of the VHPs for them. But if left up to the community only, many VHPs would end up resigning. Some temporary measures to motivate the VHPs should be instituted by SC:

- provide a refresher training to all VHP's in the very near future, with a lunch allowance as before. This should provide a baseline motivator for all VHPs.
- introduce occasional rewards (e.g., soap) to those VHPs who are performing well. This will provide some on-going incentives, and will encourage VHPs not only to stay on the job, but to do their job well. Such a reward system will require the development of performance criteria upon which to judge if a VHP is performing "well."

At the same time, SC needs to work on longer-term solutions to this problem that can be sustainable after they leave. SC should start discussing now with the community that although SC will be providing some incentives now, the communities will need to find solutions for motivating their VHPs

after SC leaves. At the same time, SC should stress the advantages for the communities of having a VHP in their village.

SC should Learn from these Experiences and Prepare for Community Responsibility for VHP Motivation from the Beginning in Future Projects:

Although SC could not have expected the changes in attitude at village level between their CS V and their CS IX project, they should incorporate their experiences into their future projects. This means that initial discussions with communities should focus on developing a “contract” with the community about shared responsibilities for child survival and VHP support from the beginning. In addition, SC should explore ways to reduce or share VHP work load so that the issue of incentives is less likely to arise or can be dealt with within the bounds of the community.

The Role of the Village Health Committee should be Clarified and Training Relative to that Role Provided:

Some of the VHCs interviewed did not have a clear sense of direction for their activities. SC should facilitate the VHCs to define their roles, and then provide formal training to all VHC members, followed by on-the-job training that is relevant to this role. The formal training is important for providing self-confidence to the VHCs and a forum for discussing and sharing issues about their role with other VHCs. SC should also facilitate “reintroduction” of VHC after training to provide legitimization and understanding of the VHC’s role for the community.

F. Recommendations regarding Relationships with Health Center Counterparts

SC should Take Steps to Improve the Communication with Health Center Staff in the Chilipa Impact Area:

The current problems between SC and health center staff could impede sustainability of CS activities after SC leaves, if they are not dealt with now. However, since most of the problem appears to be communication, the solutions are not difficult. SC should take the following steps:

- continue the newly initiated regular joint monthly meetings with health center staff, to co-ordinate work plans, assess upcoming resource needs, and discuss any issues that have arisen in the past month.
- co-ordinate health center transport needs for supplies, etc. with regular SC trips between Mango&i and Chilipa. This would involve SC **notifying** the health centers of their work schedules, and making regular stops at Kapire and Phirilongwe health centers when in the area to see if they need anything taken down to **Mangochi** on the next trip. From the health center side, staff need to notify SC about upcoming transportation needs (to or **from Mangochi**) to see if co-ordination is possible.
- involve health center staff in all training efforts (initial and refresher) of **VHPs, HSAs, VHCs**, or others. This is important for ensuring that health center staff understand what tasks these cadres are supported to perform, and the ways the cadres are supposed to perform these tasks. It also provides an opportunity to encourage ownership by health center staff of community-based CS activities. This participation should not always be limited to the same staff members, so that more people can become familiar with child survival activities.

- encourage joint supervision of **HSAs** and VHPs where possible. The midterm evaluation team recognizes that health center staff have other responsibilities and will not always have time to accompany SC on supervision. But, again, it will help health center staff to better understand what these cadres do and how they can be supervised effectively.
- ensure that SC **HSAs** work with MOH **HSAs** to cover all outreach clinics under the responsibility of the health centers in Chilipa, including those outside the impact area. When SC leaves, their **HSAs** will be totally under the responsibility of health center staff and perform all duties that are under the responsibility of that health center. Therefore, SC should make sure that their **HSAs** support all health center efforts in the areas of **MCH/EPI**, especially since health center staff currently collaborate with SC-initiated outreaches.
- stop immediately using vehicles for outreach in areas where vaccines are accessible by push bike, The fact that SC uses vehicles for outreach while health center staff must use push bikes was one area of contention, The use of vehicles in most cases is no longer necessary and only creates a feeling of inequality.

SC should develop and circulate a transport policy related to transport of patients: Another area of difficulty that was mentioned by health center staff was denial by SC vehicles to transport patients to **Mangochi**. It appears that part of the problem is due to lack of adequate communication to all SC staff, including drivers, of what actions are allowable. The transportation policy should include the following component: in cases where an ambulance would be called (an emergency), the MA at the health center should check first with SC to see if there is a vehicle already making the trip to **Mangochi**. If yes, SC will transport the patient and his/her guardian, and the MA does not need to call for an ambulance from Mangochi.

For the situation in which the district ambulance is not available and SC does not have a scheduled trip, SC needs to develop a clear policy. The policy should be discussed and developed jointly with health center staff.

SC should Facilitate Appropriate Referral by HSAs and VHPs to Health Centers by Developing a Referral Form Jointly with Health Center Staff: To ensure appropriate follow-up and feedback, health center staff and SC should develop and implement a referral form that VHPs and **HSAs** can send with patients they refer to the health center. This would help health center staff to better understand the situation of the referral, and to provide feedback if the referral was inappropriate. It would also provide the VHP and the HSA with a more formal mechanism for referring patients, and allow them to get feedback on what happened at the health center.

G. Recommendations regarding Sustainability

Although SC has three sustainability indicators, these do not really address many of the issues of sustainability. To keep the community-based activities going after they leave, SC needs to ensure that those will be supervising the activities (health center staff) understand these activities well, that health center staff have the skills to carry out that support and supervision, and that health center staff have the resources necessary to provide that support.

SC should Provide a “Reorientation” to All Health Center Staff about the Child Survival

Approaches and Strategies being Used: Although some health center staff were involved in the initial discussions about the project, there is a high level of turn-over. It would be important to “reorient” all health center staff to what SC is trying to do and how it is different from the normal MOH approach: i.e., the population-based approach. SC should use this “reorientation” as an entry point to planning with health center staff how staff can now start to become progressively more involved and integrated in the CS activities.

SC should Provide Health Center Staff with Training in Management of Community-Based

Programs: The skills that the SC field supervisors have acquired over the several years working for CS (from CS V until now) are not generally covered in medical assistant or nurse training. Yet, these cadres will have a role to play in sustaining the community-based CS activities. SC should provide training in management of community-based programs, to include such areas as: supervisory skills, community participation and mobilization, and financial accounting and logistical support to village drug revolving funds.

SC should Start Working with the District Health Management Team Now to Ensure

Sustainability of CS Activities: SC should hold regular meetings with the DHMT to discuss progress on activities, information sharing, and discussions about sustainability. Because the personnel in the Chilipa area are insufficient, SC should continue to negotiate with the District to post an area health inspector, an additional health assistant, and a community nurse to the impact area. This posting should take place well before the project ends so that these new staff can benefit from the orientations and trainings described above.

SC should Leave Some Means of Transport for MOH Supervision in the Project Area:

The MOH cannot be expected to supervise and support 134 VHPs and 23 additional HSAs with the inadequate transport they currently have. SC should assist the district by leaving some means of transport, such as a motorcycle.

SC should Ensure that their HSAs are Fully Employable by the MOH:

SC should organize, in collaboration with the District Health Inspector, a refresher training for HSAs near the end of the project period. This training should focus on those parts of the MOH HSA job description and curriculum that have not been stressed by SC, such as well protection and latrine construction. Although they were covered during the initial training, the lack of practice over three years calls for a refresher.

H. Recommendations regarding Literacy

SC should Review the Literacy Primer for Health Messages: The National Primer includes some health messages, but these should be extracted and analyzed in comparison with the project’s health objectives. If there are areas missing, the curriculum should be supplemented. This is important for ensuring integration of health and literacy objectives.

Supervision of Literacy Classes should Focus on Methods Used in the Classroom: The literacy supervisor should look for, and reinforce, methods for testing individual comprehension, encouraging self expression, and, ultimately, promoting problem solving related to texts (thinking, analysis and application of content). These objectives are important for increasing participants' self confidence. Participants, instructors, and SC all need to make mutual commitments to learning.

Clarify for All Levels the Health and Empowerment Outcomes Hoped for from Literacy: Interviews with instructors, supervisors, and participants indicated that the comprehension of the literacy goals are limited to teaching reading and writing. However, the purpose of integrating literacy into a CS program goes beyond literacy competency. The goals also include improving the health of children and the community by empowering women to be able to take better care of their families, to learn more about health, and to be able to read their child's growth and vaccination card. These larger goals need to be better communicated to instructors and participants (**further** motivation for learning). Such clarity should lead to an increased focus on writing for self expression and health: e.g. a baby book, like the one used by SC in Nepal and Mali, where women can read and write about the lives and development of their children. SC should consider comparing literacy participation and health outcomes in final evaluation, as a way of increasing staff awareness of the links between literacy and health.

SC should Evaluate the High Drop-Out Rate in the Literacy Classes: Although the high rate of drop-outs solved the problem of overcrowding, it also potentially demotivated many participants from wanting to continue or to start literacy classes. This evaluation should look what happened inside the class to cause drop-outs (e.g., too many levels combined in the same class, insufficient attention to those having difficulty), as well as factors due to the women's situation (e.g., timing of course during the day, timing during the year, husbands not supporting participation). Steps then need to be taken to remove barriers to continued participation and to encourage drop-outs to continue with the next literacy class session. Class size problems should be addressed independently of drop-outs. Some possibilities include splitting classes based on initial ability, training additional instructors, or giving priority to community members involved in development activities.

Clarify Post Literacy Class Plans: SC should focus attention on what can be done to encourage literacy class participants to continue to practice their new skills, after the first ten-month session is over. Possibilities include: radio listening groups, reading groups, a follow-on curriculum. Planning for follow-on should start immediately so it can be incorporated into the classes that will be finishing soon.

I. Recommendations regarding Future Health Projects in Mangochi

SC should Expand to Another Area the Size of Chilipa for Future Programming: In applying for any additional funding, SC should continue in Chilipa and expand to another area about the same size. There were some differences of opinion between the DHMT and SC staff as to whether it was better to expand to a contiguous area or to do the expansion in another very underserved area of the district. There are advantages and disadvantages to both:

- a contiguous area is more efficient in use of resources, since SC would be able to maintain a single project field office and combine the use of staff and vehicles for both areas
- expansion to other areas of the district would assist the district in meeting its health goals and provide access to areas which were as underserved as Chilipa was originally.

The conclusion of the midterm evaluation team was that the location of expansion would depend on the type and amount of funding available.

SC should Develop and Implement an Integrated Health Center/Community-based Model for Future Projects: SC has developed a strong community-based model, but as mentioned in the recommendations regarding sustainability, the model suffers **from** weak health center support. In future health projects, SC should focus on the interface between the health center and the community, and on strengthening the ability of health center staff to think in “population” terms. One suggestion would be to incorporate 5-10 health centers into a project area. For each health center, a catchment area should be defined, and health center staff trained to think about all the people they are supposed to serve, not just those that present themselves at the health center. The roster system that SC has established in the villages is a good basis for such a system, but health center staff need to be intimately involved in using this information for their own planning.

These pilot health centers could be used to test other aspects of integrated health center-community work, such as cost sharing with joint management of revenue. This model would provide resources necessary to make services sustainable, as well as providing a mechanism for dialogue between health center staff and communities. This is a direction that the MOH is considering and SC could offer the opportunity to try this out. Such a model could include using revenue raised in the catchment area for all needs in the catchment area: i.e., developing sustainability at catchment area level, not asking each village to be self-sufficient. Catchment area sustainability would mean pooling of revenue **from** health center and village sources. It would be important in any financing model that incentives from the system focus health staff and village energies, not only on treatments, but also on coverage with preventive interventions. Examples of possible incentives include rewards for good coverage levels with preventive interventions, as already discussed with the **VHP** soap rewards for good performance. Another aspect of this pilot project should be the assessment of the type of skills health center staff need (and can obtain) to work with communities and development of training curricula for the following areas: management skills (supervision, logistics, finances), community dialogue (mutual accountability) skills, epidemiology and population planning skills, and problem-solving skills.

This model project should also go beyond the standard child survival interventions, as child survival interventions do not give much opportunity for participation of men. There are several other priority areas that are very cost-effective that could be incorporated: treatment of sexually transmitted diseases, treatment of school children for parasites, treatment of tuberculosis, and home-based care for patients suffering from AIDS.

Besides the focus on health center/community level, SC could work with the DHMT to develop the levels of support they must provide to sustain effective population-based activities at health center and village level. SC should ask for a district counterpart who can participate in the planning and

supervision of these activities, and regular updates with the DHMT to ensure a sense of ownership and consensus. This model would be one that the district also feels would be important. SC has already shown their capability of working collaboratively with the DHMT.

VI. CONCLUSIONS

In conclusion, SC has done an admirable job in getting community-based child survival services started in the Chilipa area. They have made good progress on their objectives and are likely to meet all objectives by the end of the grant period. They have encountered unexpected difficulties in dealing with community participation and volunteer motivation, but working as an integral part of the midterm evaluation team, they have come up with recommendations that should address the problems that have arisen. The midterm evaluation team is confident that the recommendations included in this report are feasible and that SC staff have the skills and experience to implement them.

APPENDIX ONE

Data Collection Instruments used for Midterm Evaluation

QUESTIONNAIRE
HEALTH SURVEILLANCE GROUP DISCUSSION

1. What are your roles or purposes as HSAs?
2. What activities do you carry out that help your villages to solve their own problems and to involve women.
3. What kinds of discussions do you have with the VHCs/VHPs about the data from the monthly form?
4. How do you view the problem of motivation and incentives for VHPs? What kind of sustainable solutions could be effective?
5. What are the main problems you encounter in trying to carry out your job?
6. What would you consider to be the main lesson learned so far from trying to carry out project activities.

Do you tell that your training as an HSA has improved your ability to solve problems for your communities? Do you feel more able to help people? Why? In what way? Cite some examples of how your training has helped you help your community?

QUESTIONNAIRE
HEALTH SURVEILLANCE ASSISTANTS

1. What is your role or purpose as an HSA? What are you supposed to do?
2. Who are the high risk **groups** (people you should pay particular attention to) for growth monitoring? What efforts do you make to ensure they receive services?
3. Can you site some examples of how you have used the data from the monthly reporting forms to make decisions)?
4. What problems do you encounter in filling out the monthly forms and using the data? Do you share the data with the village health committees and/or village health promoters?
5. What percentage of your time do you spend doing health education? what percentage do you spend providing services (chlorination of wells, immunizations, growth monitoring, etc.)? what percentage do you spend assisting and supervising VHPs?
6. Who supervises you? How often do they come to see you? What do they do when they come to see you? How long do they normally stay with you? Is there anything else your supervisors could do that would support you in your work? Do they ever observe you carrying out your tasks?
7. How often do you visit each of your VHPs? How many do you supervise? What do you do when you supervise them? What tools and **techniques** do you use during your supervisory visits? How do you assess how well they are carrying out their tasks?
8. What motivates you to do your job and to continue working as an HSA?
4. What areas do you feel you might need some additional training or on-the-job training?

10. Does the HSA have:
- pencil
 - chloride of lime how much?..
 - ORS how many?..
 - Malaria booklet
 - salter scale
 - U5 card how many?
 - nutrition posters
 - FP booklet
 - ARI posters
 - condoms how many?
 - aids posters?
 - aids pamfret? .-
11. EFI
- (a) Name the six immunizable diseases
 - (b) What is the recomendation immunization schedule for children?
12. CDD
- (a) How do you prepare chloride & lime solution?
 - (b) Can you name three signs and dehydration?
13. Malaria
- (a) What are four signs and symptoms of malaria?
 - (b) What is the drug of choice and what is the collect dosage for a chils under 4 years of age.
14. FP
- (a) What are the benefits to the child for family planning?
 - (b) Name five mordern methods of family planning.
15. AR1
- (a) What are the three signs and symptoms of pneumonia?
 - (b) What is the drug of your choice for pneumonia?
16. AIDS
- (a) Mention three ways AIDS is transmitted.
 - (b) What is the difference between HIV & AIDS?

~~OBSERVATION OF HSAs PERFORMING THEIR WORK which tasks?~~

DRAFT QUESTIONNAIRE
VILLAGE HEALTH PROMOTERS

1. What is your role or purpose as a VHP? What are you supposed to do?
2. Which health activities do you spend most of your time on? Which activities would you consider your most important activities? How much time do you spend in a month on health activities?
3. Who are the high risk groups (people you should pay particular attention to) for growth monitoring? What efforts do you make to ensure they receive services? [ASK TO SEE ROSTER - is it up to date?]
4. What activities do you carry out that help your villages to solve their own problems?
5. What activities do you carry out to involve women?
6. Can you site other examples of how you use the data from your rosters? What difficulties do you in filling out and updating your roster? Does your HSA review your data for the monthly reporting forms? Can you cite some examples of how you and your HSA have made decisions on new action based on the monthly forms?
7. Do you share the data with your village health committees?
What kinds of discussions do you have about the data with the VHC?
8. Who supervises you? How often do they come to see you? What do they do when they come to see you? How long do they normally stay with you? Is there anything else your supervisors could do that would support you in your work?
9. What motivates you to do your job and to continue working as a VHP? What could the community, MOH, and SCF do to help motivate you to continue in your work? (If they say money, soap, et-c, ask: And how about when SCF leaves, what about continuing your work) .
10. What are the main problems you encounter in trying to carry out your job?
11. After your training as a VHP, do you feel more able to help people? If yes, In what way? If no, why? Cite some examples of how your training has helped you help your communities .

12. What areas do you feel... you might need some additional training or on-the-job training?
13. Check whether VHP has:
 a. ~~roast roster~~
~~penal pencil~~
 ORS? how many?
 notebook
 chloride solution? how much?
 malaria books
 Condoms? how many?
 AIDS posters?
 Nutrition posters?
14. EPI
 a. Can you name the six diseases ^{covered} ~~presented~~ by Immunization?
 b. At what age should the child get the measles Immunization?
15. CDD
 a. What are the signs of dehydration?
 b. What do you tell the mother to do when her child has signs of dehydration?
16. Malaria
 a. What causes malaria?
 b. What advice do you give a mother who has a child with fever?
17. ARI
 a. What are the signs and symptoms of ARI?
 b. What advice do you give a mother whose child has these signs and symptoms?
18. FP
 a. Can you name three advantages to FP?
 b. Can you name three modern methods of FP?
19. We have asked you lots of questions, do you have any comments or questions to add?

OBSEWATION OF VHP TALK

Did VHE

Introduce topic? "
State objectives?

LIST CONTENT OF TALK

Did the VHP summarize the talk?

Did the VHP:

stress important points.

ask questions to audience during the talk.

make eye contact with audience.

repeat the questions from the audience.

praise mothers who give right answer.

throw back a mother's question to the group.

Mothers Interview after H/E BY a V.H.P.

1. What was the to-days topic?
2. What were the main points?
3. Did you learn anything new today?
4. Will you be able to apply the message you have heard to your daily undertakings where is necessary?

VILLAGE HEAD MAN QUESTIONNAIRE
Malawi-CSIX MTE, May-June, 1995

1. What is your role in the Village Health Committee?
2. If you had one piece of **advice** or one recommendation to Save the Children what would it be?

VILLAGE HEALTH COMMITTEE (VHC) QUESTIONNAIRE
Malawi-CSIX MTE, May-June, 1995

- 1A. What does the VHP do in your village?
- B. What does the HSA do in your village?
- 2A. What are the major reasons that children fall ill and die in your village?
- B. **Has** this changed since the **Save the Children** project began?
- 3A. Does your **VHP/HSA** tell you about what they found from the information about health that they collected in your village?
- B. **If yes**, can you give an **example**?
- C. If yes, what did you do **after** you were told the **information**?
- 4 A. Do the **VHP** or **HSA** use any materials **during** their **talks**?
- B. If yes, can you give an example?
- C. If yes, did this help you **understand** their talk?
- 5A. You remember nominating your **VHP**. Sometimes people doing volunteer work lose interest. Has this happened in your village?
- B. Why do they lose interest?
- C. Are there any other reasons?
- D. **How** can you meet **the challenge** to encourage **VHPs** to continue working?
6. What is the role of the VHC in your **community**?

- 7A. When Save the Children **first** came to your village before starting the project, what did they talk about?
- B. Are the present activities more or less what you expected
- C. If not, how are they **different**?
- 8A. Do you feel that the activities of the **VHPs** and **HSAs** are helping you?
- B. why or why not?
9. **What else** could be done to improve the activities of the **VHPs** and the **HSAs** in your **village**?
- 10A. Since the Save the Children project started, has your use of the health centre changed?
- B. If yes, how?
- 11A. **When** was your **last** health centre visit?
- B. Did you receive the appropriate assistance?
- C. If not, what happened?
12. Is there anything else you would like to say?

COMMUNITY QUESTIONNAIRE
Malawi-CSIX MTE, May-June, 1995

- 1A. What does the VHP do in your village'?
- B. What does the HSA do in your village?
- 2A. What are the major reasons that children fall ill and die in your village?
- B. **Has** this changed since the Save the Children project began?
- 3A. Does your **VHP/HSA** tell you about what they found from the information about health that they collected in your village?
- B. If yes, can you give an example?
- C. **If** yes, what did you do after you were told the information'?
- 4A. Do the **VHP** or HSA use any materials during **their** talks?
- B. If yes, **can** you give an example?
- C. Eyes, did this help you understand their talk?
- 5A. You remember nominating your **VHP**. Sometimes people doing volunteer work lose interest. Has this happened in your village?
- B. Why do they lose interest?
- C. Are there any other reasons?
- D. How can you meet the challenge to encourage **VHPs** to continue working?
6. **What** assistance does the **VHC** give 'to the community'?

QUESTIONNAIRE
DISTRICT MANAGEMENT TEAM

1. What are the major reasons that children fall ill and die in the project area? Do you feel that the activities carried out by SCFXJS adequately address these problems?
2. Do you feel that SCF is doing something to increase the communities' capacity to participate and benefit from CF activities? How do you feel they are accomplishing this?
3. Do you receive reports from SCF/US about their coverage and activities? On a regular basis? Who at the District actually sees the data and discusses it? Do you find this information useful to you? In what way?
4. Who would you consider to be your main counterparts at SCF/US? In what ways are you collaborating with them?
5. How would you describe your relationship with SCF/US?
6. What are the referral sites for cases from Chilipa Villages (health centres, hospital)? Has SCF/US made any efforts to strengthen the referral sites or increase community access to them?
7. What steps has SCF/US taken to ensure that project activities will be sustainable for the District? (Human resources, skills training of counterparts, institution-building, cost-recovery, etc.)
8. SCF has been experiencing difficulties with some of their promoters who are asking for incentives. Does the District have any ideas about how SCF can deal with this, given the problem of sustainability after SCF leaves?
9. How, concretely, has the District been involved in the planning and implementation of project activities? Are you planning to sustain SCF/US activities after they leave (HIS, DRFs, VHP/HSEs)? In what areas do you expect difficulties in sustaining their activities? (focus on issues of supervision, transportation)
10. In what ways do you think SCF/US could improve their assistance in Chilipa?
11. How would you like to see SCF/US assistance evolving over the next several years: intensifying in the areas they are currently in? replicating at the same level to a larger area? covering an even larger population with fewer interventions? why?
12. What specific aspects would you like to see replicated?
13. Are there aspects where SCF could help improve your ability to do your job well? What aspects? How? what

QUESTIONNAIRE
HEALTH CENTRE STAFF

1. What types of health care interventions does SCF/US focus on? (mark ones mentioned)

| | |
|---------------------|----------------|
| EPI | AIDS |
| Growth monitoring | Literacy |
| Nutrition education | Diarrhoea/CPT |
| Malaria | Vitamin A |
| Family Planning | Antenatal Care |

2. Do you participate in the supervision of SCF/US HSAs?
Do they participate in the supervision of MOH HSAs?
3. Who supervises MOH HSAs? What tools and techniques do you use during your supervisory visits? How often do you supervise them in the field? How is the quality of activities assessed?
4. Who would you consider main counterparts at a SCF/US? In what ways are ^{you} collaborating with them?
5. How would you describe your relationship with SCF/US? What would you like to be different?
6. Have you experienced any difficulty with referrals from SCF/US, HSAs or VHPs?
7. How ~~concretely~~ ^{concretely}, has this health centre been involved in the planning and implementation of project activities? Are you planning to support SCF/US - initiated activities after they leave (VHPs, Antenatal, additional outreach, supervision of HSAs)? In what areas do you expect difficulties in sustaining their activities?
8. In what ways do you think SCF/US could improve their assistance in the Chilipa Impact Area?
10. Does the Health Centre have:
- Frig
 - sterilizer
 - vaccine carrier
 - syringes
 - needles
 - stove
 - kerosene or gas

- vaccines
- U5 cards
- TTV cards
- tally sheets
- monthly report forms
- CRS how many
- register books
- mixing containers
- spoon
- cup
- diarrhoea charts
- chloride of lime how much?
- SP how many?
- Aspirin how many?
- Malaria treatment guide
- weighing scale
- U5/growth monitoring register
- Likuni phala
- ferrous sulphate how many?
- folic acid
- Vit A
- Antenatal cards how many?
- bath scale
- BP machine
- speculum
- contraceptives what kind? how many?
- gloves how many?
- Private space for examination
- torch
- bactrim how many?
- ARI treatment/assesment chart
- condoms how many?
- AIDS posters

QUESTIONNAIRE
SAVE THE CHILDREN STAFF

1. What efforts are being made to reach high risk -groups. (EPI, GM/NA, CDD, Malaria)? Do you feel that these are effective in reaching those individuals? Why or why not? Have you identified any additional high risk group?
2. What has SCF done to increase the communities' capacity to participate and benefit from CS activities.
3. What are the problems encountered in the implementation and effective use of the HIS sys? Who actually sees the data and discusses it.
4. Can you cite some examples of how the HIS data has been used for decision-making?
5. How was the content of the various health education messages developed (for each intervention)? How do you ensure that the messages delivered to mothers are consistent?
6. What creative techniques for health education are used? What has SCF done to assess learning by mothers.
7. How do you supervise each level: HSAs, VHPS, Literacy instructors? What tools and techniques do you use during supervisory visits? How do you assess the quality of activities? How often do you supervise each level? What actions do you take for habitual poor performance?
8. How would you describe the supervision and support you receive from the Mangochi office? What do they do when they come?
9. Are there any areas where you feel additional, external technical support would be useful? Has previous support been useful?
10. Who would you consider to be your main counterpart? In what ways are you collaborating with them? Do you feel they have the skills and knowledge necessary to take over your responsibility when the project ends? What could be done to improve these skills?
11. What efforts have been made to strengthen the referral sites or increase community access to them?

12. What steps has **SCF/US** taken to ensure that project activities are sustainable? (human **resources skills/trining** of counterparts, institution-building, cost-recovery, etc) :
What dont the sustainability of the literacy program.-
13. How, **concretely**, have the **communities been** involved in the planning and implementation of project activities?
14. What do you consider to be the main constraihts you face in implementing your planned activities (project implementation)
15. What would you consider to be the main lessons lerned so far in project implementaion?
16. What is the accomplishment of aspect of the project you feel most proud of?
17. If you could do one thing over again, what would it be?

LITERACY ASSESSMENT - INSTRUCTOR INTERVIEW

1. What are the objectives of SCF's literacy program? Why do women want to participate in it?
2. What **challenges** have you encountered in teaching literacy?
3. How do you measure progress of the learners? What do you do if you identify someone having **difficulties**?
4. In what ways can literacy help a woman improve her family's health status?
5. What are effective ways to teach women to read, write, and calculate?
6. Who supervises you? How often does he come to see you? What does he do when he comes to see you? How long does he normally stay with you? Is there anything else your supervisor could do that would support you in your work?
7. What motivates you to do your job?
- S. What is the reason some of your learners have dropped out. What can be done to limit drop outs?

LITERACY CLASSROOM OBSERVATION CHECKLIST

DATE:

LESSON TOPIC:

HEALTH MESSAGE:

NUMBER OF PARTICIPANTS:

CLASSROOM TYPE: Building _____ Under a tree _____ School after hours _____

SUPPLIES

- Blackboard
- Chalk
- Instructor has a guide, notebook, and pens
- Participants have primers (ratio students to primers:) _____
- Attendance register (dropout rate: _____)
- Test results

LESSON DELIVERY

- Lesson objective is clear to participants
- Lesson pace is neither too fast nor too slow
- Lesson is varied, and participants' attention is engaged
- Instructor attempts to involve all participants (back row as well as front row, slow learners as well as fast learners)
- Participants demonstrate understanding of the lesson
- Instructor corrects mistakes in a clear and helpful way, and gives immediate positive feedback for correct responses
- Class is orderly

LITERACY ASSESSMENT - PARTICIPANT INTERVIEW

I. TEST

- read simple sentence
- read simple health text
- write simple communication regarding health

II. QUESTION

1. What motivated you go to literacy class?
2. What do you expect to gain from being literate?
3. What can a literate woman do that a non-literate woman cannot do
4. In what ways will you use your literacy skills to contribute to the health of your family?

**NON-PARTICIPANT INTERVIEWS
LITERACY**

1. What difference can a literacy class make in a woman's life?
2. In the lives of her family and community?
3. What difficulties have you encountered because of being illiterate?
4. Are there problems you have encountered in caring for your families health that would have been easier if you had been literate?
e.g. vaccination dates, reading medicine instructions, remembering health messages etc.

APPENDIX TWO

Child Survival Training Programme Summary

- 1. Training of Health Surveillance Assistants**
- 2. Training of Volunteer Village Health Promoters**
- 3. Training of Literacy Instructors**

CHILD SURVIVAL TRAINING PROGRAMME SUMMARY

| | TYPE:NUMBER DATES | TRAINING TOPICS | TOPIC HOURS | TRAINING METHODS FOR THE TOPIC |
|---|---|---|-------------|---|
| 1 | HEALTH SURVEILLANCE ASSTS (H.A.S.) 23 16TH APRIL - 6TH MAY 7TH NOV.-9TH DEC. '94 | <u>IMMUNISATIONS</u> - SIX VACCINE PREVENTABLE DISEASE - SIGNS & SYMPTOMS & HOME MANAGEMENT - PREVENTION - TYPES OF VACCINES - IMMUNISATION SCHEDULE AND TECHNIQUES - STERILISATION OF EQUIPMENT - COLD CHAIN/VACCINE STORAGE/TRANSPORTATION | 36 hours | - LECTURE/DISCUSSION - DEMONSTRATIONS - PRACTICALS AT A CHILDREN CLINIC - PRACTICALS ON STRELILISATIONS AND - COLD CHAIN ACTIVITIES |
| 2 | 23 H.S.AS (AS ABOVE) | <u>CONTROL OF DEARHOEAL DISEASES (CDD)</u> - Definition - Cause/Mode of transmission - SIGNS OF DEHYDRATION - Management - ORT/ORS Preparation/administration - Prevention/Water protection etc | 36 hours | - LECTURE/DISCUSSION - Use of Visual Aids (Posters, Pamphlets - DEMONSTRATIONS - PRACTICE and role Plays |

| | | | | |
|---|-------------------------------------|--|----------|--|
| 3 | 23 H.S.AS (Dates as Shown above) | <u>NUTRITION/G. MONITORING</u> - Weighing of Underfive/Plotting on Card - The importance of RTH Card - The importance/meaning of growth Monitoring - Nutritional deficiency diseases - Child feeding/weaning practices - Home visit/growth faltering child - Underfive roster/its role in growth monitoring | 36 hours | - LECTURE/DISCUSSION - DEMONSTRATIONS - PRACTICES AT AN U/S CLINIC - HOME VISITS |
| 4 | 23 H.S.AS (See above dates) | <u>MATERNAL CARE</u> - Advantages of A-N-E to mother and baby - Nutritional needs during pregnancy - Women's rosters/T.T.V - Monitoring T.BA. TRAINING NOT YET DONE | 12 hours | LECTURE/DISCUSSION - VISUAL AIDS - VISIT TO AN A.N.C IN SESSION (BY HEALTH CENTRE MIDWIFE) |

| | - TYPE OF TRAINEE - NUMBER OF TRAINEE - DATES OF THE TRAINING | TRAINING TOPICS | TOPIC HOURS | TRAINING METHODS FOR THE TOPIC |
|---|---|--|-------------|--|
| 5 | 23 H.S.As (AS SHOWN AT :I. ABOVE) | <u>FAMILY PLANNING/CHILD SPACING</u> - Advantages of Child Spacing/F. Planning (i) To the mother (ii) To the Child - Modern methods of Family Planning - Assessment of Women needing C/S/F.P. | 8 HOURS | - LECTURE/DISCUSSION - Use of Visual Aids (contraceptives) - Role Plays |
| 6 | 23 H.S.As (AS SHOWN ABOVE AT 1) | <u>ACUTE RESPIRATORY INFECTION (A.R.I.)</u> - Definition - Assessment of a Child with A.R.I. - Signs and symptoms - Management/Treatment - When to refer - Prevention | 8 HOURS | - LECTURE/DISCUSSION - Role Plays - Observation of Case Assessment at the Health Centre |
| 7 | 23 H.S.As | <u>MALARIA</u> - CAUSE/TRANSMISSION - SIGNS AND SYMPTOMS - MANAGEMENT/ TREATMENT - PREVENTION | 12 HOURS | -LECTURE/DISCUSSION - Use of Visual Aids - Role Play - Demonstration on how to calculate dosage and clean environment |

| | | | | |
|---|-------------------------|--|------------------|--|
| 8 | 23 H.S.As | <u>A.I.D.S.</u> - Definition - How the disease is spread/Signs & Symptoms - How to prevent AIDS | 6 HOURS | - LECTURE/DISCUSSION - use of Visual Aids - Role Plays |
| 9 | ZO LITERACY INSTRUCTORS | <u>LITERACY</u> - TO TEACH WOMEN IN CHILD BEARING AGE (CBA) HOW READ & WRITE TO BE ABLE - TO ARTICULATE HEALTH MESSAGES AS A RESULT OF BEING LITERATE - TO USE LITERACY CLASSES TO ADVOCATE FAMILY PLANNING TO PARTICIPANTS | 10 MONTHS COURSE | - Use of beginners Primers/States - Chalkboard/Chalk - Guided Reading - PRACTICAL READING AND WRITING |

| | TYPE OF TRAINEE NUMBER | TRAINING TOPIC | TOPIC HOURS | TRAINING METHODS |
|----|------------------------|---|------------------|---|
| 10 | 23 H.S.As | <u>HEALTH EDUCATION/TALK</u> - How to select a topic - How to prepare lesson plan - How to give a talk - Factors which can affect the effectiveness of a health talk - How to evaluate the education | 33 - 12 Hours | - Lecture/Discussion - Role Play - Demonstration - Practices |
| 11 | 23 H.S.As | <u>RECORD KEEPING/H.I.S</u> - How to compile a roster - How to keep record of Vital events - How to compile monthly report | 20 Hours | LECTURE/DEMONSTRATIONS - Practical/Field Testing/Assignments |
| 12 | 23 H.S.As | <u>PRIMARY HEALTH CARE (PHC)</u> - Definition of PHC - Components of PHC - PHC ACTIVITIES - Principles of PHC - Referral System in PHC | 24 Hours | - LECTURE/DISCUSSION - PRACTICALS - ROLE PLAYS |

CHILD SURVIVAL PROGRAMME TRAINING ACTIVITIES SUMMARY

| | TYPE OF TRAINEE NUMBER OF TRAINEES DATES | TRAINING TOPICS | TOPIC HOURS | TRAINING METHODS FOR THE TOPIC |
|---|---|---|----------------|---|
| 1 | VILLAGE HEALTH PROMOTERS (VHPs) 134 TRAINEES 24/7/ - 26/8/94 | IMMUNISATIONS TO KNOW:- SIX VACCINE PREVENTABLE DISEASES - SIGNS & SYMPTOMS - HOME MANAGEMENT OF THE SIX DISEASES - PREVENTION - TYPES OF VACCINES - IMMUNISATION SCHEDULE | 3 HOURS | - LECTURE/DISCUSSION - DEMONSTRATIONS - ROLE PLAYS - USE OF VISUAL AIDS (POSTERS/PICTURES) - COLD CHAIN ACTIVITIES |
| 2 | 134 VHPs (DATES AS SHOWN ABOVE) | CONTROL OF DIARRHEA DISEASES (CDD) - DEFINITION - CAUSE/MODE OF TRANSMISSION - SIGNS OF DEHYDRATION - HOME MANAGEMENT - ORT/ORS PREPARATION/ADMINISTRATION - PREVENTION/HOME WATER/STORAGE/CHLORINATION | 3 HOURS | - LECTURE/DISCUSSION - DEMONSTRATIONS - USE OF VISUAL AIDS - PRACTICE - ROLE PLAYS |

| | | | | |
|---|---------------------------------------|---|---------|--|
| 3 | 134 VHPs (Dates as Shown above) | <u>NUTRITION/GROWTH MONITORING</u> - THE WEIGHING SCALE/BABY WEIGHING - THE WEIGHT PLOTTING ON ROAD TO HEALTH CARD - The importance/meaning of growth Monitoring - Nutritional deficiency diseases (Kwashiorkor and Marasmus) -The Underfive roster - Home visit/Child Feeding/Weaning | 5 hours | - LECTURE/DISCUSSION - PRACTICALS - DEMONSTRATIONS - ROLE PLAYS - USE OF VISUAL AIDS (POSTERS/PICTURES) |
| 4 | 134 VHPs (AS ABOVE) | <u>MATERNAL CARE</u> - Advantages of A.N.C to baby and mother - What to eat during pregnancy - Women's rosters/T.T.V - Monitoring of pregnancy | 3 Hours | - LECTURE/DISCUSSION - PRACTICE ROSTER WRITING - USE OF VISUAL AIDS |
| | | | | |

| | TYPE OF EMPLOYEE | TRAINING TOPICS | TOPIC HOURS | TRAINING METHODS |
|---|------------------|--|-------------|--|
| 5 | 134 VHPs | <u>FAMILY PLANNING/CHILD SPACING</u> - MEANING OF FAMILY PLANNING/CHILD SPACING - ADVANTAGES TO CHILD AND MOTHER - MODERN METHODS OF FAMILY PLANNING - HOW TO DETERMINE WHO SHOULD BE CONSIDERED FOR FP/C. PLANNING | 3 HOURS | - LECTURE/DISCUSSION - ROLE PLAY - USE OF VISUAL AIDS (PICTURES/POSTERS) AND CONTRACEPTIVES |
| 6 | 134 VHPs | <u>ACUTE RESPIRATORY INFECTION (ARI)</u> - Definition - Assessment of a Child with A.R.I. - Signs and symptoms - Management in the Home - When to refer/ Prevention of Pneumonia | 3 HOURS | - LECTURE/DISCUSSION - Role Plays (Personal experiences) - Use of Visual Aids (Booklets, Posters and Pictures) |
| 7 | 134 VHPs | <u>MALARIA</u> - VECTOR/CAUSE/TRANSMISSION - SIGNS AND SYMPTOMS - HOME MANAGEMENT/TREATMENT - REFERRAL - PREVENTION/VECTOR CONTROL | 5 HOURS | -LECTURE/DISCUSSION - Use of Visual Aids - Role Play - Demonstration/Calculation of dosage |

| | | | | |
|----|-----------------------------------|--|-------------|---|
| | 134 VHPs | A.I.D.S. - Definition - How Aids is spread - Signs - How to prevent AIDS | 3 HOURS | - LECTURE/DISCUSSION - use of Visual Aids (Prevention) - How to use condom properly - Role Plays |
| | 134 VHPs | HEALTH EDUCATION/TALK - HOW TO SELECT A TOPIC - LESSON PLAN - HOW TO GIVE A TALK - WHEN TO GIVE A HEALTH TALK | 6 HOURS | - LECTURE/DISCUSSION - DEMONSTRATION/PRACTICE - ROLE PLAYS |
| | TYPE OF TRAINEE NUMBER DATE | TRAINING TOPIC | TOPIC HOURS | TRAINING METHODS |
| 10 | 134 VHPs | RECORD KEEPING/H.I.S - DEFINITION OF A ROSTER - HOW TO COMPILE A ROSTER - HOW TO KEEP RECORD OF VITAL EVENTS - HOW TO COMPILE MONTHLY REPORTS | 6 HOURS | -LECTURE/DEMONSTRATION - PRACTICAL COMPILING OF ROSTER - FIELD PRACTICE/TRIALS - ASSESSMENTS |

CHILD SURVIVAL PROGRAMME TRAINING ACTIVITIES

LITERACY SECTOR

| TYPE OF TRAINEE NUMBER DATES | TRAINING TOPICS | TOPIC HOURS | TRAINING METHODS FOR THE TOPIC |
|------------------------------------|---|--------------------------|--|
| 20 LITERACY INSTRUCTORS | <p><u>LITERACY/NUMERACY</u></p> <ul style="list-style-type: none"> - INTRODUCTION TO THE ALPHABET/NUMBERS - HOW TO MAKE WORDS OUT OF LETTERS - HOW TO USE LITERACY TO ARTICULATE HEALTH MESSAGES - TEACHING TECHNIQUES FOR ILLITERATE ADULTS | 2 WEEKS (80 HOURS) | <ul style="list-style-type: none"> - USE OF SLATES - CHALKBOARD/CHALK/ - USE BEGINNERS PRIMERS - PRACTICAL READING/COUNTING/WRITING |

LD SURVIVAL PROGRAMME TRAINING ACTIVITIES

| | TYPE OF TRAINEE NUMBER DATES | <u>TRAINING TOPIC</u> | TOPIC HOURS | TRAINING METHOD FOR TOPIC |
|--|------------------------------------|---|----------------|--|
| | 32 VHC MEMBERS | - ROLES OF VHC IN IMPLEMENTATION OF CS, ACTIVITIES IN THE VILLAGES - HOW THE VHC CAN SUPPORT VHPs/HSAs IN THEIR VILLAGES | 3 Hours | - QUESTION/ANSWER - DISCUSSION APPROACH |

NB: AT THE OPENING OF EVERY VHP COURSE VILLAGE HEADMEN AND MEMBERS OF VILLAGE HEALTH COMMITTEE WERE ASKED TO ATTEND THE FIRST 3 HOURS WHEN THE MAIN TOPIC WAS THEIR ROLES.

APPENDIX THREE

Pipeline Analysis