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VITAMIN A FOR CHILD SURVIVAL
CHIKWAWA DISTRICT, MALAWI
USAID CHILD SURVIVAL X
First Annual Report 1995

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ACRONYMS

ADRA	Adventist Relief and Development Agency
AIDS	Acquired Immune Deficiency Syndrome
CBD	Community-Based Distributor (Contraceptives)
CBM	Christoffel Blindmission
CDD	Control of Diarrheal Diseases
CHAPS	Community Health and Project Services Project
DHI	District Health Inspector
DHO	District Health Officer
DIP	Detailed Implementation Plan
DRF	Drug Revolving Fund
EBF	Exclusive Breastfeeding
EPI	Expanded Program on Immunization
FP	Family Planning
HA	Health Assistant
HCW	Homecraft Worker
HI	Health Inspector
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IEC	Information, Education, and Communication
IEF	International Eye Foundation
IFA	Invitation for Applications
IGA	Income Generation Activity
IVACG	International Vitamin A Consultative Group
KABP	Knowledge, Attitudes, Behaviors and Practices
KAP	Knowledge, Attitudes and Practices
KPC	Knowledge, Practices, and Coverage
MIS	Management Information System
MOH	Ministry of Health
NGO	Non-Governmental Organization
ODA	Overseas Development Agency
OMA	Ophthalmic Medical Assistant
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PEC	Primary Eye Care
PRA	Participatory Rural Assessment
PSI	Population Services International
PVO	Private Voluntary Agency
QA	Quality Assurance
RHO	Regional Health Officer
SCF/US	Save the Children Federation, U.S.
STAFH	Support to AIDS and Family Health Project
STD	Sexually Transmitted Disease
SUCOMA	Sugar Company of Malawi
TA	Technical Assistance
TBA	Traditional Birth Attendant
TEO	Tetracycline Eye Ointment
TTV	Tetanus Toxoid Vaccine
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
V/A	Vitamin A
VAO	Vision Aid Overseas
VHC	Village Health Committee
VHV	Village Health Volunteer

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I. OVERVIEW YEAR ONE

I.A ACCOMPLISHMENTS

The project had a very productive first year, achieving a number of notable goals. First, project Health Surveillance Assistants (HSAs) were transferred to the District Ministry of Health (MOH). The MOH now is responsible for their supervision, with support from IEF, as well as their salary. Further actions directed toward long-term sustainability included the transfer of project motorcycles to the MOH to assist with HSA supervision, to Montfort Mission Hospital and the Sugar Company of Malawi (SUCOMA) to assist with HIV/AIDS prevention activities.

The project continued to provide Child Survival (CS) services, including health education (nutrition, breastfeeding, HIV/AIDS, control of diarrheal diseases (CDD), etc.), distribution of vitamin A capsules, ORS and condoms, promotion and logistical support to EPI efforts, and primary eye care (PEC) to over 70% of the villages in the District. Village Health Committees (VHCs), and Village Health Volunteers (VHVs) were trained in the two remaining District health catchment areas not previously targeted by the earlier project objectives and new HSAs were recruited to work in these areas.

Training in CS was a major focus of the project and is described in greater detail later in this report. Training was provided to project staff, MOH health personnel including HSAs, hospital female ward attendants, MOH mid-level managers, VHVs, VHCs, Traditional Birth Attendants (TBAs), traditional healers and primary and secondary school teachers.

To expand health care access in selected rural communities, the project initiated the process of establishing drug revolving funds (DRFs) and income generating activities. It also continued to manage an AIDS Counseling Center at Montfort Hospital to provide services to people with AIDS and their families and friends.

Surveys were completed including a HIV/AIDS KABP at the site of the to-be-constructed dam at Kapachira Falls north of Chikwawa, an exclusive breastfeeding and sugar consumption KPC in the Dolo catchment area, an anthropometric survey of select villages throughout the District, and an EPI and vitamin A coverage survey on Nsua Island. All of the survey reports are included in the appendix. In addition, in-house evaluations of the VHV registers and the traditional healer training were conducted.

All of the above activities were completed despite personnel changes and additional work associated with the development of the detailed implementation plan.

In summary, the project accomplished the majority of its first year objectives and most significantly, has made the first critical move towards long-term sustainability. More specific details regarding accomplishments are listed by program component below.

EPI

The principal EPI activities include promotion of mobile under five's clinics by VHVs and HSAs, the provision of operational support at mobile under five's clinics by HSAs, and the monitoring of maternal and child coverage by VHVs through the use of village registers.

A special EPI survey was completed on Nsua Island to evaluate the progress the program has made in one of the most underserved areas of the District. The survey reported that children's immunization coverage was high, with 83% of children 12-23 months of age being completely immunized, and 75% of children receiving all of their vaccines by the age of 12 months. Mother's Tetanus Toxoid Vaccine (TTV) coverage had improved but was still low at 55.4% (mother's receiving three or more doses of TTV). Both vitamin A supplementation of children 12-23 months of age and postpartum mothers had improved from baseline to 67% and 41% respectively (Appendix A).

Control of Diarrheal Diseases

The project continued to distribute ORS through VHVs in project villages. Training of VHV's and HSA's will continue in year two of the project. Future instruction will be based on a needs assessment to determine the quality of services delivered by the VHVs and HSAs and improvements required and a review of data collection and the reporting system to improve the quality of supervisory reports.

Breastfeeding

Breastfeeding activities continued including basic promotion by VHVs, initiating pilot efforts of support groups in the Dolo catchment area, training of female ward attendants in District hospitals and support to hospitals in obtaining "Baby Friendly" status.

An evaluation of the pilot support groups showed that all mothers who participated, and whose children did not die, exclusively breastfeed their children through the first four months of life (Appendix B).

Vitamin A Supplementation

VHVs continued to provide vitamin A to children six months to six years of age and postpartum women. The project will train TBAs in year two regarding the importance of vitamin A supplementation of postpartum women. As a pilot effort, some TBAs will be given vitamin A for direct distribution to mothers.

The project continues to work collaborate with NGOs and other institutions by supplying 16,000 vitamin A capsules to ADRA, 8,000 vitamin A capsules to Montfort Mission Hospital and 2,000 vitamin A capsules to Vibanjo Health Center, a private clinic. Distribution levels remained constant through 1994 and 1995 (Appendix C).

Maternal Care and Family Planning

Twelve TBAs were trained at the end of the year in safe delivery practices, referral of high risk cases and cases with complications to maternity units, HIV/AIDS prevention, vitamin A supplementation and family planning (Appendix D). Training of community based distributors (CBDs) has been delayed until the first quarter of year two (Appendix E).

HIV/AIDS Prevention

HIV/AIDS prevention activities focused on education, counseling and condom distribution. Other events/activities included:

1. World AIDS Day - World AIDS Day was celebrated on December 3rd in Nchalo with a variety of musical and theater events. This activity was also supported by the Ministry of Education, Montfort Hospital and St. Matthews Primary School.

2. TBA Training - 180 TBAs participated in a two-day training sponsored by GTZ regarding HIV/AIDS prevention (Appendix F).

3. Malawi Medical Association - In April staff presented the results of the Nchalo AIDS KABP during a two day meeting.

4. Chishango distribution in Nchalo - IEF has recently been named the official Chishango condom (a for sale condom, socially marketed by PSI) distributor for the Nchalo area. IEF will identify an agency/individual to train over the next year to eventually sustain this activity.

5. Traditional Healer Training - Two-hundred ninety eight traditional healers were trained for two days in both AIDS control and primary eye care. A copy of the training outline can be found in Appendix I.

6. Kapachira Falls KABP AIDS Survey - A baseline survey was conducted in the northern area of the District in anticipation of the proposed construction of a major hydroelectric dam at Kapachira Falls. The results were very similar to those of the 1994 Nchalo KABP survey revealing that knowledge of HIV transmission was high while condom usage was very low. A significant number of respondents reported they did not know how to use a condom and others reported problems with condoms due to improper usage. Most people did not understand that having a STD put them at greater risk for infection with HIV. A summary of the results from this survey is found in Appendix G.

Primary Eye Care

Traditional Healers

One hundred sixty three traditional healers were trained late last calendar year (1994) in primary eye care. In July 1995, 298 traditional healers were trained for two days, one day each in AIDS control and primary eye care.

Commodities Donated to Other Institutions

IEF continued to supply tetracycline eye ointment to the following institutions: ADRA, 375 tubes; Montfort, 75 tubes; SUCOMA, 50 tubes; and, MOH, 50 tubes.

All HSA's in the district received 6 hours of PEC training as part of their week long CS orientation. Additionally, many of the VHV/VHC's trained in Chapananga in July received PEC training as part of their week-long orientation. Training focuses on understanding what an health eye looks like, common diseases and conditions, and referral.

ChildSight Activities

The IEF is also operating a project called ChildSight through a USAID Matching Grant. The project's primary objective is to increase children's access to clinical and surgical services for sight restorative surgery. Although, not directly part of the CS project, IEF is attempting to integrate these activities within the CS project. The activities that coincide with the CS activities during this reporting period include the following:

Apr-May 1995:	Meeting between Karin van Dijk, Advisor for Low Vision, CBM, Mrs. Rosemary Lowdon, Optometrist and consultant to VAO, John Barrows and Joe Canner, IEF regarding collaboration plans.
June 23, 1995:	Meeting between IEF staff and Karin van Dijk to plan curriculum development for PEC/Vision Screening activities.
July 24-25, 1995:	Training of IEF HSA supervisors in PEC and vision screening, facilitated by Karin van Dijk and Steve Kanjaloti.
Aug 7, 1995:	Vision screening practice session at Ndakwera Health Center for HSA supervisors.
Oct 5-9, 1995:	Training of 7 Ophthalmic Medical Assistants (OMA) in objective refraction, facilitated by Rosemary Lowdon and Karin van Dijk.
Oct 19-20, 1995:	Training of IEF HSA supervisors as trainers in PEC/ Vision Screening, facilitated by Karin van Dijk.
Oct 30-31, 1995:	Planned first training of MOH HSA's in selected areas in PEC/Vision Screening.

The purpose of the training is to provide simple skills in eye screening to identify large numbers of children for referral to an ophthalmologist.

Drug Revolving Funds

Project staff were trained by Save the Children/US, six villages were identified for DRFs and volunteers were identified and trained. Drugs have been ordered through Central Medical Stores jointly with Montfort Mission Hospital. Actual drug sales will begin in the first quarter of project year two.

Income Generating Activities

A consultant, Ms. Kristine Jones (Appendix H), was hired to investigate potential IGAs in Malawi and make recommendations regarding activities to be pursued in Chikwawa district. This investigation was recently completed. In addition to this, Ms. Jones coordinated the training of staff in Participatory Rural Appraisal (PRA) methodology to better involve communities in the identification of priority IGA activities. Household vegetable gardens were identified as one feasible activity and have been started in one village. At this time one additional site is being considered.

Another IGA which will be piloted in year two is the provision of fuelwood in the Kapachira Falls, to attempt to mitigate potential deforestation due to the great number of workers that will temporarily relocate to this area for the construction phase of the dam.

DIP Development

A significant amount of time was invested in obtaining community input into developing the DIP. The following workshops were held in the month of January:

Area	Group	Attendance
Kakoma	TBAs	39
Chipwaila	TBAs	26
Ng'abu	Religious leaders	18
Chikwawa	Religious leaders	24
Ng'abu	MOH Mid-level managers	19
Chikwawa	MOH Mid-level managers	20
Chikwawa	HSAs	31
Ng'abu	HSAs	35
Chapananga	Local leaders	22
Maperera	VHC members	27

I.B. TRAINING ACTIVITIES

Training provided to project staff is summarized in Table 1 below.

TABLE 1: IEF STAFF TRAINING

Date	Staff Trained	Subjects	Hours
11/21-24/94	Supervision Coord.	Micronutrient Message Development	32
8/7-11/95	Accountant	Quicken	16
9/4-15/95	Senior staff (6)	Word processing/Lotus	4
6/12-16/95	AIDS Coordinator	Training of Trainers - Community-based counseling (Action Aid)	40
7/14/95	AIDS Coordinator	Training of Trainers - Anti-AIDS school clubs (UNICEF)	8
6/29-30/95	Project Manager	Drug revolving funds (SCF/US)	16
7/27-8/3/95	Senior staff (4)	Participatory Rural Appraisal (CURE)	80

In addition, the Country Director attended both the Johns Hopkins CSSP Child Survival Impact Conference in Bangalore, India and the International Vitamin A Consultative Group (IVACG) Meeting in Chiang Rai, Thailand in October 1994.

IEF organized the training health care personnel, volunteers and teachers from the MOH, Montfort Hospital and the SUCOMA sugar plantation. Nineteen training sessions were held in the past year, including post-training evaluations when possible. Illiteracy among groups trained made examinations difficult in the case of TBAs, traditional healers, and volunteers. IEF is looking into methods of testing these groups. A summary of our training activities can be found in Appendix I.

I.C. TECHNICAL SUPPORT

Kristine Jones, was hired for five months to initiate the IGA component of the project and to review and make recommendations regarding modifications to the HIS to increase its sustainability potential and to improve community feedback. Both John Barrows, IEF/HQ Director of Programs and Jeffrey Brown, IEF/HQ Child Survival Coordinator visited the project once to provide management and program development support.

Save the Children/US provided technical training to the Project Director to assist in the start-up of the proposed drug-revolving funds. Action Aid trained the AIDS coordinator in how to train community-based HIV/AIDS counseling volunteers, while UNICEF trained him in how to initiate anti-AIDS clubs in both primary and secondary schools. Finally, CURE (Coordination Unit for the Rehabilitation of the Environment) provided training to senior staff in participatory rural appraisals (PRAs). This assessment technique will be utilized in developing community interest and identifying key priorities within each community for IGAs.

I.D. COMMUNITY ORGANIZATIONS SUPPORTING HEALTH

Regarding VHCs, a summary of those active in the last ninety days is as follows:

Area	# VHCs	# Active VHCs
Ndakwera	45	25
Chikwawa	72	40
Maperera	33	20
Nakhwira	54	41
Kakoma	26	11
Chapananga/ Gaga	61	35
Chipwaila	31	16
Ng'abu	37	10
Dolo	32	7

Motivation of the VHCs remains a problem. Some factors that may be contributing towards lack of motivation are lack of clarity on their role, and inadequate supervision and feedback from HSAs, IEF staff, and MOH staff. The past year has also seen tremendous political change in the country with the first national Presidential elections. Because village leadership is often tied to the former Malawi Congress Party, the elections may have contributed towards willingness to met. As stated above, during the second year, the use of PRA techniques will be expanded to develop community interest through VHCs.

I.E. LINKAGES BETWEEN PROJECT AND HEALTH ACTIVITIES

The project has developed strong linkages with the MOH, Montfort Mission Hospital and SUCOMA, the major providers of health care in the District. Meetings are held regularly between these institutions and most training of health workers includes both participants and facilitators from each organization. The project has actively participated in the Nchalo AIDS Committee, Chikwawa AIDS Committee, and Southern Region AIDS Network. Recently, the project transferred all of its HSAs to the MOH, and six motorcycles to the MOH, Montfort Mission Hospital and SUCOMA so that they could increase the level of supervision of their field health workers. Vitamin A was also provided to each of these institutions to distribute to women and children seen at their health facilities.

Excellent collaboration also exists with other PVOs. Technical assistance from Save the Children/US was utilized to train project staff and to develop the DRF implementation plan. The Project Manager participated as a member of the evaluation team of World Vision's evaluation and the project provided vitamin A to ADRA and another small private clinic in the District. In addition, PVOs and local NGOs were instrumental in assisting the IGA investigation conducted by the consultant.

I.F. NEW STAFF

Three new senior staff were hired during the first year of the project. Mr. Genner Chipwaila, was hired in May as the new Project Manager, replacing Mr. Henderson Chikhosi. Mr. Chipwaila is the previous Director of the National EPI Program for the MOH.

Ms. Grace Funsani was hired in July to be the Training Coordinator, a newly created position. She will be in charge of revising training curricula and organizing training of both volunteers and MOH staff.

Finally, Ms. Alena Chabwera was hired as the third Field Supervisor to help improve the capability of the MOH to supervise HSAs. She previously worked with Project Hope's CS project in the Thyolo Highlands. (Appendix H.)

The Peace Corps volunteers working on AIDS prevention and food production and preservation were phased out of the project at the end of January 1995. Given the move towards long-term sustainability, they will not be replaced.

An organizational chart of our project in Malawi is provided in Appendix J.

II. FOLLOW-UP OF DIP REVIEW

Each response below follows the points raised by the reviewers.

General
There are several reasons for small increases in objectives:

1. Based on IEF's experience in Malawi, projected modest increases in health objectives are much more realistic than larger increases of twenty percent or more. The previous project's objectives were set very high and as a result the project failed to achieve some of its goals, even though significant progress was made.

2. Because the main emphasis of this project is sustainability, we do not necessarily expect indicators to continue increasing at the same rates. When the project directly supervised HSAs, it had more control over the field work. As the HSAs have been transferred to the MOH the project has much less control for their daily work. IEF would consider the project successful if activities are sustained and indicator levels do not drop appreciably, let alone increase.

3. Indicators such as exclusive breastfeeding will never show statistical significance because the sample size is too low (children < 4 months). This goal reflects our optimism for improvement, but we believe does not set unreasonable targets.

4. The comment regarding the indicator for full immunization being below the present coverage is incorrect. It states that vaccination coverage is already at 83% and the proposed objective is only 75%. The reviewers confused the age groups for the two different indicators. Current vaccination coverage for children 12-23 months of age is indeed 83%. The project proposed to raise vaccination coverage for these children (children 12-23 months) to 90%. The project also proposed to raise the vaccination coverage for children 0-11 months to 75%. This second objective more accurately address the target population for immunization.

Regarding the targeting of specific groups for certain interventions, the project has targeted Nsua Island for special attention because it has no health center and very limited access to health care. Nsua Island is physically separated by the Shire River and is part of the Elephant Marsh. Access is only possible by canoe or motor launch. Although the Shire River is not wide, staff have been reluctant to cross the river because of abundant and dangerous hippopotamus and crocodile found in the river. In the recent past, islanders crossed the river to seek services. Consequently, past surveys have shown that both EPI and vitamin A coverage were very low. A recent survey included with this report has been conducted to help monitor progress in attempting to increase coverage. IEF has also assisted Montfort Hospital in conducting mobile clinics on the island itself.

Bar girls, adolescents and HIV positive individuals have been targeted for HIV/AIDS education activities. Rural villagers, VHVs and VHC members have been targeted for IGAs and drug revolving funds.

Regarding improving community participation, a consultant was hired to assist the project in formalizing its community participation strategy. PRA strategies have been employed in several villages and will continue throughout the life of the project in order to help villages better understand and cope with their health problems and also to help staff understand these problems and apply them to other villages.

Immunizations

While outbreaks of measles can and do occur in communities with high coverage, the project does not feel that a special village level surveillance system for measles is warranted. Outbreaks are rare and are dealt with quickly by existing EPI mechanisms in place. The attached chart shows that measles cases presenting at the hospital or health center are infrequent (Appendix K).

Management of Diarrheal Diseases

1. Messages regarding feeding during diarrhea were inadvertently left out of the DIP, even though the DIP did include objectives for management of diarrheal disease The curriculum for VHVs has the following related messages:
   - When a breast fed child has diarrhea, it is important to continue breast feeding,
   - A child with diarrhea needs food,
   - A child who is recovering from diarrhea needs an extra meal every day for at least a week.

2. Regarding cereal based ORT, neither IEF staff, MOH staff, or other NGOs were aware of any shift in emphasis to cereal based ORT. The message that IEF uses is that if ORS sachets are not available, rice-based or phala-based ORT should be used. Rice has limited availability in Chikwawa district because it is not a staple and needs to be purchased. Very weak phala, a gruel made from the staple corn flour, is in fact often used for the child who is recovering from diarrhea.

3. Current messages on diarrhea emphasize that children with severe diarrhea should be referred to the health center. If and when the Sick Child Algorithm is introduced, IEF will seek to determine its feasibility in this population.

4. IEF will be initiating quality assurance exercises aimed at evaluating the ability of VHVs and mothers in properly managing diarrheal disease. IEF intends to carry out a survey of VHVs over the next six months which will highlight training needs.

Nutrition

1. IEF would like to devote more effort to nutritional interventions, especially to address long term measures that could help with the problem of stunting. However, the food security issues in Chikwawa are difficult and massive and resources would be required to make modest improvements. Nevertheless, IEF does maintain simple messages on selecting, preparing and eating the foods that are available in Chikwawa district.

2. IEF worked with Wellstart in 1994 to complete a one month qualitative research investigation on the issue of exclusive breastfeeding. This research identified beliefs/behaviors that need changing (i.e. colostrum is bad milk, breastmilk is insufficient for very young children, breastfeeding during pregnancy is dangerous for both the mother and the child, etc.); beliefs/behaviors that need supporting, and recommendations for action. Recommendations for action included providing exclusive breastfeeding messages to women at ante-natal clinics, providing messages regarding feeding a sick child during health center and under fives clinic consultations, including a notation recommending exclusive breastfeeding on under fives cards, training female ward attendants, training VHVs to be good role models, and including female advisors in the training process to convince them of the advantages of exclusive breastfeeding and to pass these messages to their young advisees. IEF has followed all of these recommendations. Additionally, as part of these actions, IEF has been able to successfully promote exclusive breastfeeding with the MOH. For further information see, SE Castle, The Social Context of Breastfeeding and Early Supplementation in Chikwawa District, Malawi (1992), Wellstart, April 1993.

   Both Chikwawa District Hospital and Montfort Hospital were recently evaluated by UNICEF to determine if they meet UNICEF's criteria for "Baby Friendly Hospital". When the results of these evaluations are known, IEF will assist the hospitals in improving any areas of deficiency. In addition, IEF will be initiating breastfeeding support groups in some areas, both to further its own objectives and to assist the MOH and Montfort in achieving goals for the Baby Friendly Hospital program.

3. Supporting data on dietary habits to substantiate the claim that food availability and not education is the problem with inappropriate weaning is inconclusive. In an earlier project, IEF attempted a nutrition/weaning intervention to improve infant and child feeding practices, ensuring that infants and children are appropriately fed. Promotion concentrated on increasing the consumption of energy-dense and vitamin A-rich foods as well as the frequency of feedings among the infant and weanling population. A 30 cluster sample survey attempted to measure a 7-day consumption frequency. The follow-up survey data were somewhat difficult to interpret due to the small sample size and a change in the way the questions were asked (consumption to questions on availability). It was also during this time that the drought 1992/93 was on the horizon. The need for exclusive breastfeeding programs became apparent. Additionally, the JHU CSSP standardized survey methodology was also in development. Although, weaning and other nutrition

education continued, and still continues, a decision was made to shift emphasis to breastfeeding as a more realistic and changeable behavior. This was also in part a response to evaluators recommendations (MTE, 1990 and Final evaluation, 1992) to focus on a limited number of priority nutrition behaviors that can/should be changed.

Regardless, IEF recognizes the reviewers concerns that regardless of chronic malnutrition and chronic food security, that small improvements in existing weaning practices may be possible. IEF is considering a review of the nutrition interventions and the means for their measurement.

4. IGA for food security is currently underway on a limited basis and will be expanded if successful. IEF is employing a consultant who has been active both in the area of food security monitoring and food security networking. IEF has also obtained a volunteer who will be trained in permaculture methods and who will mobilize, train and encourage local farmers in these methods.

5. The Malawi MOH is one of the few ministries worldwide that has institutionalized a system for supplementation of children with high-dose vitamin A capsules at both mobile and static clinics. IEF will continue to investigate other long term strategies such as sugar fortification and dietary diversification (in conjunction with the above food security efforts). However, given the problems in Chikwawa with food security, capsule distribution continues to be the most reliable, short-term method of addressing vitamin A deficiency.

6. IEF does indeed plan train TBAs in vitamin A distribution to postpartum women. This was previously stated in the DIP,, on page 28, paragraph 1 and in Table B, page 8 under "Project Design." For clarification a training objective will be added to those on page 9 (of the DIP) to train 50 TBA's in the distribution of one high dose vitamin A capsule to women immediately post-partum. The main obstacle envisioned with TBA distribution of vitamin A involve the recording of doses given by illiterate TBAs.

7. The following messages are commonly used by all HSAs and VHVs who provide vitamin A education:
   a. All children who are not exclusively breastfed need foods rich in vitamin A,
   b. Pregnant and breastfeeding women need foods rich in vitamin A,
   c. Foods that are rich in vitamin A include <u>animal sources:</u> fish, eggs, meat, milk; <u>vegetable sources:</u> dark green leafy (a list of indigenous varieties is provided), pumpkins and sweet potato, and; <u>fruit sources</u>: mangoes and papayas.
   d. To best utilize the vitamin A-rich foods you also need to eat sources of fat (groundnuts, small fish, cooking oil) mixed into the meal,
   e. Vitamin A helps children maintain good eyesight, and helps to fight off serious diarrheal and respiratory infections,
   f. Children should receive half a vitamin A capsule at six months of age and a whole capsule every six months thereafter,

g. Mothers should receive a vitamin A capsule within one month of delivery.

The following cadres are being trained to give these messages at the appropriate times:
- VHV/VHC (house to house, group talks)
- TBAs (postpartum women)
- HSAs (group talks in villages and U/5 clinics)
- Female ward attendants (postpartum women)
- Medical assistants (to clinic patients)

8. Each of the above groups trained in vitamin A education and distribution are also encouraged to remember to make a notation in the appropriate card regarding vitamin A supplementation. In the case of illiterate persons, they are encouraged to find someone who can write to assist them. VHVs use registers to monitor vitamin A coverage and follow-up women and children who do not receive their doses. They compare health cards with the registers to ensure that their targets of supplementation have not already received a vitamin A capsule within the time period in question. Annual register reviews also target random families to ensure that vitamin A is noted in both the registers and the children's and mother's health cards.

HIV/AIDS Prevention

1. A condom use indicator was included in the baseline survey measuring ever/average use of condoms. This indicator has been criticized as being too non-specific, although in this instance it was felt that anything more specific would not have yielded enough positive responses to provide meaningful data. Nonetheless, in the next survey, this indicator will be repeated for comparison purposes, and a new indicator on condom use in the last month or in the last sex act will be added. IEF presently tracks condom supply on a monthly basis to monitor inventory and the success of supply efforts.

2. IEF has embarked on a program of training teachers in HIV/AIDS primarily for the purpose of enabling them to set up Anti-AIDS clubs in schools. IEF will also be assisting teachers in the use of the available AIDS curriculum. IEF will also embark upon attempts to reach out-of-school youth through the training of traditional advisors who deal with children, especially girls, around the time of puberty.

Eye Care

MOH does not routinely administer silver nitrate or antibiotics to newborns to reduce the risk of ophthalmia neonatorum. The prevalence of ophthalmia neonatorum is unknown. A review of Chikwawa District maternity records will be considered to determine whether data exists at maternity wards on ophthalmia neonatorum, what the current levels of knowledge are among nurses and midwives, and whether there are supplies available.

Human Resources

1. It is unlikely that the MOH will be able to fully absorb training plans and schedules, as currently operating. While the MOH is able to maintain adequate personnel levels for such projects (thanks in part to money from World Bank), additional funds needed for training are not available. Currently the allowance given for one day of training is MK160 (US$10.6), or about 25% of a monthly salary for an HSA. At these rates, the only way MOH can support training is with donor support, unless MOH changes their per diem policies. One possible strategy may be to decentralize training to the health center level where staff can be brought together for short periods of time (one day or less) without the need for allowances. This will require highly effective training of at least one member of health center staff to carry out such training, or else the hiring of a District Hospital staff member who can travel around to all the health centers for training.
2. The use of volunteers to deliver village level services can be problematic, especially due to drop-out. To attempt to identify women who are most likely to work well as health volunteers, IEF conducted operation research during the previous project. This research showed that unmarried women or women whose husbands had a non-farming occupation were more likely to complete their assigned responsibilities than married women, especially those whose families depended on subsidence farming. Nevertheless, no matter the marital status of volunteers, it is generally felt that without incentives attrition will remain a significant problem. In earlier projects, IEF provided incentives to volunteers in the form of a uniform and badge and a bar of soap monthly. To comply with the MOH policy not to provide material incentives, IEF has alternatively given opportunities to volunteers to participate in drug revolving funds and income generating activities. PRAs will also be employed to further explore what factors may influence sustainability of volunteers.

Sustainability

1. Both the MOH and Montfort do recognize VHVs and VHCs. The project will work to improve the communication and coordination of these community level workers with their associated institution. Montfort has the continuing support of the Catholic Church, and as such, should be able to sustain its village-level activities, albeit at reduced levels.
2. IEF IGAs will include both those targeted to all community members and those targeted particularly at VHV/VHC members. Experience with both of these methods will be used to determine future direction. Other organizations that have implemented loan schemes such as community banks are being contacted to find out the best methods for starting such projects.
3. IEF has begun discussions with MOH regarding how they might be involved in DRFs. The, MOH has begun its own small DRFs in some villages, centering around malaria medications (aspirin and Fansidar). This experience will enable IEF and MOH to merge their activities at a later stage. The only other agency with considerable experience in DRFs is Save the Children/US, who have published a detailed report on their experiences and have provided training to the Project Manager regarding the start-up of IEF DRFs.

III. CHANGES MADE IN PROJECT DESIGN

III.A. MEASURABLE OBJECTIVES

Only two objectives have been modified since the development of the DIP. Regarding maternal health, the number of CBDs to be trained and deployed has been reduced from 160 to 80 due to the lack of sufficient approved trainers. The rationale for this reduction is the limited number of certified CBD trainers and to bring the indicator down to a realistic level. Experience with CBDs elsewhere has shown that much higher levels of management are required to supervise CBDs than anticipated.

In addition, the project has decided not to train VHVs in treatment of conjunctivitis, instead preferring to focus on the referral to HSAs who would be trained in the use of tetracycline eye ointment (TEO). VHVs will still be trained in recognition of eye conditions, but because TEO is often misused at the community level, HSAs will be responsible for verification of the eye condition, treatment, and/or further referral.

These changes in objectives are pending further discussion and approval with the USAID project officer.

III.B. TYPE/SCOPE OF CHILD SURVIVAL INTERVENTIONS

Reduction of Number of CBDs to be Trained
The Government of Malawi has established certification procedures for CBD trainers. Certification training is only held a few times a years and can only accommodate a few individuals. Consequently, only a few trainers are available to train CBDs. Compounding this problem is the requirement that no more than twenty CBDs can be trained in any one group. As a result, the project has reduced its goal of number of CBDs trained to a more realistic number of 80 for the remaining two years of the project.

Treatment of Conjunctivitis in Project Villages
The DIP originally proposed training all VHVs in the recognition and treatment of conjunctivitis. The supply of TEO has been problematic and will probably continue to be so. Furthermore, their is a tremendous demand for TEO in all communities to be used for a host of other non-eye complaints including treatment of wounds and skin conditions. Thus, serious concerns exist regarding the appropriate use of TEO in villages and the ability of the MOH to continue to supply volunteers with this resource. As a result the project has decided instead to only supply HSAs with TEO and encourage VHVs to make referrals directly to HSAs.

III.C. LOCATION/NUMBER OF PROJECT BENEFICIARIES

No changes have been made to the project regarding location or number of project beneficiaries.

III.D. BUDGET

No changes have been made to the budget since it was submitted with the DIP. See Appendix L.

IV. CONSTRAINTS, UNEXPECTED BENEFITS, AND LESSONS LEARNED

IV.A. CONSTRAINTS

The project faced a number of constraints during its first year. First, the recruitment of a new Project Manager took over six months. Other previous candidates accepted the position, delayed in reporting to the field and eventually informed the Country Director of their decision to accept positions with other agencies. No new activities were initiated until the current Project Manager assumed his duties.

The transfer of HSAs to the MOH was accomplished with insufficient planning due to the MOH's inability to project when it would finish processing the administrative work required to absorb them. This was compounded by the absences of the District Health Officer (DHO) who left on maternity leave and District Health Inspector (DHI) who was and is terminally ill. This uncertainty led to a decrease in the motivational levels and field performance of the HSAs who were anxiously anticipating this transfer.

IV.B. STRATEGIES USED TO OVERCOME CONSTRAINTS

During the six months the project was left without a Project Manager, the Supervision Coordinator managed on-going field activities on an interim basis. Regarding the decreased motivation level of HSAs, the project identified the following support/supervisory activities:

1. Assist the MOH with transporting HSAs to their new duty stations if they had been transferred to a new site upon joining the MOH,

2. Develop a new VHV supervision schedule for the Supervision Coordinator and the Project manager to make random, rotating visits to villages at least twice per week to monitor program progress at the village level.

IV.C. CIRCUMSTANCES FACILITATING IMPLEMENTATION

Circumstances facilitating implementation included the interest of other donors in supporting project activities, the development of both District and local (Nchalo area) AIDS committees to coordinate AIDS programming and the excellent level of collaboration among local PVOs. The project received funding from GTZ to train TBAs in HIV/AIDS education, Action AID to support the Montfort AIDS Counseling Center and village-level activities around the Nchalo area, and UNICEF to initiate anti-AIDS clubs in primary and secondary schools. All AIDS programming has been strongly supported by the local AIDS committees. Finally, the sharing of lessons learned and technical assistance among PVOs has been exceptional, allowing these institutions to confront problems as a groups and thus be more effective with each of their responses.

IV.D. LESSONS LEARNED

Institutions that will sustain project personnel and activities need to be fully-integrated into the project from the start. The hiring of project specific personnel needs to be minimized. The current project was designed to develop an effective infrastructure of community volunteers and then to transfer this structure to the MOH for its continued management. The complexity of this transfer became obvious once it was started and now it is clear that a significant amount of time will be required to build the capacity of the MOH to continue to support community-level activities. In the future, consideration should be given to not hiring project specific staff, and to working directly with the MOH and its field workers to gradually increase their ability to support community-based programming. This style of implementation would avoid many of the difficulties involved with transferring loyal employees from a PVO to the Government, a move that is not always seen as positive by the affected employees and would equally focus on the capacity-building of the MOH as well as that of community-level workers. IEF will take this proposed approach in its new project in Eritrea.

The transfer of personnel from one institution to another requires a detailed plan understood by all involved to avoid any disruption in on-going field activities. Clearly defined objectives and indicators need to be created to measure this process. The transfer of HSAs was not very well planned by the MOH (nor IEF), even though it was anticipated in the DIP, and thus activities and commodity distribution were delayed in many communities during this critical period.

V. PROGRESS IN HIS DATA COLLECTION

V.A. CHARACTERISTICS AND EFFECTIVENESS OF PROJECT HIS

The project health information system consists of the following elements:

1. Family register
2. Monthly commodity distribution forms (ORS, condoms, vitamin A and family planning methods)
3. Monthly health education report forms
4. Annual assessments (register reviews) of the following items:
   a. Vitamin A coverage
   b. Immunization coverage

The HIS has been supplemented by surveys and focus groups studies to gather information related to breastfeeding knowledge and practice, AIDS, and volunteer performance and dropout.

The register system has been effective in the sense that it has allowed volunteers to identify children and mothers requiring follow-up for vitamin A supplementation and vaccination. Over the past four years both vaccination and vitamin A supplementation have increased significantly.

Nevertheless, this system, while perceived as being very useful by volunteers, has experienced problems with accuracy. An evaluation of the system reported that the most common problem was the failure of VHV's to update registers in a timely fashion. For example, not all children born had been entered on the mother's card, leading to inaccurate and incomplete recording of the child's visits. Secondly, registers are only useful for 2-3 years after which time they have to be replaced. This replacement, in addition to the effort necessary to continuously support VHVs in data collection activities has required a considerable amount of effort. Furthermore, it is unclear if the MOH can provide enough support and supervision to effectively continue with this register system.

V.B. HOW HIS DATA ARE BEING COLLECTED AND UTILIZED

HIS data is collected continuously by VHVs using family registers. VHVs maintain these registers in their own households. HSAs abstract data annually from family registers. HSAs and supervisors monitor commodity data on a monthly basis. The Information Coordinator collects data for special surveys and also collects data annually from a sample of village registers to monitor program performance and compare with the results of other surveys and month service data. These results are shared with the MOH, Montfort Hospital and SUCOMA during regular bi-monthly and technical advisory council meetings.

Summary data is shared with volunteers and VHCs on an infrequent basis. Volunteers report using the register data for their everyday work. They mention that they occasionally share this data with VHC members.

V.C. NEEDS FOR FURTHER REFINEMENT OF SYSTEM

At this time it is unclear at what level the register system is sustainable, and if so, whether it is possible to improve data accuracy and collection. Given the dependence on surveys for collecting data on project indicators, it may be more valuable to train key MOH staff in survey methods so that the MOH can carry out annual surveys to determine progress in certain activities. The project will work with the MOH during the second year to answer these questions and if needed, make modifications to the HIS.

VI. BUDGET AND EXPENDITURES

No major budget revisions have been made since the DIP was submitted and approved. Please find the attached pipeline analysis in the Appendix.

While no unit costs per intervention can be identified at this time, the project recently initiated a system of timecards to track the time spent per intervention. This should allow the project to better estimate cost per intervention by the end of project year two.

The budget is currently underspent due to the following reasons: the project carried over from the previous project adequate supplies and commodities so that the purchase of new supplies was not necessary; the Malawi Kwacha devalued to MK15/US$1; the Country Director was on a home leave last year, thus no new project activities were initiated in his absence, and; the HSA staff were turned over to the MOH reducing the payroll. Although the average monthly burn rate has been low, expenditures are now increasing to budgeted levels. IEF is on track regarding making the cash match requirements and does not anticipate any problems. A centralized accounting system is still in effect. However, there have been improvements in the ability for tracking expenditures in Malawi. A spreadsheet program is used to input all monthly expenditures by IEF account code and USAID project budget line items. This allows the Country Director more discretion on making spending decisions locally.

VII. OTHER

In Appendix D and E please find a copy of the maternal health and family planning curricula used by the program to train TBA's and CBD's. The training's emphasize health messages to participants, using open discussion and hand's on practicals in health clinic settings.

VIII. APPENDICES

VITAMIN A FOR CHILD SURVIVAL
CHIKWAWA DISTRICT, MALAWI
USAID CHILD SURVIVAL X

ANNUAL EPI SURVEY

COOPERATIVE AGREEMENT # PAO-0500-A-00-0041-00

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LIST OF ABBREVIATIONS

A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
BCG	Bacillus Calmette-Guerin (Vaccine)
BHR/PVC	Office of Private and Voluntary Cooperation, Bureau for Humanitarian Response (USAID)
CDD	Control of Diarrheal Diseases
CS	Child Survival
CSSP	Child Survival Support Project (JHU)
CS/VA	Child Survival/Vitamin A
DPT	Diptheria, Pertussis, Tetanus (Vaccine)
EPI	Expanded Program on Immunization
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IEC	Information, Education, and Communication
IEF	International Eye Foundation
IMR	Infant Mortality Rate
JHU	Johns Hopkins University
KPC	Knowledge, Practices, and Coverage
LSV	Lower Shire Valley
MOH	Ministry of Health
NGO	Non-Governmental Organization (see also PVO)
OPV	Oral Polio Vaccine
PHC	Primary Health Care
PVO	Private Voluntary Organization (see also NGO)
TBA	Traditional Birth Attendant
TTV	Tetanus Toxoid Vaccine
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VHV	Village Health Volunteer
WHO	World Health Organization

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I. EXECUTIVE SUMMARY

A Coverage, Knowledge and Practices (KPC) survey was conducted in 18 villages around Chikwawa District in the Lower Shire Valley of Malawi in September 1995 for use in the mid-term evaluation of the final phase of the International Eye Foundation's (IEF's) Vitamin A for Child Survival Project. The data was collected as part of a an effort to evaluate IEF's village health volunteers and their use of a community-based register system. Results will aid with the design of new activities and modification of some continuing activities.
The objectives of the survey were to obtain information regarding the knowledge, attitudes and practices of mothers of children 12-23 months of age concerning immunization and Vitamin A supplementation. The objectives of the survey were accomplished within tw weeks.

The Vitamin A for Child Survival Project is being implemented by the International Eye Foundation, under a grant from the A.I.D. Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation (BHR/PVC). The project is implementing Child Survival activities in over 470 communities. The project is currently in its final phase of implementation and phase-over to the Malawian Ministry of Health (MOH). It is scheduled to end August 31, 1997.

The survey was designed by IEF Headquarters and its Malawi field office. External, paid interviewers were trained in WHO cluster sample survey methodology. Three teams of three interviewers and one supervisor conducted this survey. It consisted of ten clusters of up to thirty cohort household survey interviews of mothers with children 12-23 months of age.

Major findings include:

- Children's immunization coverage is high with 83.3% of children 12-23 months of age being completely immunized, and 75.0% being completelt immunized before the age of 12 months.

- Mother's Tetanus Toxoid Vaccine (TTV) coverage, while improved, was still low, with 55.4% of mothers having received three or more doses of TTV.

- Vitamin A supplementation of children 12-23 months of age was 66.7%, an increase from baseline

- Vitamin A supplementation of postpartum women is low, at 40.6%, but improved from baseline. In addition, another 39.4% reported receiving Vitamin A even though there was no documentation.

II. INTRODUCTION

A. BACKGROUND

The project works in Chikwawa District in the Southern Region of Malawi. Chikwawa District was originally chosen because of its dense population, high rates of infant and child mortality and high rate of chronic malnutrition. This district has been severely impacted by the presence of over 100,000 Mozambican refugees, many of whom lived in Malawian villages and utilized already

overburdened health resources.

Malawi has some of the highest child mortality rates in the world. The Malawi 1992 Demographic and Health Survey measured an infant mortality rate (IMR) of 136 per 1000 and an under five's mortality rate of 240 per 1000. This means that nearly one-quarter of all children born in Malawi do not reach their fifth birthday. Chikwawa District rates closely mirror the national rates.

In Chikwawa District, major causes of child morbidity include malaria and diarrheal diseases. The leading causes of child mortality are malnutrition, AIDS-related complaints, pneumonia, measles, malaria and diarrhea diseases, all of which are devastating when accompanied with vitamin A deficiency. The maternal mortality rate is approximately 450 per 100,000 according to a 1990 Malawi MOH population-based study in the country's Southern Region.

Vitamin A deficiency is a significant public health problem in Malawi. A 1983 population-based survey of children conducted by the MOH, Johns Hopkins University and the IEF in the Lower Shire Valley revealed a prevalence of active xerophthalmia of 3.9%. Night blindness prevalence was five times in excess of the World Health Organization's (WHO) criteria for a problem of public health significance while corneal scars were 10 times above WHO diagnostic criteria. Similarly, in 1992, the current project analyzed serum retinol levels of 50 children admitted to the Southern Region's Central Hospital for malaria. All 50 children had abnormally low serum retinol levels.

Malnutrition is a serious health problem. Recent nutritional assessments have shown a 3.5% prevalence of moderate to severe wasting (<80% weight for height) and a 49% prevalence of moderate to severe stunting (<90% of height for age), one of the highest rates of chronic malnutrition in the world. Only 3% of mothers exclusively breastfeed their children during the first four months of life (Malawi Demographic and Health Survey, 1992).

Chikwawa District vaccination coverage is significantly lower than national levels. Baseline data show only 65% of children 12-24 months of age are fully immunized and 65% were immunized against measles compared with respective national figures of 82% and 86%. District Tetanus Toxoid Vaccination (TTV) coverage is abysmally low, with only 31% of mothers having received at least two doses of TTV compared with the national average of 86%.

The project goal is to decrease infant and child morbidity and mortality in Chikwawa District in Malawi's Lower Shire Valley through vitamin A supplementation, improved nutrition, infection control, improved maternal care, increased family planning and HIV/AIDS prevention.

Principal interventions and their associated beneficiary populations are as follows: 1) vitamin A supplementation of children under 6 years of age and postpartum women, 2) diarrheal disease management of children under 24 months of age, 3) nutrition education for mothers with children under two years of age, emphasizing exclusive breastfeeding and timely supplementation with appropriate weaning foods, 4) support of MOH immunization activities focusing on children under 12 months of age and women of child-bearing age, 5) training of MOH personnel, including health surveillance assistants (HSAs), health assistants, health inspectors, nurses, medical assistants and clinical officers in the treatment

of vitamin A deficiency and control of diarrheal diseases (CDD). 6) provision of HIV/AIDS education and distribution of condoms, and 7) training and support of traditional healers in primary eye care and AIDS prevention.

B. OBJECTIVES OF THE SURVEY

The objectives of the survey were to provide the IEF with information about the following issues:

- Coverage rates of BCG, DPT3, OPV3, measles vaccines and drop out rates between series antigens.
- Coverage rates of vitamin A capsule distribution in the last six months.
- For mothers, the coverage rates of TTV and vitamin A capsule distribution (pregnant mothers).

The data collected will assist the project with planning, management and assessment of project activities targeted towards changing behaviors at the household level.

III. METHODOLOGY

A. SAMPLING PROCEDURES

Two villages were chosen at random from each of nine health center catchment areas. In each village a point in the center of the village was chosen and a pen was spun, the point determining the direction in which the survey team located the nearest house. The team then counted the number of houses to the boundary of the village and chose a house at random to begin with. The team then proceeded to survey each household, in each case choosing the nearest household. At each household, a short demographic survey was completed and if the household contained any children 12-23 months of age the complete interview was administered with respect to the youngest child in that age group in the household. A calendar of events going back to 1945 was prepared to assist interviewers in determining the ages of mothers. The number of questionnaires completed in each village varied depending on the number of VHVs and the completeness of their registers. In general ten questionnaires were completed in each village.

The sample reflects mothers with one or more (live) children under 12-23 months of age. Mothers who have no children in this age group, although they may have given birth in the past two years, were not included for interview. There were no refusals; all villages were notified a day in advance to ensure cooperation.

B. SURVEY FORM

The survey form (Appendix) was a modification of the JHU PVO-CSSP standard survey questionnaire. The forms were translated into Chichewa (Malawi national language), re-translated into English, modified and pre-tested. Three enumerators, who had worked with IEF on several surveys in the past, were hired and trained in a one day session.

C. TIME FRAME & SURVEY TEAMS

The survey was started on 20th September, 1995 and was completed on 30th September, 1995, a total of nine working days. The survey team was supervised by Mr. George Mekeseni, IEF Evaluation Coordinator.

D. DATA ENTRY, ANALYSIS & REPORTING

Data were entered by IEF staff in Blantyre into a personal computer using EPI-INFO software. EPI-INFO was also used to perform checks on the data and basic tabulations. Data was cleaned and analyzed by the Country Director, Mr. Canner.

IV. RESULTS AND DISCUSSION

A. DEMOGRAPHIC INFORMATION

A total of 175 mothers in 18 villages were interviewed. The sample size per village ranged from 4 to 14.

The age of the mothers interviewed is given in Table 1. As can be seen in the table the average age of mothers was less than thirty years.

Table 1
Age of Mothers Interviewed

Age of Mother	No. (%)
<20 years	25 (14.3)
20-29 years	89 (50.9)
30-39 years	49 (28.0)
40+ years	12 (6.9)
	175 (100)

B. ACCESS TO/UTILIZATION OF HEALTH CARE FOR MOTHERS & CHILDREN

Road to Health Cards

Road to Health cards are issued by the Ministry of Health and all other health providers to children upon birth. If a Road to Health card is lost or temporarily missing an additional card will be issued. It is suggested that women keep these cards until the child is at least five years of age. Thus, a Road to Health card indicates that there has been the most basic interaction between the health system and the child. The absence of a card does not assume that there has been no interaction; the presence of a card does indicate that there has been interaction. Overall, 2.9% of the children had no Road to Health card, a somewhat lower rate than found in the baseline survey.

All analyses based upon collection of information from Road to Health cards (immunization, vitamin A supplementation, growth monitoring) will represent children with these cards. Children without Road to Health cards are assumed to not be fully immunized and not to have received vitamin A in the past 6 months.

Table 2
Does Mother have Road to Health Card for Child?

	No. (%)
Yes	170 (97.1)
No	4 (2.3)
Lost	1 (0.6)
	175 (100)

Maternal Health Cards

The mother, as well, is given one or more cards for recording various services received. When she is pregnant and visits an ante-natal clinic she receives an ante-natal card which is only used during that pregnancy. In addition she may also receive a TTV card when she receives her first TTV so that future vaccinations can be recorded. Presence of an antenatal card was not assessed in this survey. As can be seen in Table 4, 81.1% of women had a TTV card and 26.6% had lost them, indicating the need to retain the card for a longer period of time.

Table 3
Does Mother have TTV Card?

	No. (%)
Yes	142 (81.1)
No	13 (7.4)
Lost	20 (11.5)
	175 (100)

Discussion

Access to care for children under 24 months age in this sample is very good as evidenced by the large proportion of mothers who have Road to Health Cards for their children. Access to care for the mothers themselves is less complete as evidenced by the proportions of women with TTV cards. About four-fifths of the women had TTV cards. Both figures are slightly better than the correseponding figures from the baseline survey.

If we include a lost card as evidence of access to care, the figure rises to 88.5% for TTV cards. These figures suggest good access to care for mothers as well. Nevertheless, MOH and project staff need to remind mothers as to the importance of guarding TTV cards.

C. KNOWLEDGE & PRACTICE REGARDING VITAMIN A SUPPLEMENTATION

Vitamin A Supplementation of Children

Vitamin A supplementation of children under 6 years of age is generally recorded on the Road to Health card. Among children in the survey aged 12-23 months, 66.7% had received a vitamin A capsule in the last six months. This rate is somewhat higher than that found during the baseline survey (49.4%).

Vitamin A Supplementation of Post-Natal Mothers

Vitamin A supplementation of post-natal mothers is recorded either on the TTV card or the Road to Health card. However, it is sometimes recorded elsewhere or not at all. Of all mothers in the survey, 40.6% were documented as having received a vitamin A capsule within two months of delivery. Another 39.4%

reported having received a capsule but with no documentation and 3.4% received a capsule after the recommended two month limit. The first figure (documented supplementation within two months) is somwhat higher than that found during the baseline survey (30.3%). The second figure (undocumented supplementation within two months) is substantially higher than that found during the baseline survey (6%). The third figure (supplementation after two months) declined slightly from baseline (6%).

Discussion

While Vitamin A supplementation of children has improved since past surveys, the coverage noted by this survey is much lower than recorded by internal IEF family register audits which suggest that the coverage rate may actually be as high as 75-80%. Reasons for this discrepancy could include any of the following:

- Failure of HSAs and VHVs to record vitamin A supplied in the village on the Road to Health Cards so that the full extent of vitamin A coverage can be documented.

- Failure of VHVs to record all eligible children in their family registers.

HSAs and VHVs need to be encouraged to record vitamin A supplied in the village on the Road to Health Cards and to ensure that their registers are regularly updated to record all children in a village.

Vitamin A supplementation of postpartum women is improving but also needs attention. Special efforts need to be undertaken to improve this situation, including:

- Increasing awareness of post-partum women and maternity nurses of the need for supplementation. Also increase awareness of primary health care (PHC) providers regarding possibility of supplementing mothers at first immunization visit.

- Education of TBAs regarding vitamin A supplementation and providing TBAs with vitamin A capsules.

- Increased education of VHVs and HSAs to provide vitamin A in the villages during household visits.

- Increasing awareness of health care workers regarding recording of mother's vitamin A supplementation and increasing consensus among health care workers as to where to note mother's vitamin A supplementation.

It is also clear that there is considerable problem in this area with recording as nearly as many women reported having received Vitamin A as actually had it recorded in their cards. Thus, surveys focusing on recorded Vitamin A supplementation will substantially underestimate coverage (assuming even some of the women are correct in their report). Health personnel need to be diligent to record Vitamin A given to mothers. At this time there is considerable confusion over this issue because MOH policy is to record maternal Vitamin A supplementation on the TTV card but often the card is not available or there is

no room. Clearly a better place would be the Under-5 card since there needs to be supplementation with each new child. However, in order to conform with current MOH practice, health personnel are instructed to record on the TTV card and if it doesn't exist or there is no room to record on the Under-5 cards. IEF survey enumerators are then asked to check both cards when assesing Vitamin A coverage.

D. IMMUNIZATIONS

Immunization Coverage

Road to health cards were used to determine immunization coverage for children aged 12 to 23 months. All children without a Road to Health Card were assumed not to have received any immunizations. Clearly, this is a conservative assumption and will lead to an underestimate of coverage. However the bias is relatively small since less than 3% of children had no card.

Immunization coverage is listed in Table 4. As an indicator of access to health services we found that 95.8% of children had received BCG and 95.8% had received DPT1. Compliance with the DPT and OPV schedules was good: 87.5% received all the DPTs and 88.9% received all three OPVs. Measles coverage was 87.5%.

Full coverage is defined as having received all three DPTs, all three OPVs and measles vaccine. Full coverage was achieved in 83.3% of children.

A dropout is defined as a child who received DPT1 vaccine but did not receive DPT3 vaccine. Given the short space between DPT vaccines, this type of dropout indicates a serious failure of the system to maintain contact with a mother. In this survey 8.7% of children 12-23 months who received DPT1 failed to receive DPT3.

Table 4
Immunization Coverage for Children 12-23 months
(n=72)

	No. (%)	By 12 months (%)
BCG	69 (95.8)	68 (94.4)
DPT 1	69 (95.8)	68 (94.4)
DPT 1-3	63 (87.5)	62 (86.1)
OPV 1-3	64 (88.9)	63 (87.5)
Measles	63 (87.5)	61 (84.7)
Full	60 (83.3)	54 (75.0)
Dropout (n=69)	6 (8.7)	

Timing of Measles Immunizations

Table 6 shows at what age children actually received their measles vaccinations. It is somewhat comforting that most of the errors in belief and practice

regarding measles vaccine are in the direction of too early vaccination, a problem that health center staff should have some control over.

Table 5
Timing of Measles Immunizations

Age when measles was given	No. (%)
Before 9 months	19 (25.0)
Nine months	28 (36.8)
10-12 months	27 (35.5)
After 12 months	2 (2.6)
	76 (100)

Tetanus Toxoid Vaccination (TTV)

About four-fifths (81.1%) of mothers had a TTV card. Almost one-fifth of mothers (19.6%) had no TTV inoculation (all but one of these had no TTV card); 75.4% had two or more TTV inoculations. 21.1% of mothers had received all five inoculations. All of these figures are slightly higher than those found during the baseline survey.

Discussion

Immunization rates in all areas have improved significantly in the past few years but there is still significant room for improvement. Rates have not changed substanitially since baseline. This however, might be expected due to substantial disruption in HSA activities due to turnover to MOH.

A substantial proportion of women continue to be unvaccinated with TTV. Among vaccinated women, however, the number of vaccinations per women has improved since baseline. Activities need to focus on identifying women who have never been vaccinated. TBAs and advisors may be valuable in this regard.

As with the rest of the District it is disturbing that 25.0% of children were vaccinated with measles vaccine before nine months. Health care workers need to improve their field procedures to ensure that children are not vaccinated until after nine months of ag .

I.D. #: ___ ___

IEF/MALAWI CHILD SURVIVAL PROJECT
HEALTH INFORMATION SYSTEM EVALUATION
CARD VERSUS REGISTER

All questions to be addressed to the mother with a child under 2 (less than 24 months of age) chosen at random from the village.

Interview date ___/___/___ Reschedule interview ___/___/___

Village and T/A: _____

Volunteer Name: _____

1. Name of mother: _____

   Birth date: _____ / _____ / _____ Age: ___ ___

2. For youngest child under 24 months:

   Name of child: _____

   Birth date: _____ / _____ / _____ Months: ___ ___

3. Do you have a TTV card or child's Under-5 card with information on TTV recorded?
   1 yes (must see card)
   2 no ----------> go to #5
   3 lost ----------> go to #5
   4 don't know ----------> go to #5

4.

Look on the mother's card and record the number of TTV injections received:

0 1 2 3 4 5

5. Does [name of child] have an "Under five" card?
   1 yes (must see card)
   2 no ----------> go to #7
   3 lost ----------> go to #7
   4 don't know ----------> go to #7

6.

Look at the card and record the dates [illegible] provided

	date
BCG	___ / ___ / ___
OPV:	
1st	___ / ___ / ___
2nd	___ / ___ / ___
3rd	___ / ___ / ___
DPT:	
1st	___ / ___ / ___
2nd	___ / ___ / ___
3rd	___ / ___ / ___
Measles	___ / ___ / ___

7.

Record the dates and dosage of all vitamin A capsules given to the child and mother in the space below:

	Date	Source
Child:		
1st	___ / ___ / ___	card verbal
2nd	___ / ___ / ___	card verbal
3rd	___ / ___ / ___	card verbal
4th	___ / ___ / ___	card verbal
Mother (Check U/5 Card, TTV Card, ANC Card):		
	___ / ___ / ___	card verbal

8. If the child is 6-23 months of age and has not received Vitamin A in the past six months ask the mother and the VHV:
Why hasn't child received Vitamin A in last six months?

VITAMIN A FOR CHILD SURVIVAL
CHIKWAWA DISTRICT, MALAWI
USAID CHILD SURVIVAL IX

DOLO EXCLUSIVE BREASTFEEDING AND SUGAR CONSUMPTION SURVEY

COOPERATIVE AGREEMENT # FAO-0500-A-00-4041-00

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September 1994

LIST OF ABBREVIATIONS

A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
BHR/PVC	Office of Private and Voluntary Cooperation, Bureau for Humanitarian Response (USAID)
CDD	Control of Diarrheal Diseases
CS	Child Survival
CSSP	Child Survival Support Project (JHU)
CS/VA	Child Survival/Vitamin A
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
EA	Enumeration Area
EPI	Expanded Program on Immunization
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IEC	Information, Education, and Communication
IEF	International Eye Foundation
JHU	Johns Hopkins University
KPC	Knowledge, Practices, and Coverage
LSV	Lower Shire Valley
MOH	Ministry of Health
NGO	Non-Governmental Organization (see also PVO)
OR	Odds Ratio
OPV	Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PVO	Private Voluntary Organization (see also NGO)
SUCOMA	Sugar Company of Malawi
TBA	Traditional Birth Attendant
TTV	Tetanus Toxoid Vaccine
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
VHV	Village Health Volunteer
WHO	World Health Organization

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APPENDIX
Questionnaire

I. EXECUTIVE SUMMARY

A Knowledge and Practice survey was conducted in 30 rural villages in the area around Dolo Health Centre in Chikwawa District in the Lower Shire Valley of Malawi in July 1995 for use in the mid-term evaluation of the final phase of the International Eye Foundation's (IEF's) Vitamin A for Child Survival Project. Results will aid with the design of new activities and modification of some continuing activities.

The main objective of the survey was to obtain information regarding the knowledge, attitudes and practices of mothers of children under one year of age concerning exclusive breastfeeding. A secondary objective was to collect information on access, availability and consumption of sugar with a view to evaluating the potential impact of fortifying sugar with Vitamin A. The objectives of the survey were accomplished within three weeks.

The Vitamin A for Child Survival Project is being implemented by the International Eye Foundation, under a grant from the A.I.D. Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation (BHR/PVC). The project is implementing Child Survival activities in over 470 communities. The project is currently in its final phase of implementation and phase-over to the Malawian Ministry of Health (MOH). It is scheduled to end August 31, 1997.

The survey was designed by IEF Headquarters and its Malawi field office. External, paid interviewers were trained in WHO cluster sample survey methodology. A team of five interviewers and one supervisor conducted this survey. It consisted of thirty clusters of twhenty cohort household survey interviews of mothers with children less than one years of age.

Major findings include:

- The rate of exclusive breastfeeding for children under four months of age is low at 20.8%. However, if water is not considered as a supplement the rate increases to 48.0%. The rates for infants three months of age are 11.6% and 23.3% respectively.

II. INTRODUCTION

A. BACKGROUND

The project works in Chikwawa District in the Southern Region of Malawi. Chikwawa District was originally chosen because of its dense population, high rates of infant and child mortality and high rate of chronic malnutrition. This district has been severely impacted by the presence of over 100,000 Mozambican refugees, many of whom lived in Malawian villages and utilized already overburdened health resources.

Malawi has some of the highest child mortality rates in the world. The Malawi 1992 Demographic and Health Survey measured an infant mortality rate (IMR) of 136 per 1000 and an under five's mortality rate of 240 per 1000. This means that nearly one-quarter of all children born in Malawi do not reach their fifth

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birthday. Chikwawa District rates closely mirror the national rates.

In Chikwawa District, major causes of child morbidity include malaria and diarrheal diseases. The leading causes of child mortality are malnutrition, AIDS-related complaints, pneumonia, measles, malaria and diarrhea diseases, all of which are devastating when accompanied with vitamin A deficiency. The maternal mortality rate is approximately 450 per 100,000 according to a 1990 Malawi MOH population-based study in the country's Southern Region.

Vitamin A deficiency is a significant public health problem in Malawi. A 1983 population-based survey of children conducted by the MOH, Johns Hopkins University and the IEF in the Lower Shire Valley revealed a prevalence of active xerophthalmia of 3.9%. Night blindness prevalence was five times in excess of the World Health Organization's (WHO) criteria for a problem of public health significance while corneal scars were 10 times above WHO diagnostic criteria. Similarly, in 1992, the current project analyzed serum retinol levels of 50 children admitted to the Southern Region's Central Hospital for malaria. All 50 children had abnormally low serum retinol levels.

Malnutrition is a serious health problem. Recent nutritional assessments have shown a 3.5% prevalence of moderate to severe wasting (<80% weight for height) and a 49% prevalence of moderate to severe stunting (<90% of height for age), one of the highest rates of chronic malnutrition in the world. Only 3% of mothers exclusively breastfeed their children during the first four months of life (Malawi Demographic and Health Survey, 1992).

The project goal is to decrease infant and child morbidity and mortality in Chikwawa District in Malawi's Lower Shire Valley through vitamin A supplementation, improved nutrition, infection control, improved maternal care, increased family planning and HIV/AIDS prevention.

Principal interventions and their associated beneficiary populations are as follows: 1) vitamin A supplementation of children under 6 years of age and postpartum women, 2) diarrheal disease management of children under 24 months of age, 3) nutrition education for mothers with children under two years of age, emphasizing exclusive breastfeeding and timely supplementation with appropriate weaning foods, 4) support of MOH immunization activities focusing on children under 12 months of age and women of child-bearing age, 5) training of MOH personnel, including health surveillance assistants (HSAs), health assistants, health inspectors, nurses, medical assistants and clinical officers in the treatment of vitamin A deficiency and control of diarrheal diseases (CDD), 6) provision of HIV/AIDS education and distribution of condoms, and 7) training and support of traditional healers in primary eye care and AIDS prevention.

B. OBJECTIVES OF THE SURVEY

The objectives of the survey were to provide the IEF with information about the following issues:

- Knowledge of mothers of children under one year of age about appropriate nutrition/weaning practices

- Actual practices of mothers with regard to the above and target groups
- Availability, access and consumption of sugar among children

The data collected will assist the project with planning, management and assessment of project activities targeted towards changing behaviors at the household level.

III. METHODOLOGY

A. SAMPLING PROCEDURES

The most recent census information available is for 1987. Census data is collected by enumeration area (EA) which are designed to be approximately equal in population. Thus, some EAs include several villages and some villages span two EAs. The village was used as the sampling unit (total villages = xxx). Village populations were listed in EA number order to form a sample frame. Thirty villages were chosen at random using the cumulative populations from the sample frame.

In each village a point in the center of the village was chosen and a pen was spun, the point determining the direction in which the survey team located the nearest house. The team then counted the number of houses to the boundary of the village and chose a house at random to begin with. The team then proceeded to survey each household, in each case choosing the nearest household. At each household, a short demographic survey was completed and if the household contained any children under one year (12 months) of age the complete interview was administered with respect to the youngest child in the household. A calendar of events going back to 1945 was prepared to assist interviewers in determining the ages of mothers. The survey team completed their work in the village when twenty questionnaires had been completed or when there were no more children under the age of one year.

The sample reflects mothers with one or more (live) children under 12 months of age. Mothers who have no children in this age group, although they may have given birth in the past two years, were not included for interview. There were no refusals; all villages were notified a day in advance to ensure cooperation.

B. SURVEY FORM

The survey form (Appendix) was a modification of the JHU PVO-CSSP standard survey questionnaire. Questions were added concerning sugar availability and consumption and the exclusive breastfeeding section was expanded to include a historical assessment. The forms were translated into Chichewa (Malawi national language), re-translated into English, modified and pre-tested. Five enumerators, who had worked with IEF on several surveys in the past, were hired and trained over a two day period with time set aside for practice. After each practice session the team reviewed problems and appropriate modifications were made to the survey questionnaire.

C. TIME FRAME & SURVEY TEAMS

The survey was started on July 18, 1995 and was completed on 1st August, 1995, a total of thirteen working days. The team of enumertors was supervised by Mr. George Mekeseni, IEF Evaluation Coordinator.

D. DATA ENTRY, ANALYSIS & REPORTING

Data were entered by IEF staff in Blantyre into a personal computer using EPI-INFO software. EPI-INFO was also used to perform checks on the data and basic tabulations. Data was cleaned and analyzed by the Country Director, Mr. Canner.

IV. RESULTS AND DISCUSSION

A. DEMOGRAPHIC INFORMATION

The age of the mothers interviewed is given in Table 1. As can be seen in the table the average age of mothers was less than thirty years.

Table 1
Age of Mothers Interviewed

Age of Mother	No. (%)
<20 years	67 (12.1)
20-29 years	236 (42.8)
30-39 years	181 (32.8)
40+ years	66 (12.0)
Unknown	2 (0.4)
	552 (100)

Few mothers were literate as can be seen in Table 2, consistent with other surveys in Chikwawa District. It is encouraging to see that the youngest age groups have the greatest proportion of literate mothers.

Table 2
Literacy of Mothers by Age

Age of Mother	No. (%)
<20 years	22 (32.9)
20-29 years	44 (18.7)
30-39 years	23 (12.9)
40+ years	5 (7.6)
Unknown	0 (0.0)
	94 (17.1)

Most mothers (87.1%) had a source of income, however small. The most common sources of income by far was harvesting and/or selling farm products. Only 1.1% had what could be considered a regular source of income: household servant, shopkeeper, etc.

Conclusion

Only 17% of mothers are literate, slightly less than that of all of Chikwawa (22%). The Project should continue to utilized adult learning methodologies such as demonstrations, role plays, pictorial presentations and group discussions.

Many mothers are engaged in some sort of work outside of the household, whether it be in the fields or in the market. As a result project activities should take place with due consideration of the mother's large workload and busy schedule.

B. KNOWLEDGE & PRACTICE OF WEANING

Knowledge & Attitude Regarding 1st Introduction of Supplemental Foods

Over one half of the mothers (43.5%) reported that weaning foods should be first introduced between four and six months of life; 50.9% said it should be before four months of life; 4.9% said after six months. Only 0.7% of mothers did not know when weaning foods should be introduced. There were no discernable trends in this beliefs by mothers' age. However, illiterate women were 2.4 times as likely as those who were literate to report that weaning foods should be introduced before four months of age (p=0.0002). The knowledge levels of this population are somewhat lower than the general population in Chikwawa, where over 60% of mothers reported that weaning foods should be introduced at four months of age or later, as opposed to 48.5% in this survey.

Practice Regarding 1st Introduction of Supplemental Foods

Only 38.3% of infants under four months of age are being exclusively breastfed. However, if one does not consider water as a supplement this figure increases to 55.3%. Considering only children three months of age, the figures are 10.0% and 16.7.%, respectively. The figures for infants under four months of age are considerably better than the figures for all of Chikwawa (20.8% and 48.0% respectively), while the figures for children three months of age are slightly less (11.6% and 23.3%, respectively)

Comparing the results in Table 3 with the comparable results for Chikwawa District, we find that for ages 0-2 the percentage supplemented with food or water was 20 points lower in Dolo than in Chikwawa, but that by the age of three months the figures are nearly the same.

In order to obtain alternative estimates of the incidence of introduction of supplemental foods we asked all women when they first introduced certain foods to their child. Table 4 and Figure 1 summarize the results in terms of life table survival probabilties.

Clearly, practice regarding exclusive breastfeeding is lagging behind knowledge. Of those women with children under four months of age who said supplementation should start at four months or later, the 62.2% had already begun supplementing with either water or food.

Early supplementation is only a concern if it gives rise to adverse health consequences in the infant. Giving support to the claim that early supplementation is harmful to infants, 14.9% of children under the age of four months who received supplemental food had diarrhea in the last two weeks, versus 5.6% of children who were exclusively breastfed (p=0.087). A similar finding was noted when compariing children receiving supplemental food with those receiving only breastmilk or water.

Table 3
Early Supplementation by Age

Age	% given food and/ or water	% given at least food
<1 mo	48.5	18.2
1	47.6	28.6
2	66.7	55.6
3	90.0	83.3
0-3	61.7	44.7

Table 4
Probability of not receiving certain foods by a given age

Age	Probability of not receiving:					
	Water/ Milk	Phala	Nsima	Ndiwo	Any (inc.H20)	Food
1	0.906	0.971	1.000	1.000	0.900	0.971
2	0.760	0.893	1.000	1.000	0.732	0.893
3	0.604	0.752	0.998	0.996	0.567	0.752
4	0.399	0.544	0.993	0.980	0.356	0.544
5	0.173	0.258	0.979	0.939	0.121	0.258
6	0.082	0.129	0.935	0.875	0.047	0.124
7	0.025	0.021	0.787	0.766	0.002	0.018
8	0.015	0.008	0.568	0.580	0.000	0.008
9	0.008	0.000	0.336	0.382	0.000	0.003
10	0.000	0.000	0.162	0.234	0.000	0.000
11	0.000	0.000	0.111	0.166	0.000	0.000
12	0.000	0.000	0.556	0.103	0.000	0.000

Conclusion

Significant improvements have been achieved regarding the knowledge and practice of inappropriate early introduction of weaning foods. These results also compare favorably to the National Demographic and Health Survey (DHS). However, there is still substantial room for improvement in knowledge and large gaps between knowledge and practice. It is apparent that the special efforts aimed at increasing exclusive breastfeeding are having success in the first two months of life but less success in subsequent months.

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C. ACCESS, AVAILABILITY AND CONSUMPTION OF SUGAR

Availability and Access

Nearly one-quarter of women (24.7%) reported that they had sugar in the house currently. Of these, 34.1% obtained the sugar from a store in the village, 13.3% obtained the sugar from Ngabu (the nearest large trading centre) and 51.9% obtained it from other smaller and closer trading centers such as Nsangwe (23) and Sorgir (30) in Nsanje District.

Consumption

Each mother was asked about the sugar consumption of all children under six years of age in the household. Over three-quarters (78.4%) claimed that at least one child in the household consumed sugar. Of these households the consumption patterns are as follows:

Table 5
Sugar Consumption by Age

Age (mo)	frequency per month		Mean quantity per serving (teaspoons)		Mean quantity per month (teaspoons)	
	Mean	Median	Mean	Median	Mean	Median
<6	12.3	0.0	1.0	0.0	24.0	0.0
6-11	27.9	10.0	1.3	1.0	63.2	10.0
12-23	----	----	----	----	-----	----
24-35	43.6	30.0	10.5	3.0	437.1	225.0
36-47	39.8	30.0	10.5	3.0	464.6	90.0
48-59	42.0	30.0	14.4	3.0	688.5	90.0
60-71	35.3	30.0	14.9	3.0	657.6	90.0

* 1T = 3t; 1C = 16t

Conclusion

Children in this area consumed an average of about 3 teaspoons of sugar per day. While this is encouraging in view of the possibility of fortifying sugar with Vitamin it is of concern that so few households actually had sugar indicating that the consumption figures are either exaggerated or idealistic. A better way to ascertain realistic consumption figures would have been to ask about daily consumption for the previous week or even the previous 1-2 days.

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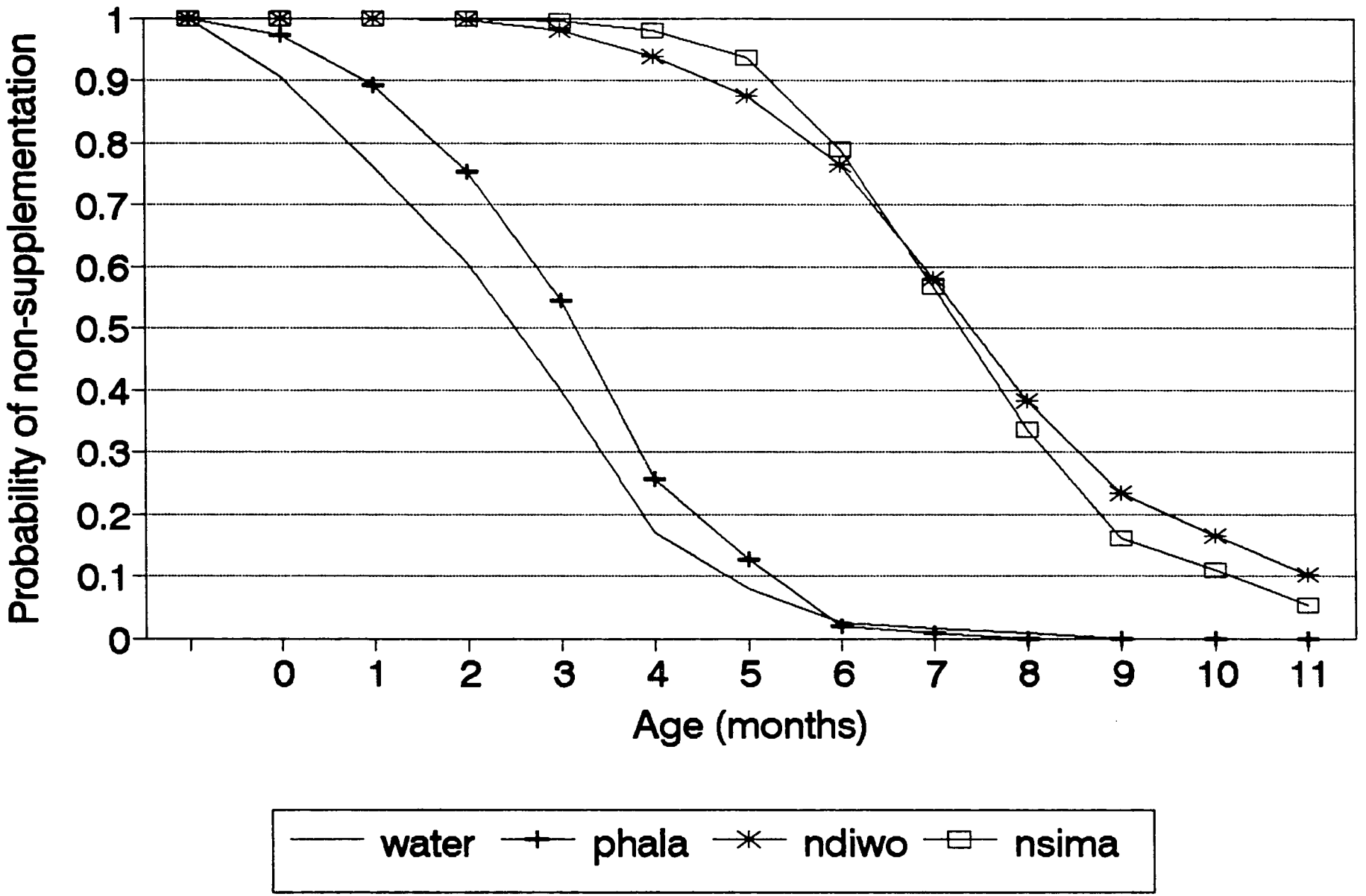
FIGURE 1

Time to supplementation

Dolo area, Chikwawa District



ID #: ___ ___ ___

IEF/MALAWI CHILD SURVIVAL PROJECT
DOLO BREASTFEEDING SURVEY

All questions to be addressed to the mother with a child under 1 (less than 12 months of age).

Interview date ___/___/___ Reschedule interview ___/___/___

Interviewer name: _____

Village: _____

1. Name of mother: _____

   Age of mother: _____ _____ (years)

2. For youngest child under 24 months:

   Name of child: _____

   Birth date: _____ / _____ / _____ Months: ___ ___

Mother's education/occupation

3. What level of school have you completed?
   1 none
   2 primary but I can't read
   3 primary and I'm able to read
   4 secondary

4. Do you have any work or method of getting money? **(Circle all answers given)**
   1 no
   2 handicraft, sewing, etc.
   3 harvesting, fruit picking
   4 casual labour
   5 selling farm products
   6 selling food, milk
   7 servant/household services
   8 storekeeper
   9 fulltime employed
   10 other (specify: _____)

5. Did **[name of child]** suffer from diarrhea (three or more stools in one day) in the last two weeks?
   1 yes
   2 no
   3 don't know

Breastfeeding/Nutrition

6. Do you breastfeed **[name of child]** ?
   1 yes ----------> go to #8

7. Have you ever breastfed **[name of child]** ?
   1 yes
   2 no ----------> **go to #9**

8. How long after delivery did you start breastfeeding **[name of child]**?
   1 one hour
   2 one to eight hours
   3 over eight hours
   4 don't remember

9. When should mothers start supplementary feeding?
   1 between four and six months
   2 before four months
   3 after six months
   4 don't know

10. Do you feed **[name of child]**:

	Yes	No	DK
a. water or tea?	1	2	3
b. cow's milk or formula?	1	2	3
c. soft food such as phala?	1	2	3
d. fruit or fruit juice?	1	2	3
e. carrot, mango or papaya?	1	2	3
f. green leafy vegetables such as pumpkin leaves/amaranth?	1	2	3
g. meat or fish?	1	2	3
h. peas, beans or groundnuts?	1	2	3
i. eggs or yogurt?	1	2	3

11. **Fill in chart on page 3 regarding foods**

12. **Fill in chart on page 4 regarding sugar**

13. Is there sugar in the house currently?
    1 yes
    2 no --------> **End interview**

14. Where was it purchased?
    1 friend
    2 village store
    3 Ngabu
    4 elsewhere: _____

11. Has [name of child] ever received any food or drink other than breastmilk?
1 yes
2 no -----> **go to question #12**

In each column write the frequency of food given in each month of life (record as quantity per time, for example "phala: one cup per day"):

Age of child (in months)======>

Food	0	1	2	3	4	5	6	7	8	9	10	11
Herbs/ Herb Tea												
Water/ Milk												
Phala												
Nsima												
Relish												

Relish=vegetables, fruits, meats, eggs

12. Have any children under the age of six in this household ever consumed sugar?
   1 yes
   2 no -----> **go to question #13**

For each child under six years of age in the houshold ask the following and fill in chart:

1. Name of child

2. Age of child (approximate)

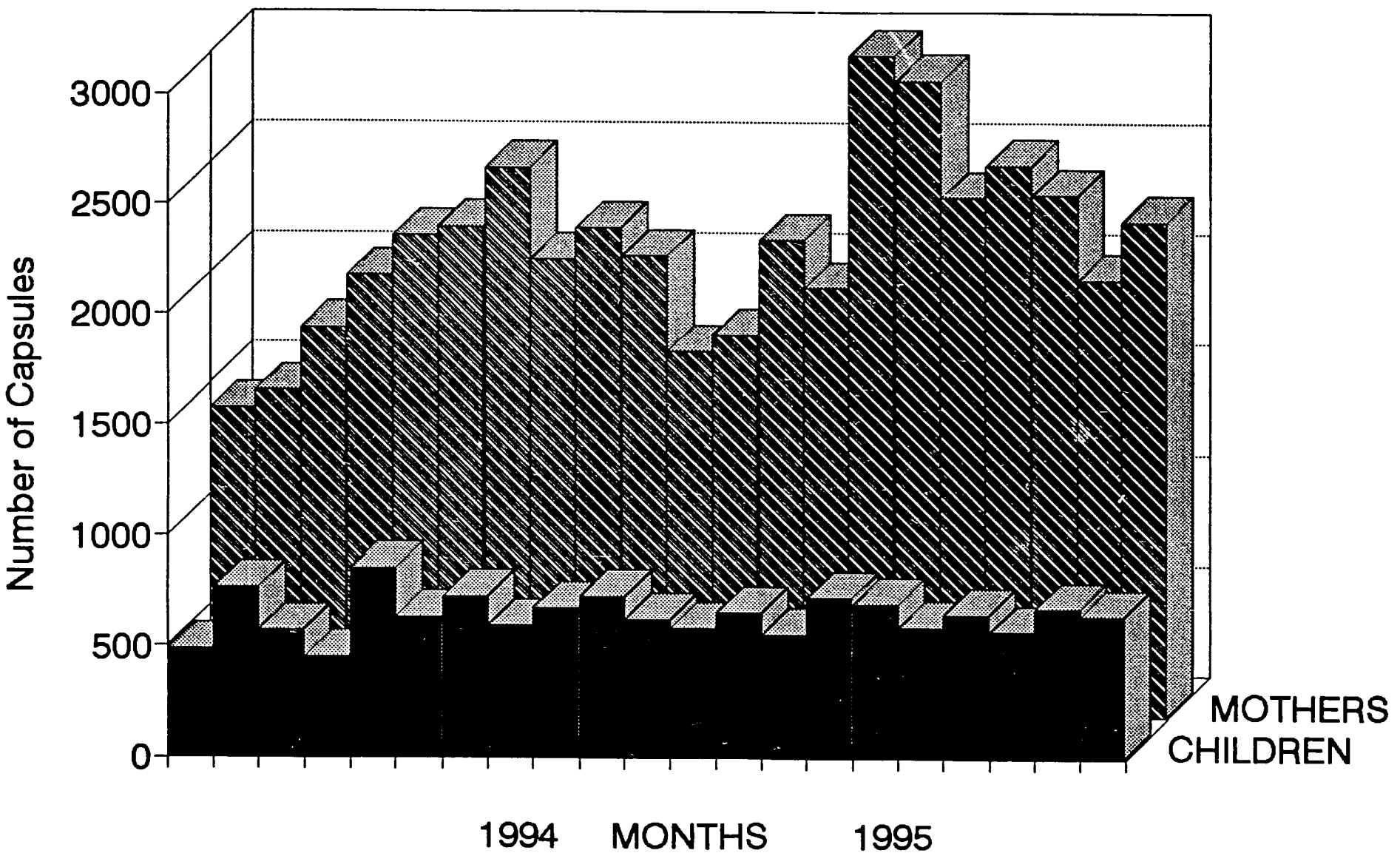
3. How much sugar does child consume?
   0 none
   1 pinch (the amount that can be held between thumb and finger)
   2 teaspoon (small spoon)
   3 tablespoon (large spoon)
   4 cup
   5 other (specify in chart)

4. How often does child get sugar?
   0 never
   1 less than once per week
   2 once per week
   3 2-6 times per week
   4 once per day
   5 2-3 times per day
   6 other (specify in chart)

1. Name of child	2. Age	3. Quantity	4. Frequency

CHIKWAWA DISTRICT HEALTH CLINICS

VITAMIN A CAPSULE DISTRIBUTION



MINISTRY OF HEALTH MALAWI

TRADITIONAL

BIRTH ATTENDANTS TRAINING

SYLLABUS / CURRICULUM

3rd Revision August 1987

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INTRODUCTION

The first curriculum/syllabus for the training of traditional birth attendants was introduced by the Ministry of Health in July 1980. This was revised and modified in April 1981. The revision of the 1981 version became necessary for three main reasons:

1. Internal monitoring and evaluation from the field;
2. Recommendations from the August 1984 MCH Review; and
3. Introduction of child spacing component into the MCH Programme

This was further revised in a workshop in some parts from 20-25th April, 1985 and August 1987. The third revision has taken into account the recommendations made in the recent TBA Evaluation of November 1986.

Report compiled by:

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   and TBA Coordinator

2. Dr S. N. Darfoor
   MCH Advisor

LIST OF ABBREVIATIONS

TBA	Traditional Birth Attendants
ANC	Antenatal Clinic
CPD	Celphalopelvic Disproportion
PHW	Primary Health Worker
HCW	Home Craft Worker
FHI	Field Health Inspector
MCH	Maternal and Child Health
PHC	Primary Health Worker
PPH	Post Partum Haemorrhage

ANTE PARTUM PERIOD

GENERAL OBJECTIVE: TBA will be able to provide safe and effective antenatal care

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
1. Identify at risk mothers for referral at antenatal clinics	1.1 Take appropriate history from a pregnant mother	Medical history, any serious medical/surgical diseases that mother has had in her life and present. Previous health status obstetric history - Previous pregnancies and births - Present obstetric history - signs - present pregnancy and LMP	Lecture/ role play	Demonstrate back to trainer on history taking and examination	
	1.2 Conduct a pysical examination of a pregnant woman	Procedure of examination head to toe. Check for general hygiene, nutritional status, gait status, examination, abdominal palpation for lie of baby and fundal height oedema of legs and varicuse and scars			
	1.3 Intepreto normal present, past medical obstetric history and findings of physical examination	Signs of pregnancy, no history of complicated pregnancies and births, no serious illness appropriate fundal height fetal movements, heart, lie, normal gait, height and nutritional status, no edema of legs or prominent veins	Discussion Lecture		

OBJECTIVE	OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
	1.4 Identify any risk factors. Factor findings at physical examination for referral.	Any serious disease; short stature (>5 measure on wall) abnormal gait (hunch back, limping mothers), lordosis, rickets and other deformities, previous scar. [Contributes to slow progress of labour and CPD) Anaemic - pale mucous membranes and nails, tongue, general weakness, edema, palpation and shortness of breath. Under-nutrition - thin, looking mother, jaundice, breech, twins, abnormal lie, big baby [may cause PPH abortion and retarded growth of fetus]	Discussion Visual aids	Practice to identify. an anaemic & under-nouri-rished mother use of modules & patients use of booklet on risk	
	1.5 Identify mothers with bad obstetric history for referral	Grand multiparity, History of previous prolonged labour, APH,PPH neonatal deaths, still births, pre eclampsia abortions, operative deliveries	Visual aids	Use of teaching aids, book-let on risk factors	
2. Advise mothers on care of the breast during pregnancy	2.1 Recognise flat and inverted nipples abnormal wellings (lumps) in the breast	- Normal nipples are elevated and pointed offering a place for baby to grip during breast feeding . - Flat nipples lack the elevation and the pointed end - does not provide grip for sucking - Inverted nipples - the pointed end of breast points inwards instead of outwards forming a small dimple - also lacks grip for sucking	Demonstration	Observation Practice	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
	2.2 Demonstrate on care of flat and inverted nipples	- General hygiene - daily bath special attention should be paid to areola - After the bath, nipples should be pulled outwards and rolled in between thumb and forefinger and middle finger. This can be done twice a day			
3. Maintain a proper nutritional status of the mother during pregnancy	3.1 Identify common food items available in the locality	Common food items: maize, cassava, rice, tomato, potato, millet, pumpkin leaves, cassava/potato leaves, cabbage, beans, cowpeas, pegion peas, millet peas, peanuts (mouse, crabs, grass hoppers) fish, meat, chicken, eggs, pawpaw, banana, mango, pineapples	Demonstration	Participate in listing food items	
	3.2 Explain functions of the identified common food items uterus	Maize, rice, potatoes, cassava, millet = provide strength and energy for the individual to carry out daily work. Peanuts, beans, mouse, crabs, chicken, cowpeas, milk eggs, repairs broken down tissue e.g. wound healing. It also helps in building body tissues for the growing featus Cabbage, banana, mango, cassava leaves, protects the body agaist diseases and helps in formation of new blood	Discussion,	Participate in listing food items	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
	3.3 Advise mother on proper eating behaviour	- Expectant mother should eat frequently and enough food throughout pregnancy - At least she should eat three times a day and some other small food items in between e.g she should eat something in the morning, mid-day and evening - Each meal shold contain an energy providing, body building and protective food items	Discussion	Plan a one day meal for for a pregnant mother using common food items	
	3.4 To dispel misconceptions of foods to be eaten by pregnant	- List taboos and misconceptions of eating habit and stress			
4. Advise the mother on progress of normal pregnancy pregnancy	4.1 Advise mother on frequency of antenatal care visits	Depending on gestation age: 0-28 wks every 4 wks 28-36 wks every 2 wks 36-40 wks every week	Discussion	Role play and practice	
	4.2 Estimate progress of pregnancy	Mother should be fully examined at each visit Determine increase of abdominal size. Estimate gestation age. Check with mother for any fetal movements. Palpate to determine lie and size of baby.			

OBJECTIVE	OBJECTIVE/ACTIVITY	CONTENT	METHOD	EXPERIENCE	EVALUATION
5. Advise mothers on management of minor disorders of of pregnancy	5.1 Identify and list minor disorders of pregnancy and their management	Morning sickness - avoid oily food, eat dry food e.g. cassava, roast maize heart burn - eat small meals but frequently constipation - drink plenty of fluids and eat plenty of vegetables Piles - if troublesome, refer to hospital and avoid constipation Low back pain - maintain a proper posture of walking. Vomiting - avoid fatty foods, lesser physical work, if it persists refer to hospital - suck lemon Vaginal discharge - general hygiene -frequent baths if it becomes itchy refer to hospital. Discourage the use of any local herbs and medicines in the management of these conditions	Lecture Discussion	Let the participants give their life experience and how they deal with such problems	
6. Select mothers who develop complication during antenatal period for referral	6.1 Identify abnormal progress and risk factors during pregnancy	Mothers who present with the following: - abnormal lie or presentations - presence of fetal movements/heart - Rupture of membranes before EDD - Premature labour - Bleeding at any stage of pregnancy - Hyperemisis	Discussion Lecture visual aids		
	6.2 Recognise signs of pre-eclampsia for immediate referral	Severe headache, edema, dizzness, scanty urine, heart palpitations [Not all patients will present with all symptoms but presence of any of	Discussion Lecture Visual	Observation of pre-eclamtic mother	

OBJECTIVE	OBJECTIVE/ACTIVITY			EXPERIENCE	
7. Explain benefits of prophylaxis treatment during pregnancy	7.1 Identify health problems (diseases) that can be treated prophylactically by TBA	- Malaria: signs and symptoms, dangers, abortion, anaemia and retarded fetal growth - Anaemia: signs and symptoms, dangers, abortion, PPH and retarded growth of featus	Discussion Demonstration	Demonstrate to trainer what explanation will be given to mother with the medication	
	7.2 Identify dosage of medicines used to prevent malaria	- White bitter tablets called chloroquine or norolon mother should take by mouth - tablets (300mg) a week. TBA should provide each mother with enough tablets. - Mother should take tablets as directed without fail - May develop itching after taking medication Mother should wash frequently to minimize itching but should never stop taking the medicines; if mother develops malaria, refer to hospital			
	7.3 Identify iron tablets their functions and dosage	- Provided during pregnancy to correct nutritional anaemia which could be detrimental to progress of pregnancy - Green round tablet which should be taken everyday after meals or according to preference - The problems can be minimized by taking the tablet with or after meals.	Discussion Demonstration	TBA should identify anti-malarial and iron tablets	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
	7.4 Describe storage of drugs at TBA unit and advise mothers on storage of medication at home	- TBA medications should stored at a cool dry place and should not be dispensed by unothorised people - Mothers should be advised to keep their medicines at cool dry place and away from children. Medication should not be shared with other people who fall ill at home but should be advised to go to an appropriate place to get their own medicine.	Discussion	Participation in class	
	7.5 Keep appropriate records on medication dispensed to mothers	Show type of record to use and how recording should be done to indicate medications used and clients given	Demonstration	Practice on recording	
	7.6 Advise mothers on prevention of neonatal tetanus (kalongonda/Kalongokoso kafumbata)	- Advise mothers on availability of tetanus toxoid vaccine in all antenatal clinics - Number of times given - Refer patients to the clinics for vaccination - Keep record of all these patients that were referred and vaccinated	Discussion	Devise best referral method to ensure that clients get vaccinated	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
8. Create awareness in the clients on the dangers of some traditional practices associated with pregnancy	8.1 Identify local traditional practices that are dangerous for a pregnant woman and the child	- Cutting of hemorrhoids (mauka) at home - Utilisation local medicines to speed labour - Application of dung, dust, local pulp on cord and fontanalle - Unattended home delivery - Waiting at home in labour for a long time or coming to TBA in second stage of labour	Discussion	Provide list list of local practices and give a health talk to advise mothers on such dangers	
	8.2 Advise mother on dangers of local practices	- Cutting of mauka - severe bleeding and infection - Local medicine for labour - precipitate labour, ruptured uterus fetal death - maternal death - Application of dung on cord. neonal infection - tetanus - Unattended delivery - may develop PPH and other complication (asphixia) that may require help	Discussion	Provide list of local practices and give a health talk to advise mothers on such dangers	

GENERAL OBJECTIVE: The TBA will be able to conduct a safe and clean delivery of a live infant and healthy mother.

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
The TBA will be able to:					
1. Provide an environment which will prevent infection during delivery	1.1 Provide a safe clean environment and and deliver her patients in a clean dry and well ventilated room.	Safe environment free from contamination. Advantages of clean room with windows. No leakage in the roof. Sweeping of the rooms and outside. Heating.	Discussion. Home visit to an ideal TBA.	Practice sweeping and dusting where TBA training takes place.	[illegible]
b. Maintain Self cleanliness when attending to the mother and baby	1.2 Maintain appropriate personal hygiene	Advantages of personal hygiene. Emphasis on - TBAs daily bath - Washing clothes - Hand washing	Lecture. Demonstration	Practice hand washing Wash her own clothes. Have daily baths	
2. Prepare instruments and materials for delivery	2.1 Identify instruments she will use during delivery and use them appropriately	Instruments required to deliver. Bowls, scissors ligatures, nail brush.	Lecture Demonstration	Naming and explaining use of the instruments	
Identify contents and use of TBA kit	2.2 Wash instruments and boil them (sterilization)	Advantages of washing the nail brush, cheatle forceps, instruments before boiling. Preparation of instruments to be done every morning	Lecture Demonstration	Practice washing the instruments and boiling them.	
3. Confirm onset of labour	3.1 Take history on mothers who come in labour	Age of gestation. Time of onset of labour. Signs and symptoms of labour.	Lecture Discussion Demonstration	Practice taking history and interpret.	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
	3.2 Differentiate between false and true labour	Show contractions, rupture of membranes. Examine the mother to confirm signs of true labour.	Lecture Demonstration	Practice examine a mother in labour. State signs and symptoms of true labor	
4. Identify at risk factors in labour and abnormal labour for referral	4.1 Examine mother for anaemia and oedema.	Look for anaemia of conjunctiva, tongue, hands. Oedema pressure of ankles for pitting	Demonstration Discussion and observation (labor ward)	Observe an anaemic and oedematous patients.	
	4.2 Recognise abnormalities and other contraindications for delivery at a TBAs unit.	Discuss abnormal lie, twins. Previous scars, APH, bad obstetric history. Premature labour. Grand multiparity.	Lecture Demonstration	Differentiate between normal and abnormal cases.	
	4.3 Recognise early signs of external bleeding	Signs, symptoms and observations of bleeding	Lecture Demonstration	The TBA explains verbally. Demonstration	
	4.4 Identify signs and symptoms of cephalo pelvic disproportion	Signs and symptoms of CPD High ballotable head, full bladder, Bandil's ring, Non descent of head during labour in the presence of good contractions. Prolonged labour.	Lecture Demonstration through role play with a piece of cloth to indicate sub-division on the abdomen	The TBA explains verbally. Demonstrate to trainer	

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SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
	4.5 Manage prolapsed cord	Cause - premature rupture of membranes, abdormal lie. Dangers - asphyxia and uterine death. Management - Wash hands replace the cord in the vagina. Place a clean pad. Knee chest position and refer.	Lecture Discussion Demonstration	TBA Explains	
	4.6 Recognised early signs of obstructed labour	Causes of obstructed labour: Abnormal lie, big baby, small pelvis, foetal abnormalities Signs and symptoms: - No progress in labour in the presence of strong contractions. Bandils ring, dehydration, fever. Dangers: Ruptured uterus Haemorrhage, intrauterine death, VVF, RVF, infection, maternal death	Lecture Observation in the labour ward Lecture observation Demonstration	The TBA explains	
	4.7 Recognise ruptured uterus	Causes: Obstructed labour, traditional medicine causing very strong contractions. Signs and symptoms: shock, pain, no contractions, tenderness over abdomen. Foetal parts easily seen. Foetal heart sounds may be absent, vaginal bleeding. Dangers: Intrauterine death. Haemorrhage leading to anaemia - maternal death.	Discussion, observation in the labour ward, visual aids	The TBA explains Demonstration	

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SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
5. Manage the normal 1st stage of labour	Provide adequate care during 1st stage of labour	Encourage general bath regular examination of the mother for contractions. Ballotment of the ~~early labour.~~ Head in early labour Engagement of head, Lowering of the fundus, Importance of taking light meals during labour Frequent emptying of the bladder. Length of 1st stage of labour. Not to let the sun set twice (recommended length in labour from sun rise to sun set or sun set to sun rise	Lecture Discussions Demonstration Observation	The TBA explains demonstration	
6. Manage the abnormal 1st stage of labour	6.1 Identify causes of delay 1st stage of labour	Weak uterus, very strong contractions, but baby not coming out. Baby not lying properly, Big baby, Full bladder	Lecture Discussion	The TBA can explain	
7. Manage the normal 2nd stage of labour	7.1 Recognise the onset of second stage of labour.	Signs of second stage of labour. - Strength and frequency of contractions - Gaping of anus - Head may be seen on the vulva - Sweating on forehead and upper lip - Desire to bend down	Lecture Discussion Observation of the patient in labour ward Role play	The TBA explains demostrates through role play	
	7.2 Put a patient in a position preferred for delivery	Preparation of delivery place by arranging a mat and mackintosh in	Lecture Demonstration	Explain Practices	
	7.3 Put on an apron before wash[illegible] her hands with soap and	Reasons for using an apron and for washing hands	Lecture [illegible]nstration	TBA Explains Demonstration	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
	7.4 Arrange instrument ready for delivery	Reasons for arranging instruments	Demonstration	Explains Practices	
	7.5 Cleanse the perineum using clean material and water.	Method of cleaning the perineum with water and cotton or material	Discussion Demonstration (labour ward)	Practices	
8. Take necessary precautions to prevent tears, infection, and asphyxia	8.1 Instruct the mother to push with a contraction using clean material and water.	Reasons for instructing mother to push with each contraction and encouragement to relax in between contractions	Discussionion Demonstration	Practice	
	8.2 Support the perineum during crowning of head	Advantages of supporting the perineum Dangers of unassisted delivery	Discussionion Demonstration	Practice	
	8.3 Assist in the delivery of the baby	Deliver the head by flexion and extension of the head for control Wipe the baby's eyes, nostrils, and mouth with cotton wool, piece of clean cloth. Deliver the anterior shoulder by extension and flexion of the body over mothers abdomen.	Discussionion Demonstration	Practice Explanation	
	8.4 Prevent asphyxia	Hold baby upside down, pat at the back, wipe the mucus from mouth and nostrils. Check for signs of asphyxia blue skin colour and blue lips. Shallow and difficulty in breathing and general weakness. Dangers of asphyxia and infection: Death	Discussionion Demonstration	Practice Explanation	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
9. Give appropriate care to the baby immediately after birth	9.1 Prevent bleeding from the cord, cold injury and infection of the cord	Place the baby on a clean cloth. Ensure any residual mucous is wiped away from baby's mouth and nostrils to maintain a clear airway. Check for bleeding from the cord. Wrap the baby and encourage mother to put to the breast to Cent. Wipe the baby's face and head. Tie the cord with two sterile ligatures and cut the cord between the ligatures with sterile scissors or razor blade. wrap the baby in a clean cloth to keep it warm. Dangers of using dirty material; dangers of exposing the baby to cold Infection and death due to cold injury. Put the baby to mothers breast immediately to control bleeding	Discussion Demonstration	Practices	
10. Manage the third stage of labour	10.1 Stimulate uterine contractions to aid placental separation	Put the baby to the breast immediately after initial wiping to stimulate uterine contractions. Benefits: Aids early placental separation; controls PPH Promotes early milk production	Discussionion	Practice	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
	10.2 Deliver the placenta and membranes by maternal effort and check the placenta and membranes for completeness	Check for signs of placental separation by feeling the firmness of the uterus, lengthening of the cord and trickling of the blood. ~~Let the~~ and Encourage mother to push with a contraction. Lift the placenta by the cord and let it hang to check for ragged membranes. Examine the maternal side of the placenta for completeness of the lobes.	Discussion Demonstration	Explanation Practice	
	10.3 Check fundus for contraction of the uterus after delivery of placenta	Feel for firmness of contracted uterus	Discussion Demonstration	Explanation Practice	
	10.4 Inspect the perineum for tears and refer extensive ones	Examine for tears involving the vaginal wall and perineum. Dangers of unrepaired tear: Bleeding infection VVF and RVF scarring Personal hygiene. Salt bath with small ~~ones~~ tears refer extensive ones	Discussion Demonstration	Explanation Practice	
	10.5 Make the mother comfortable	Clean her up. Put on a clean pad. Let her rest on her back with her legs crossed.	Discussion Demonstration	Explanation Practice	
	10.6 Assess blood loss	Measure blood with gallipot in kit (300mls)	Discussion Demonstration	Explanation Practice	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
11. Manage problems associated with 3rd stage of labour	11.1 Control PPH	Let patient empty bladder Rub up a contraction Put baby to breast Immediate referral	Discussion Demonstration	Explanation Practice	
	11.2 Refer retained placenta and membranes	Signs of retained placenta not delivered after 30-60 minutes after delivery of the baby. May be associated with bleeding. Dangers: Bleeding and infection both leading to death.	Discussion Demonstration	Explanation Practice	
12. Identify babies with congenital abnormalities before giving the first bath	12.1 Examine the new born and refer those with abnormalities	Check from head to toe for any abnormalities. Signs of: swellings on the head, neck, hare lip, cleft palate, imperforate anus. Importance of early referral to correct the abnormality and prevent further complications	Discussion Demonstration	Explanation Practice	
	12.2 Bathing the baby	Keep the baby warm. Clean the eyes from inside out using one swab or clean material for each eye to prevent infection. Do not expose to cold as baby looses heat quickly and could catch cold and pneumonia. Dry well, dress and wrap in a dry chitenje after treating the cord. Give the baby back to the mother	Discussion Demonstration	Explanation Practice	

POST- NATAL PERIOD

GENERAL OBJECTIVE: The TBA will be able to:
Differentiate the normal from abnormal in the immediate post partum and provide safe care for the mother and baby through the post partum period.

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
The TBA should be able to:					
1. Diferentiate a full term baby from a premature baby	1.1 Recognise the features and characteristics of full term baby	List the features of a full term baby + Pink [illegible]	Lecture, Discussion Demonstration	Verbal explanation by TBA to trainer Observation-Labour ward	
	1.2 Recognise the features of premature baby for referral	List the features of a premature baby		As above	
2. Have adequate knowledge of care of premature baby	2.1 State the problems of premature baby	Feeding, warmth, breathing, jaundice	Lecture Discussion Demonstration	Demonstration and verbal explanation	
3. Identify common congenital abnormalities	3.1 Examine for talipies, cleft palate, harge lip, imperforated anus and spina bifida and refer appropriately	Signs of cleft palate, harge lip, talipes, imperforated anus and spina bifida. Importance of early referral	Lecture Discussion	Explanation by TBA to trainer	
4. Weigh a new born baby accurately	4.1 Identify low birth weight baby for referral	- Keep warm, advice on - Refer	Lecture Discussion Demonstration	Demonstration	
	4.2 Use the weighing scale correctly characteristics of full term baby	- Explain and show how to adjust scale and weigh the baby	Lecture, Demonstration	Practice	
	4.3 Record the weight in the register book	- Recording of weight in the register book	Lecture Demonstration	Practice	
	4.4 Explain the ight to mother	- Importance of knowing birth weight of a baby	[illegible]ture [illegible]onstration	Practice	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
5. Provide appropriate cord care during post natal period	5.1 Prevent cord infection	- Cord care: keep dry - Use of methylated spirit	Lecture Discussion Demonstration	Practice in post natal ward	
6. Identify the problems of new born baby during the post partum period and refer appropriately	6.1 Differentiate a normal baby from a cerebral baby	- Signs of cerebral injury - High pitchy cry - Twitching of the facial muscles - Convulsions - Clenched fists	Lecture Discussion Demonstration Lecture, Discussion Demonstration	Verbal Explanation Observation	
	6.2 Recognise jaundice in a baby	- Signs of jaundice - Treatment of mild jaundice - Refer of severe jaundiced baby - Dangers of untreated jaundiced baby	Lecture Discussion Demonstration	Verbal Explanation Observation	
	6.3 Detect the presence of infection in a baby	- Failure to suck - Convulsions	Lecture Discussion Demonstration	Verbal Explanation	
	6.4 Recognise baby with neonatal tetanus	- Signs of neonatal tetanus	Lecture Discussion Demonstration	Verbal explanation	
7. Identify anaemia in the post partum period	7.1 Differentiate between normal and abnormal colour of conjunctiva and tongue	- Normal colour of conjunctiva and tongue - Abnormal colour of conjunctiva and tongue - refer moderate and severe anaemia patients	Lecture and Demonstration	Demonstration and verbal Explanation	
8. Provide educational advice on nutrition	8.1 Identify nutritious food within their locality	- List of nutritious foods - Grouping of foods	Lecture Discussion Demonstration Role Play	Demonstration Practice	
	8.2 Advise mothers on nutrition during post natal period	- Provision of advice to mother during post natal period	Lecture Discussion Demonstration	Demonstration practice	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
9. Detect breast engorgement	9.1 Recognise breast engorgement	- Breast examination - Signs and symptoms of breast engorgement - Management of breast engorgement.	Lecture Discussion Demonstration	Practice	
	9.2 Recognise cracked nipples	- Cleaning of nipples - Treatment of cracked nipples - Advise mother on how to breast feed the baby	Lectureion Discussion Demonstration	Verbal Explanation Demonstra-tion	
10. Differentiate a well contracted form uncontracted uterus	10.1 Recognise well contracted uterus	- Palpating the fundus of uterus - Causes of uncotracted uterus - Management of uncontra-cted uterus - Dangers of uncontracted uterus	Lecture, Discussion Demonstration	Verbal explanation Demonstra-tion	
11. Acquire under-standing of involution of the uterus	11.1 Recognise and advise mother on normal colour, amount, odour of lochia	- Normal colour, amount and odour of lochia, and normal involution of the uterus;	Discussion Demonstration	Practice and verbal explanation	
	11.2 Recognise ~~and advise~~ abnormal ~~premature baby~~ Lochia, sub-involution, sub-involution	- Abnormal lochia - Sub-involution of uterus	Discussion Lecture Demonstration	Practice and verbal explanation	
12. Assess and manage a child with diarrhoea and mild dehydration	12.1 State two dangers of diarrhoea	- Dangers of diarrhoea - Dehydration - Death	Discussion	Verbal Explanation	
Signs & symptoms of	12.2 Explain the signs and symptoms of dehydration	- Signs of dehydration - Sunken eyes and fontannelle, diminished urine, slow return of skin after being pinched	Demonstration Discussion at ORT corner Use visual is	Explanation Visit to ORT corner	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
	12.3 State management of child with diarrhoea and dehydration	- Management of diarrhoea (As plan A) - Management of some dehydration (As Plan B) - Refer of moderate and severe dehydration	Lecture Discussion Demonstration	Observation at ORT unit and discussion	
	12.4 Reconstitute ORS correctly or prepare correctly sugar and salt solution	- Care of hands - Clean water - Clean measuring container - 1 litre capacity - 1 packet of ORS, SSS = Sugar 10 bottle tops; 1 bottle top salt; and 3 fanta bottles clean water	Lecture Demonstration	explanation Practice	
	12.5 Explain the storage of ORS packet and ORS solution	- Keep packets in dry places. No holes in the packets - ORS solution to be used within 24 hours	Lecture	explanation Observation	
	12.6 Advise mother on management of diarrhoea and need for referral	- Contunue breast feeding - Give ORS or salt and sugar solution or any available fluids - Continue feeding the child frequently and in small amounts - Refer if diarrhoea continues for 2 days or signs of dehydration persists	Lecture Discussion Role play	Practice	
13. To motivate clients and advise community on child spacing	13.1 Explain the health benefits of child spacing	Health benefits of child spacing to child, mother, family	Lecture and Discussion	Explanation	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
	13.2 List the traditional methods of child spacing	Traditional methods	Discussion	Participation	
	13.3 State the modern methods of c/spacing available in Malawi	List modern methods	Lecture Discussion	Explanation	
	13.4 Identify the role of the TBA in C/s progr	Teach mothers on adv. of C/S, what they can do			
	13.5 Identify and state the child spacing clinics available in her area to the client	List of child spacing clinis in TBAs locality	Discussion	Explanation	
14. State the importance of immunization and nutrition	14.1 State reason for mother to attend under five clinics	- Activities at underfive clinics - Growth monitoring. Immunization schedule vaccines - DPT, polio BCG Measles	Discussion Demonstration Clinic visit	Observation Explanation	
	14.2 Describe a well nourished and a poorly nourished child and select those for referral	- Advise on feeding - Type of feeds: breast feeding, likuni phala- weaning foods - Signs of kwashiorkor and marasmus	Lecture Discussion Demonstration	Practice Demonstration	
	14.3 Advise feeding during the weaning period	- Continue breast feeding - Start introducing weaning foods at 4 months - Proper handling of food and utensils	Discussion	Explanation	
	14.4 Identify harmful taboos related to child/infant feeding practices	- List of harmless and harmful taboos and misconceptions related to weaning practices	Discussion	Explanation As above	

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
	14.5 Explain the danger of harmful taboos to the mother and baby [redacted]	- Depriving the child of the required nutrients - Development of malnutrition	Discussion	Explanation	
15. Identify childhood illness and make proper referrals	State the common signs and symptoms of illness in children	- Signs and symptoms - Fever, Diarrhoea, vomiting, jaundice, anaemia, otitis, media intestinal worms skin diseases, conjuctivitis	Lecture Discussion Demonstration	Explanation Demonstration	Q/U.C.I/Ans

PRIMARY HEALTH CARE

GENERAL OBJECTIVE: The TBA will be able to appreciate the existence and role of other Primary Health Workers in her community and be able to work hand in hand

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
The TBA will be able to:					
1. Know her role in the health team and her relation to other primary health care workers	1.1 ~~Understand~~ Explain the duties of other P.H.C workers	- Duties of PHW, HCW, FHI, MCH Assistants Practices Panel.	Lecture Field Trip	Explanation of the duties of health team	
2. Assist in follow-up and reporting disease outbreak	2.1 Locate and utilize centres for referral	- Health centre - Hospital			
	2.2 Recognise disease outbreak	- Disease outbreak e.g. measles, diarrhoea	Lecture Discussion	Verbal Explanation	
	2.3 Report outbreaks to nearest health centre	- Methods of reporting (call H. Assistance). N.H.C. Sur Ass.	Lecture-Discussion	Explanation	
	2.4 Follow up her clients	- Methods of follow-up - Types of clients for follow-up		Practice	

GENERAL OBJECTIVE: The TBA will be able to understand the principles o. personal and environmental hygiene and sanitation and appreciate their importance in maintaining health.

SUB-OBJECTIVE	SPECIFIC OBJECTIVE/ACTIVITY	CONTENT	METHOD	LEARNING EXPERIENCE	EVALUATION
The TBA will be able to:					
1. Demonstrate good personal hygiene and be able to advise others	1.1 Instruct a mother on cleanliness of herself and her family	General hygienic measures - Safe water - Proper handling of food	Lecture Discussion Demonstration	Demonstration Explanation on the importance of boiling water, washing hands before meals and after visiting the toilet	
2. Demonstrate good sanitary practices in her own environment and be able to advise others	2.1 Explain to mothers how to prevent the spread of diseases	- Prevention of diseases by using pit latrines - Refuse pits - Filling of cracks where bugs enter - Sweeping - Separate houses for animals	Lecture Discussion Field trips	Explanation of the importance of having toilets and refuse pits and proper care and sweeping of the house and surroundings	
	2.2 Explain the importance of having a clean separate bath, pit latrine and delivery room	- Daily care of bathroom and delivery room	Lecture Demonstration	Practice	

Supplement to : Ministry of Health, Malawi
Traditional Birth Attendants Training 1987.

Supplemental training curriculum to be used by TBA's, emphasizing breastfeeding, family planning, vitamin A supplementation, immunizations and AIDS.

Part I: BREASTFEEDING, lecture time 1 hour 10 minutes.

Topics to be covered:
- Definition of exclusive breastfeeding.
- Benefits of exclusive breastfeeding.
- Preparation of mothers for breastfeeding.
- Informing mother's regarding methods of increasing breastmilk production.
- Identification of problems with children who can not suck properly and how to manage such a child.

Methods/Materials:
- Lectures
- Open discussion
- Practical demonstrations in labor ward
- Breastfeeding propaganda, including posters

Messages:
- "No water, Nothing else" (exclusive breastfeeding up to 4 months of age).
- Dangers of early supplementation
- Benefits of exclusive breastfeeding.

Comments regarding training: The TBA's showed a keen interest in the lecture and promised to implement the teachings upon return to their villages.

Part II: FAMILY PLANNING, lecture time 1 hour 10 minutes.

Topics to be covered:
- Definition of the term family planning.
- Benefits of family planning to mother, child and family.
- Discussion of modern and traditional methods available and use of each.
- Discussion of the negative effects of unplanned pregnancies on particular age groups.

Methods/Materials:
- Lectures
- Open discussion
- Demonstrations of methods.
- Pacticals on motivational talk used in family planning clinics.
- Discussion of sterilization techniques for both men and women.

Remove

Part III: VITAMIN A, lecture time 45 minutes.

Topics to be covered:
- Definition of vitamin A.
- Discussions of food sources of vitamin A.
- Importance of vitamin A.
- Signs and symptoms of vitamin A deficiency.
- When to use vitamin A capsules, what dose and to whom.

Methods/Materials:
- Lectures
- Open discussion
- Demonstrations of supplementation at an under-five clinic.

Part IV: IMMUNIZATIONS, lecture time 1 hour.

Topics to be covered:
-Types of vaccinations available and schedule information.
- Importance of proper immunization and impact on child mortality.
- Recognition of side effects from vaccinations.

Methods/Materials:
- Lectures
- Open discussion
- Group sing-a-longs, using lyrics that present importance of immunization.

Messages:
-Emphasized the importance of receiving 9 doses of the different vaccine by the age of 1 year (4 polio, 3 DPT, BCG, measles).

Evaluation:
- TBA's were required to state six types of vaccines for the mother and child.

Part V: AIDS, lecture time 1 hour.

Topics to be covered:
-How to prevent the spread of HIV.
-How to identify and AIDS patient.
-Background/definitions of HIV and AIDS
-What high-risk groups exist,

Methods/Materials:
- Lectures
- Open discussion

Messages:
-Emphasized ways HIV can and can not be spread
-Teaching mother's about safe sex methods.

Evaluation:
- TBA's were required to know the definition of HIV and AIDS.

Remove.

REVISED

CURRICULUM FOR TRAINING OF COMMUNITY BASED DISTRIBUTORS

BY

MALAMULO COMMUNITY BASED DISTRIBUTORS PROGRAMME

1994

INTRODUCTION

Malamulo Hospital initiated a Community Based Distributors programme on Family Planning Service in collaboration with Adventist Health Services beginning August, 1992.

The Community Based Distributors are members of the Community who voluntary choose to serve their fellow community members on non-salary basis.

However, they were selected by community using criteria which was established by community with the assistance of Malamulo CBD project staff.

The curriculum was set up to meet the knowledge skills and attitudes required for Community Based Distributors in order for them to perform their work effectively. The training period is two weeks.

We are pleased to acknowledge that the curriculum was initially formed and prepared by Ekwendeni Hospital in the North and was revised by Malamulo Hospital CBD programme staff.

This curriculum does not include supervisor for CBD.

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

I. GOAL

To provide the Community Based Distributors trainees with the necessary knowledge, skills and attitudes to enable them to educate and motivate the community on Family Planning, advise them on Primary Health Care and distribute Oral Contraceptives and condoms.

II. GENERAL OBJECTIVES

By the end of the weeks training, each participant will be prepared to:

1. Carry out a community study
2. Develop a workplan
3. Educate and motivate people to accept Family Planning
4. Counsel client on informed Family Planning methods
5. Distribute methods of Family Planning
6. Refer Family Planning clients where necessary
7. Care for equipment, materials and supplies
8. Keep Family Planning records
9. Be able to carrying follow-up clients in fields

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

SESSIONS:

1. 8:30 am - 10:00 am
2. 10:30 am - 12:00 noon
3. 1:30 pm - 3:00 pm
4. 3:15 pm - 4:45 pm

TOPIC:

INTRODUCTION (ORIENTATION) TO THE COMMUNITY BASED DISTRIBUTION (CBD) PROGRAMME

SPECIFIC OBJECTIVES:

At the end of this session participants will be able to:

- Explain the aims of a CBD programme
- Describe the role of a CBD
- Name all the participants, including the trainers

TIME: - 3 HOURS

CONTENTS	TEACHING METHODS
Welcome	
Official opening speech	
Introductions	Interviews in DYADS
Expectations	
Warm-up	Song
Aims of CBD Programme	Lecturette
Criteria for selection	Small group work
Personal qualities	Small group work
The task of a CBD	Lecturett

MATERIALS

Trainer developed handout

Chalkboard

Chalk

Flipchart

Markers

EVALUATION

Pre/Post test questions and standardized marking sheet.

Reference materials

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

SESSIONS:

1. 8:30 am - 10:00 am
2. 10:30 am - 12:00 noon
3. 1:30 pm - 3:00 pm
4. 3:15 pm - 4:45 pm

TOPIC:

MALAWI:- POPULATION/DEVELOPMENT AND HISTORY OF FAMILY PLANNING

SPECIFIC OBJECTIVES:

- Describe the population situation in Malawi
- Explain the linkage between population growth and economic development

TIME: - 3 HOURS

CONTENTS

Malawi's population

Population growth and effects on social and economic development

Definition of Family Planning concern

TEACHING METHODS

Lecturette - mini presentation

Small group Work/Presentation

MATERIALS

Trainers prepared handouts

Newsprint

Markers

EVALUATION

Pre/post test questions

Reference materials

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

HISTORY OF FAMILY PLANNING IN MALAWI

SPECIFIC OBJECTIVES:

- List at least four family planning needs in Malawi
- Describe the history of family planning in Malawi

TIME: ONE AND HALF HOURS

CONTENTS	TEACHING METHODS
Unmet needs for family planning e.g couples who want to space but cannot get information or methods abortions	Large group discussions
History of family planning in Malawi	
Present day family planning services	

MATERIALS

Chalkboard

Chalk

Newsprint

Markers

EVALUATION

Pre/post test questions

Reference materials

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

RATIONALE FOR CBD SERVICES

SPECIFIC OBJECTIVES:

- Explain what is meant by Primary Health Care
- Explain the concept of Community Based Distribution
- State and clearly explain at least 10 tasks of a CBD
- Recognize the CBD role in relation to:

  Clients

  Supervisors

  Other Community Workers

  Community groups and leaders

TIME: - 45 MINUTES

CONTENTS	TEACHING METHODS
The meaning of primary health care	Teacher - led discussion
The 10 elements of primary health care	
The duties of a Community Based Distributor and role in the Community	Role-play CBD agent visits Community Health Committee to explain her job responsibilities

MATERIALS

Chalkboard

Chalk

Newsprint/markers/markers

Handouts on Tasks of a CBD

EVALUATION

Accuracy of role plan

H A N D O U T

PRINCIPLES OF FAMILY PLANNING FOR CBDs TO REMEMBER

1. Voluntary family planning is an important health measure--the availability of family planning services has an impact on the health of an individual, a family and indeed a community and the entire nation.
2. Unless a certain method is medically usage for a client, clients have a right to make a voluntary, unpressured decision concerning family planning contraceptive methods.
3. It is the CBD agent's responsibility to provide thorough information to and encourage question from the clients.
4. Clients have a right to be treated with dignity in a private setting. This encourages frank discussion of embarrassing questions and personal matters and reduces the fear of examination.
5. Clients have a right to complete confidentiality of the information they give and their medical records.
6. CBD agents are responsible for providing high quality health education to the community as well as to individual clients.
7. Each member of society has a right to family planning care regardless of marital, financial or social status.
8. Identification and treatment of sexually transmitted diseases in clients family planning clients are vial to the preservation of both individual and community health and fertility.
9. Participation of male partners in family planning adds an important dimension to care by encouraging couples to share responsibility for fertility decisions.

10. Family Planning services ensure a healthier community as it also can provide many non-contraceptive services to clients. Clients may come for: a pap smear and breast examination which can help detect cancer; pregnancy tests; urine analysis; treatment of vaginal infections; STD tests; evaluation of an infertility problem; youth counselling or marital counselling.

11. Family Planning services can help the entry of individuals into other parts of the health care system such as environmental sanitation, oral rehydration therapy, parasite control or nutrition.

12. Population concerns should not be the major focus or objective of family planning services. For the most part our clients come for services out of concern for personal well-being and not national population pressures. Individual clients may be annoyed by the association of family planning services with efforts to achieve population stabilization.

H A N D O U T S

SOME HEALTH BENEFITS OF FAMILY PLANNING

- Anaemia is less in children and women
- Fewer women may die during childbirth
- Low-birth weight babies are less likely to occur
- Young children and babies are less likely to die of infectious diseases
- Mothers can breastfeed babies for longer periods
- Contraceptive pills may protect against cancer of the womb and lining and egg baskets
- Condoms and spermicides may protect against some sexually transmitted diseases
- Spermicides may offer protection from some cancers

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

GETTING FOR KNOW THE COMMUNITY

SPECIFIC OBJECTIVES:

- Define Community
- Describe information that CBD needs to collect regarding the community

TIME: - 45 MINUTES

CONTENTS	TEACHING METHODS
What is a community	Training - led discussion
How do communities grow	
What is a community study	Question/answers

MATERIALS

Newsprint/markers

Charts

EVALUATION

Checklist for question/answer session

ORGANIZATION CHART

AUTHORIZED OFFICIAL

PROJECT DIRECTOR

PROJECT COORDINATOR

FAMILY PLANNING
CBD SUPERVISORS

AHS STAFF

CBD AGENT

COMMUNITY

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

HEALTH AND SOCIAL BENEFITS OF FAMILY PLANNING

SPECIFIC OBJECTIVES:

- Define family planning
- Identify four high-risk groups to be reached by CBDs
- Explain the benefits of family planning

TIME: - 3 HOURS

CONTENTS	TEACHING METHODS
Definition of family planning	Lecturette
Risks of pregnancy where the four "toos" apply:	
"Too" Young mother under age 18 years	
"Too" old mother over age 35	
"Too" many births four or more births	
"Too" close together Two years or less between births	
Benefits of family planning to family and nation	

MATERIALS

Chalkboard/chalk

Newsprint/markers

Handout

EVALUATION

Pre/post test questions

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

TRADITIONAL METHODS OF FAMILY PLANNING

SPECIFIC OBJECTIVES:

- State at least four reasons why traditionally family planning was encouraged.
- List the methods used traditionally

TIME: - ONE AND HALF HOURS

CONTENTS	TEACHING METHODS
Rationale for traditional family planning List of known traditional methods of family planning and how they prevented pregnancy	Large group discussion

MATERIALS

Newsprint/markers

EVALUATION

Group list

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

ORGANS OF REPRODUCTION - DESCRIPTION AND FUNCTION

SPECIFIC OBJECTIVES:

- Describe the male organs of reproduction
- Explain the function
- Describe the female organs of reproduction
- Explain their functions

TIME: - 1 HOUR

CONTENT	TEACHING METHODS
Male organs of reproduction	Lecturette
Functions of the male organs	
Female organs of reproduction	
Functions of the female organs	
Pregnancy	
Abortion	

MATERIALS

Anatomical charts

Trainer developed handout

Flipchart

Markers

EVALUATION

Pre/post test questions

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

ORAL PILLS

SPECIFIC OBJECTIVES:

- List the types of Oral Pills used in Malawi
- State how the oral pills prevents pregnancy
- State advantages, disadvantages and effectiveness of oral pills
- Initiate and resupply the oral pill to at least two clients

TIME: - ONE AND HALF HOURS

CONTENTS	TEACHING METHODS
Oral pills available in Malawi	Lecturette
Oral pills distributed by CBDs	Trainer-led group
discussion	
How the pills prevent pregnancy	
Advantages, disadvantages and effectiveness	Role play on Checklist instructions
Counselling clients	
Use of pill checklist to identify women who are medically unsuited to use the pill	
Instructions for pill use	
Management of clients on pill including referral	
Record keeping and reporting	

MATERIALS

Newsprint/markers

Charts

samples of pills packets

Handouts on checklist and instructions

EVALUATION

Accuracy of role play

Pre/post test questions

Checklist for field practice

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

THE PILL CHECKLIST

SPECIFIC OBJECTIVES:

- Describe the pill checklist
- Identify the medical conditions on a pill checklist
- Demonstrate the ability to use the pill checklist to identify women who can and those who cannot use the oral pills

TIME: - 2 HOURS

CONTENTS	TEACHING METHODS
Description of pill checklist	Lecturette
Identification of medical conditions and their relevance in pill use	Case studies
Using pill checklist in the field	Role plays
Recording	Field practicums

MATERIALS

Handout - pill checklist

Newsprint/markers

EVALUATION

Checklist for field practicums

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

CONDOMS

SPECIFIC OBJECTIVES:

- State how the condoms prevent pregnancy
- Explain advantages, disadvantages and effectiveness of condoms
- Initiate and resupply condoms to at least five clients

TIME: - 45 MINUTES

CONTENTS	TEACHING METHODS
What is a condom	Lecturette
How the condom prevents pregnancy	Trainer-led group discussion
instruction	
Advantages, disadvantages, effectiveness of condoms	
Instructions on condom use	Condom instruction field
Record keeping and reporting	Field practicums

MATERIALS

Newsprint/markers

Samples of condom

Make model

Handout - condom instructions

EVALUATION

Pre/post test questions

Checklist for field practicums

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

THE CBDs THREE - WEEKLY WORKPLAN

SPECIFIC OBJECTIVES:

- Identify importance of a workplan
- Explain how to develop a workplan
- Practice using a workplan

TIME: - ONE AND HALF HOURS

CONTENTS

Define workplan in identifying

Importance of workplan in identifying clients to be supplied and resupplied

Development of a three weekly workplan

TEACHING METHODS

Question/answer sessions

Individual assignments

MATERIALS

Rulers

A4 Sheets

Pencils

Rubbers

Newsprint/markers

EVALUATION

Comparison with sample workplan

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

HOME VISITS

SPECIFIC OBJECTIVES:

- State what is meant by home visit
- Explain when to pay home visit
- Demonstrate how to do a home visit

TIME: - UNDER THE TOPIC WORKPLAN

CONTENTS

Meaning of home visit

When to do home visits

How to do home visits

TEACHING METHODS

Discussion Practicums

MATERIALS

None

EVALUATION

Checklist for practicums

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

DEPO PROVERA/INJECTION

SPECIFIC OBJECTIVE:

- State how depo provera prevents pregnancy
- State advantages, disadvantages and effectiveness
- Describe the referral system for Depo provera

TIME: - 45 MINUTES

CONTENTS	TEACHING METHODS
What is depo provera	Lecturette
How does it prevent pregnancy	Large group discussion
Advantages, disadvantages and effectiveness	Role play on referral
Referral procedures for women requesting depo provera	
Record keeping	

MATERIALS

Newsprint/markers

Samples of depo provera vials

Handouts or referral form

EVALUATION

Checklist for field practicums

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

REFERRAL METHODS

SPECIFIC OBJECTIVES:

- Identify at least 5 family planning methods available only at clinics and hospitals
- Explain advantages, disadvantages, side effects and effectiveness of Intrauterine Contraceptive Devices,
- Describe how each method prevents pregnancy

TIME: - FIVE AND HALF HOURS

CONTENTS

Describe each method	Lecturette
How the method prevents pregnancy	Group discussions
Client counselling	Role play on referral
Referral procedures	

MATERIALS

Newsprint/markers

Samples of all methods

Diagrammatic charts

Handout - referral form

EVALUATION

Checklist for field practicums

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

COMMUNICATION AND OVERCOMING BARRIERS TO COMMUNICATION

SPECIFIC OBJECTIVES:

- Define and explain the communication process
- List and explain four criteria for effective communication
- Demonstrate how communication can be used by CBD agents in their role as change agents
- List four barriers to communication
- Explain how to overcome these barriers

TIME: - ONE AND HALF HOURS

CONTENTS	TEACHING METHODS
Definition of communication	Lecturette
Explanation of how people	Group discussion
communication and non-verbal	Role plays
communication	
Why people communicate	

MATERIALS

Newsprint/markers

Handout - duties of CBD agent

EVALUATION

Pre/post Test questions

Checklist for role plays

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

EDUCATION TALKS

SPECIFIC OBJECTIVES:

- Define education talk
- List the content to be covered in a talk
- Give at least two talks
- State the target audience

TIME: - ONE AND HALF HOURS

CONTENTS	TEACHING METHODS
Defination of education talk	Lecturette
Importance of this type of education	role play
Content covered in a talk	Practicum
Target groups for talks recording	
talks given	

MATERIALS

Flip charts

Newsprint/markers

Samples of all methods

EVALUATION

Checklist for education talk practicum

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

COUNSELLING

SPECIFIC OBJECTIVES:

- Define counselling
- Name three purposes of counselling about family planning
- List four counselling skills
- State three qualities of a good counsellor
- Explain the counselling steps
- Demonstrate skills in counselling

TIME: -60 MINUTES

CONTENTS	TEACHING METHODS
Definition of counselling and its	Lecturette
its purpose	
Explanation of counselling skills	Group discussion
Asking questions that encourage people to talk about themselves	Role play demonstration practicum
Showing understanding	
How does it prevent pregnancy	Large group discussion
Advantages, disadvantages and	Role play on referral
effectiveness	
Referral procedures for women	
requesting depo provera	
Record keeping	

MATERIALS

Newsprint/markers

EVALUATION

Checklist for practicums

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

DISTRIBUTION AND REFERRAL

SPECIFIC OBJECTIVES

- Give out appropriate numbers of desired family planning commodities to people in the community
- Identify correctly the people who need to be referred to hospital or clinic
- Use referral form to send with people who are referred

TIME: - ONE AND HALF HOURS

CONTENTS	TEACHING METHODS
How many cycles of pills and pieces if condoms to give to each client	Lecturette
Identification of clients who need referral	Demonstration
Use of referral form	field practicum role plays
Following-up referred clients	

MATERIALS

Handout - referral form

Client cards

Record Book

Newsprint/markers

EVALUATION

Checklist for field practicums

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

SYMBOLS USED IN RECORDING

SPECIFIC OBJECTIVES:

- List and explain symbols used in recording
- Use the symbols in recording

TIME: - 45 MINUTES

CONTENTS	TEACHING METHODS
List of symbols	Group discussion
Explanation of symbols	Demonstration
Use of symbols	Practicums

MATERIALS

Newsprint/markers

Handout on symbols

EVALUATION

Checklist of practicums

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

SEXUALLY TRANSMITTED DISEASES INCLUDING AIDS

SPECIFIC OBJECTIVES:

- Explain what sexually transmitted diseases are
- Identify at least 2 signs and symptoms for each disease
- Give accurate counselling and referral advice to clients

TIME: - 45 MINUTES

CONTENTS	TEACHING METHODS
What STDs are and how they are transmitted	Lecturette
Signs and symptoms of STDs	
How to prevent STDs	

MATERIALS

None

EVALUATION

Pre/post test questions

TRAINING FOR COMMUNITY BASED DISTRIBUTORS

TOPIC:

RIGHTS OF THE CLIENT

SPECIFIC OBJECTIVE:

- Define and explain the RIGHT
- List and explain TRN rights of the client
- Demonstrate how rights are useful to a client

TIME: - ONE HOUR

CONTENTS	TEACHING METHODS
- Definition	Lecturette
- Explanation on how useful rights are	Demonstration and Group discussion
- Common barrier to explanation of the right	

MATERIALS

Handout

Right 1 - 10

H A N D O U T S

SYMBOLS

NF	=	NEW FEMALE USER
CF	=	CONTINUING FEMALE USER
NM	=	NEW MALE USER
CM	=	CONTINUING FEMALE USER
R	=	REFERRED
GA	=	GONE AWAY
V	=	VISITOR
RN	=	REGISTRATION NUMBER
NR	=	NEW REFERRAL
RS	=	REFERRED FOR SIDE EFFECTS

Mr. Canner

CURRICULUM FOR TWO-DAY TRAINING OF TBA's

DAY ONE - HIV/AIDS AWARENESS AND PREVENTION

1. What is AIDS?

   * A-I-D-S
   * Disease
     - dangerous
     - no cure/vaccine
     - destroys immunity so that one is unable to fight other infections.
   * Everyone can get AIDS, it doen't choose
   * AIDS in Malawi.

2. What is HIV?

   * H-I-V?
   * Virus that causes the disease AIDS
   * HIV destroys body's ability to fight disease.
   * How one is tested for HIV
   * What is meat by HIV(+) and HIV(-)

3. What is the relationship between AIDS and HIV?

   * Stages of infection
     - Initial infection
     - Window period (6 - 8 weeks) till antibodies are detectable in blood.
     - Asymptomatic (carrier and transmitter)
     - Symptomatic (include common symptoms)
     - Terminal.

4. How is HIV transmitted?

   * Sexual intercourse
   * Blood/blood transfusion
   * Perinatal transmission (during pregnancy or childbirth)
     - mother and baby share blood
     - baby can ingest blood and mucous passing through the birth canal

5. How is HIV not transmitted?

6. What are high risk behaviours and situations?

   * sex with an infected person
   * becoming pregnant if HIV(+)
   * using contaminated skin-piercing instruments
     - injections outside of hospital
     - needles for ear-piercing
     - razors for circumcision, traditional medicine

7. How is HIV transmission prevented?

* Preventing sexual transmission
  - Sexual abstinence/delayed sexual debut.
  - Mutual faithfulness.
  - Condom use (include demonstration).
* Preventing perinatal transmission
  - family planning
* Avoiding unsterile instruments

DAY TWO - TOPICS RELATED TO TBA PRACTICE

8. What can TBA's do in order to decrease the risk for mothers and babies?

* Promote condom use and distribute condoms
  - helps prevent HIV infection and other STD's
* Encourage child spacing
  - 3 out of 10 babies born to HIV(+) mothers will be born HIV(+)
  - babies with HIV will develop AIDS and die within 2 years
  - HIV(+) mothers will eventually die from AIDS and leave orphans
* Refer STD cases to the hospital
  - people with STD's are at high risk for HIV infection because blood and open sores are present
  - STD's must be <u>properly</u> treated or else the organism causing it won't die and the person isn't really cured; also, a person can become immune to medicine if not taken properly
* Refer problem pregnancies to the hospital
  - obstructed labour and other problems can cause hemorrhage which increases the amount of blood present and the risk to the baby
  - anaemic women must be referred as soon as possible to prevent blood transfusion and possible HIV infection
* Do not give injections during pregnancy
  - unsterile equipment can cause HIV infection
* Do not give medicine to force contractions
  - this can cause hemorrhage - blood is dangerous for baby and mother can become anaemic
* Use new razor blades when cutting umbilical cord.
* Wait for natural expulsion of placenta
  - pulling it out can cause hemorrhage - dangerous for mother and also TBA as blood is present
* Burn or bury placenta
  - avoids infection in anyone who may come in contact with the fluids

8.5 What TBA's <u>should</u> promote for healthy mothers and babies.

* Promote breastfeeding
  - risk of HIV infection is low for baby but lack of breast milk can cause serious diseases
  - mothers should make sure nipple is not cracked and bleeding
* Encourage mothers to have babies immunized
  - hospitals use sterilized equipment so there is no risk of HIV infection for baby

9. What can TBA's do to decrease their risk of HIV infection?

* Wear gloves and shoes
  - avoids contact with blood, secretions, placenta
* Wash hands with soap after contact with blood, secretions, placenta
* Sterilize gloves and other instruments (ie. scissors)
  - boil for 20 minutes or at least wash with soap and dry in the sun
* Sterilize surfaces (table or floor) and any cloths (chitenje, blanket)
  - wipe/wash with soap and water
* Dispose of any soiled materials by burning them (ie. cotton wool, rags)

REPORT ON AIDS KABP SURVEY
CONDUCTED BY INTERNATIONAL EYE FOUNDATION
AT KAPACHIRA FALLS, MALAWI

FUNDED BY THE U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
CHILD SURVIVAL X

Cooperative Agreement No. FAO-0500-A-00-4041-00

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Sample questionnaires (English and Chichewa)

I. INTRODUCTION

The International Eye Foundation supports a child survival project in Chikwawa District in the Lower Shire Valley of Malawi. As the AIDS epidemic is expected to significantly increase infant mortality, IEF has integrated AIDS education into its child survival activities. Kapachira Falls, located in the Majete Game Reserve in northern Chikwawa District, is soon to be the sight of a major hydroelectric dam project, coordinated by ESCOM and funded by the World Bank. During the construction phase the area will be the temporary home for over a thousand contractual workers, many of them single men. The area currently supports a population of about 2,800, many of whom are women whose husbands spend most of the year in other parts of the district seeking employment. At the request of the District Health Officer International Eye Foundation planned and carried out a KABP survey in preparation for AIDS education activities.

Some qualitative information has been gathered on HIV/AIDS and sexually transmitted diseases knowledge, attitudes and practices through training, briefings and discussions in the area. While some basic information has reached many people, there is widespread ignorance and denial of the transmission of HIV. Moreover, there are cultural attitudes and practices which inhibit behavior change in relation to the AIDS virus. The quantitative information obtained from this AIDS KABP survey is used to determine the attitudes and beliefs as well as external factors influencing existing behavior. Also, this information can be used to assess the effectiveness of the currently used educational messages and to develop appropriate prevention and control activities for the Kapachira Falls area as a whole as well as for specific target groups.

II. SURVEY METHODS

SURVEY INSTRUMENT

The AIDS KABP survey instrument was developed in collaboration with the District Health Officer (Chikwawa), SUCOMA medical officer, Montfort Hospital medical officer, and Regional Health Officer South). There are a total of 61 questions in the instrument for males; the married female instrument omits one question about salary, and the unmarried female and female head of household instrument omits 3 questions about spouse. One male and one female questionnaire in English are included as Appendix I. On average, trained interviewers were able to complete one interview in approximately 30 minutes, and Chichewa was the language used in the interviews. The survey was conducted between 22-28 March, 1995.

ENUMERATORS

The data was collected by five enumerators, four men and one woman, all of whom are permanent residents of Chikwawa District and most of whom had been trained by IEF previously for other surveys. As the same instrument had been used for a previous survey in Nchalo, Chikwawa, enumerators underwent a one day refresher on survey

methodology.

VILLAGE SELECTION

Six villages in the vicinity of Kapachira Falls were chosen for the survey: Bwalo, Kandeu, Liwonde, Maganga, Mwalija 1 and 2. One village was covered each day.

SUBJECT SELECTION

The survey populations included men and women of the approximate child-bearing ages of 15-45 years. Unmarried women, however, were a maximum of 25 years of age. The planned and achieved sample sizes are as follows:

Group	Planned	Actual
Males	50	50
Spouses of selected males	45	35
Unmarried women (ages 15-25)	100	104
Female heads of household	100	95
Total	395	384

Village leaders were briefed regarding the nature of the survey and assured that the information would be kept confidential. From a central location in the village, the starting household was randomly chosen.

At each house the following information was obtained: presence of males aged 15-45, presence of unmarried women aged 15-25, and whether a female aged 15-45 was head of household. If an male was present, he was interviewed, as was his wife, if married. The most recently visited house with an unemployed male was then revisited, and that male interviewed along with his wife if married. When 9 men and their wives were interviewed, this categories were completed for that village. Any unmarried female aged 15-25 who was not head of household was interviewed in these houses. When 17 such women were interviewed in a village, this category was completed. If the household was headed by a female aged 15-45, she was interviewed until 17 such interviews were done in a village.

DATA ANALYSIS

Data was entered onto personal computer using Epi-Info. Invalid data was excluded at entry through the use of range checks and skip patterns. Frequency tabulations were also done using Epi-Info.

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III. RESULTS

DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS

Of 50 men surveyed, 69% were married, 19% of those men were polygamists. Of those that were married, 35 wives were interviewed, as well as 104 unmarried women. Of the 95 female heads of household, 14% were married currently, 62% were separated, divorced or widowed and 24% had never been married.

Of all men, 26% were employed full-time, and 74% were unemployed or farmers. The monthly salary was less than K 400 (US$ 26) for 80% of employed men. Only 2.9% of married women and 23% of unmarried women earn some income for their family, while 27% of female heads of household earn some income. Between 77% and 90% in all groups were permanent residents of the Kapachira Falls area. Those who are temporary residents mostly came to stay with relatives, or, in the case of the married women, because of their husbands. Almost all (97%) of men and their wives live together all of the time.

The average age of males surveyed was 28.3 years, and 27.2 years for married females. The average ages for unmarried females and female heads of household were 17.9 and 31.5 years respectively.

Half of men own radios, but between 16-34% of other women own radios. One-quarter of men and married women own bicycles, while less than 10% of other women own bicycles.

Many men (62%) could read a newspaper in Chichewa easily or with some difficulty. Likewise, 66% had attended school, 5 years of primary school on average. Nearly half of unmarried women (49%) had attended an average of 4.4 years of primary school, but 58% could not read at all. Most married women (74%) and women heads of household (70%) never attended school and could not read at all (74% and 81%).

The vast majority of people in all groups were Mang'anja by ethnic group, ranging from 84% to 90%. Sena and Lomwe were also represented. The majority in all groups were Christians, about 10% being non-Christians.

The overwhelming majority of people had children, except for only 14% of unmarried females aged 15-25. About half of each group wanted more children; 34% of married men, 17% of married women and women heads of household, and 5% of unmarried women were using a family planning method.

Five different categories of interviewees were surveyed, and percentages of responses to questions were calculated separately for each category. However, in the data analysis, the numbers reported will be those of the male responses when the percentages for the other categories closely follow the same trends. If there are significant differences among categories, those percentages (usually as a range) will be given and comments will be made.

AIDS KNOWLEDGE AND SOURCES OF INFORMATION

While only 2% of men said they had not heard about AIDS, the percentages were higher for most groups of women. Among married women 6% had not heard about AIDS, 24% of unmarried women had not heard about AIDS, and 15% of female heads of household had not heard about AIDS. The most common source of AIDS information is radio (60%), with health workers (12%) and friends (12%) as the next most common sources. Despite high levels of awareness of the existence of AIDS among most people, only 4% of unmarried women, 1% of women heads of housegolds and none of the married men and women considered AIDS to be the most serious health problem in their community. Moreover, 72% of people admitted that they knew nothing or very little about AIDS.

Nearly three-quarters (71%) of men and around half (43-58%) of the women have seen a person thought to have AIDS, but very few (8.2%) admitted to having a friend or relative with AIDS.

When asked the cause of AIDS, 67% of men, but less than half (39-48%) said "having many boy/girlfriends." The next most common answer was virus (18-33%), followed by "I don't know" (4-21%), and sex with bargirls (2-9%).

Knowledge of the asymptomatic period associated with HIV infection was low. When asked how a person can know if he is infected with the virus that causes AIDS, 84% said that the person feels sick; 6% (15-18% of women) said that they didn't know, and 10% said that you could know by having a blood test done at the hospital. A person with the AIDS virus could not look strong and have no symptoms according to 76%. However, most of those who did know that an HIV infected person could be asymptomatic (24%) also knew that such a person could transmit the virus to someone else (92%).

In accordance with the lack of understanding of the importance of a blood test in discovering HIV infection, few people said they had been tested: 24% of unmarried women, 6.1% of males, 15% of married women, and 8.9% of female heads of household.

Knowledge of HIV transmission was fairly high, with the majority of people recognizing the main modes of transmission. However, a significant number of people had misconceptions about transmission involving donation of blood, mosquitoes, and casual contact. (See Table 1).

Only 1.3% of unmarried women and none of the rest thought it was possible to get the AIDS virus out of the body once a person has been infected.

Interviewees were asked about the likelihood of them being infected with the AIDS virus. Most people (83%) answered that it was possible, but many (10-31%) answered that it was impossible. Very few thought it was probable (2-6%).

They were then asked if they were doing anything to protect themselves against AIDS. Over three-quarters (76-87%) said that they were taking

some protective measures. Most men and women said they were "avoiding certain types of men/women".

Regarding the problem of AIDS in their community presently, a large number (65%) thought it was not a problem at all or only a small problem. A larger number of people thought that the seriousness would increase in the future.

Only 12% of men, 3.0% of married women and 22% of the rest said they had been taught or counselled about AIDS in the past six months. Those who did receive some AIDS education or counselling got it from health personnel or community health workers. Men mentioned the latter more often, while women mentioned the former.

ATTITUDES REGARDING AIDS

Interviewees were then read statements focusing on attitudes about AIDS. The large majority of people agreed that AIDS infection could be avoided through behavior change. Less than half of women thought that women were primarily to blame for the spread of AIDS, but three-quarters of men agreed with that idea. The majority of people agreed that sex with many partners and having sex while infected with STDs increases the risk of HIV infection.

Significant numbers of people, especially women, did not agree that the very old and the very young could become infected, suggesting that people associate AIDS mainly with sexual behavior. Likewise, many people did not agree that an infected woman should not bear a child. It is not clear if this is because perinatal transmission is not thought of as a major transmission mode or if people do not think this is a good reason to stop having children.

The overwhelming majority thought that both primary and secondary school students should learn about AIDS at school, although fewer women heads of household felt this way. The majority felt that a person with AIDS could be cared for at home. From 6-30% thought that traditional healers could cure AIDS, this despite the fact that almost everyone believed that HIV could not be removed from the body. (See Table 2).

The next questions focused on responses to the impact of AIDS on the community. The large majority (84% of men, 69% of women) felt that the government is doing enough to fight AIDS in Malawi. Over half the men and women heads of household (55% and 52%) felt that they personally were doing something to help the community fight AIDS, and less than 40% of women felt they were doing something. The most frequent action mentioned was abstinence/monogamy, followed by condom use (men and female heads of household only) and proper care of razors.

Over half (57%) of the men felt that they could do something to influence their friends to change their sexual behavior to prevent the spread of AIDS, but only 18-30% of women felt this way.

Despite the failure of most people to take concerted measures against

AIDS, the large majority (78% of men, 84-90% of women) thought AIDS could be prevented by taking care of oneself.

ATTITUDES REGARDING SEXUAL BEHAVIOR

Interviewees were asked to agree or disagree with statements about sexual behavior and acceptability in order to gain insights into attitudes and practices which may be related to the spread of AIDS. About 20-30% of men, unmarried women and women heads of household thought it acceptable for boys and girls to experiment with sex before marriage, but only about 5% of married women felt this way. While few (0% of men, 9-17% of women) agreed that it was acceptable for a man to have extramarital partners, 50% of men and over 60% of women agreed that this is common. Conversely, less than 20% of all respondants agreed that this practice was acceptable for women. These findings illustrate the large degree of hyporcrisy and inconsistency in these matters. Over half (68%) of men but only 29-44% of women thought that it is easy for girls to refuse money or gifts in exchange for sex. (See Table 3).

In order to determine at what stage in their lives people begin to have sexual intercourse and possibly put themselves at risk for HIV infection, people were asked about their age at their first sexual experience. The answers vary among the different groups of women and men. (See Figure 1). A significant number said they did not remember, perhaps because they preferred not to answer this sensitive question. We can see that the majority of people became sexually active before their nineteenth year, thus demonstrating the need for education targeted at the youth. To try to understand the reasons why young people begin having sex, the question, "Did you personally feel ready to have sexual intercourse?" was asked. The great majority (82%) answered, "Yes," although the percentage was lower (67%) for unmarried women.

TRADITIONAL HEALERS

Two questions were asked concerning traditional healers. Over half (62-72%, 43% for married women) said they never went to a traditional healer for treatment for themselves or a family member. However, those that have been to see a traditional healer go regularly. Of those who see a healer, 29% go once a week and 43% go once a month (more frequently for women). Thus, a significant number of people have frequent contact with traditional healers, and it is generally said that people prefer to see these healers for very personal issues because there can be a lack of privacy at hospitals. Thus, these healers can be an important source of information on HIV/AIDS, STD's and condoms in their communities.

KNOWLEDGE AND ATTITUDES REGARDING CONDOMS

The next section of the survey focused on knowledge and attitudes concerning condoms. Interviewees were asked to agree or disagree with statements about condoms. There was a fair amount of variation in responses among groups, and all percentages are given in Table 4. The majority (83-90% of men and married women, 59-72% of others) agreed

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that condoms offer protection against STD's, pregnancy and AIDS, with extremely high numbers of bargirls agreeing. There were mixed opinions about condom usage and problems arising from condoms, and some misconceptions as well. The majority (62-90%) agreed that it is acceptable to advertise condoms on the radio. The majority (80% of men, 53-64% of others) of all but married women also agreed that if a man suggested using condoms with his wife, she would suspect him of being unfaithful to her. A significant number answered that they didn't know how to respond to a statement, indicative of a lack of experience using condoms and also lack of knowledge about condoms.

When asked where they would get a condom if they wanted one, 12% of men and 17-23% of women said they didn't know. The large majority (74%) of those who did know where to find one said they would get a condom from a hospital or health centre. Others (14%) said they would get a condom from a store or resthouse, but very few people said they would get a condom from a spouse, friend, or sex partner.

There was also significant variation between men and women regarding knowledge of how to use a condom. While 50% of men said that they knew how to use a condom properly, only 11-14% of women felt that they knew how to properly use a condom. One-third of married women and over half (56-65%) of the others who said they did not know wanted to learn.

SEXUAL PRACTICES

Interviewees were asked to reveal how many sexual partners they had in the last three months, other than their spouses. Of the men, 84% said they had none, and 100% of the married women said they had none. The remaining 16% of men had an average of 1.9 other partners. These figures point to a high rate of monogamy among married people, but other factors may have influenced these results. Three months may be too short a period of time to fully ascertain the full extent of extra-marital relations. Also, men and their wives may have been reluctant to answer truthfully, especially if their spouses were being surveyed at the same time and location.

Among unmarried women, 48% said that they had no sexual partners in the last three months, and the other 52% had an average of 1.1 partners. Among female heads of household, 69% said that they had no sexual partner in that period of time, and the other 31% had an average of 1.8 partners. The rates of abstinence seem high, and again, the results may have been influenced by the sensitive nature of the question.

CONDOM USE

All interviewees were asked if they ever used a condom. Only 36% of men and 9-14% of women had used one. The main reasons given for not having used a condom were "don't know how" (61%), partner refuses (13%), and lack of availability (16%). Very few mentioned cost, dislike, or religion as reasons.

Those who had used a condom were asked questions about condom usage.

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However, due to the small numbers using condoms the responses to these questions are hard to interpret.

Next, those who had used a condom were asked about their personal experiences with condoms during the last six months. The vast majority of men and married women felt that using condoms was helping them to avoid AIDS. Only a small number reported problems with condom usage and breakage. However, a significant number had used the same condom more than once, and, in fact, many reported wanting a condom but not having one available.

Very few (5.9%) of these interviewees reported increased condom use within the last six months, 18% of men and 33-44% of women reported decreased condom use, and for most (58-100%) it did not change. The reasons for these trends were not reported. Unavailability of condoms is one possibility, a factor which could be easily remedied.

ALCOHOL CONSUMPTION

All interviewees were then asked questions related to alcohol consumption. Two-thirds of men said they never drink alcohol. Approximately 95% of women (77% for women heads of household) said they never drink alcohol. Once again, because of small numbers reporting drinking, the reponses concerning frequency, location and type of drinking are difficult to interpret. Most drink in Chikwawa (boma) or with friends in the village, and most drink either Chibuku (local beer) or kachasu (local cane spirits). Very few interviewees reported that they found a sex partner the last time they drank.

SEXUALLY TRANSMITTED DISEASES

The final portion of the survey addressed STD's. People were asked if they ever suffered from gonorrhoea and syphilis. The overwhelming majority of people did not admit to ever having these diseases. Again, this is a very personal subject which people may have been unwilling to talk about truthfully. See Figure 2 for the breakdown of responses by groups.

Most of those who had either or both diseases also had treatment for the symptoms, but to varying degrees. Treatment was sought by 100% of all groups except married women (75%). The most common sources of treatment were traditional healers and hospitals/health centers. Men, married women received treatment more often at hospitals and health centers, while unmarried females and women heads of household preferred traditional healers.

When asked if one's spouse also received treatment for such diseases, 67% of men and 75% of married women said, "Yes." Only 40-44% of unmarried women and women heads of household reported that their partners received treatment. For men and married women the most common reason given for partners not receiving treatment was that they were not married at the time. For unmarried women, all reported that the partner was not treated because he refused.

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IV. RECOMMENDATIONS

Although most people have heard that there is a disease called AIDS, this awareness alone will do little to slow the impact of AIDS on the country and the people of Malawi. Basic information about HIV/AIDS, modes of transmission, and methods of prevention must reach all people. Common misconceptions about the disease must be clarified, and the need for behavioral changes must be reinforced.

There is still a need for AIDS education targeted at all groups in the Kapachira Falls community, especially unmarried women, since they will be sought out for sex by workers on the dam project. Women seem to have a different level of knowledge and have responded differently to the AIDS crisis than men. Emphasis should be placed on all modes of transmission, especially perinatal transmission. The orphan situation and the need for child spacing should be stressed, and protective measures against AIDS examined. As the main caretakers of children, it is crucial for women to have accurate information. A forum in which women can discuss their concerns about AIDS with other women might be especially helpful, as dialogue between men and women about sex is not common in Malawi. While these topics should also be understood by men, women have an especially important role to play.

Likewise, men are in a position to take responsibility for certain factors related to AIDS. Men are generally more mobile and have access to cash more often than women. They are more likely to leave their homes and have sex with women away from their homes. "Sugar Daddies" and men who have sex with bargirls must be made aware of the riskiness of this behavior, not just for themselves but for their entire families as well as for the women with whom they have sex. Since most people already know that HIV is transmitted through sex, simply restating the modes of transmission does not seem to be enough to bring about behavior change. Perhaps giving statistics on the prevalence of HIV among bargirls, antenatal women, and the difference in rates of HIV infection between young girls and boys would cause men to think about the implications of their sexual behavior.

Of particular concern in this population is the effect of the influx of the hydroelectric dam project contractors on single women in the area. Because they are unlikely to refuse sex if offered gifts or money, these women need special attention, both in terms of education and income generating activities.

SEXUALLY TRANSMITTED DISEASES AND AIDS

Many people do not understand that having an STD puts one at increased risk of HIV infection. Furthermore, many people do not get proper treatment for STDs, and they do not get proper treatment for their partners. The link between STDs and HIV infection should be part of an AIDS briefing for all groups of people in order to avoid high-risk behaviors. Also, people already suffering from STDs must be targeted so that they can prevent HIV infection in themselves and others. Those attending STD clinics must be briefed on AIDS. Traditional healers must be taught to refer STD cases to the hospital for proper treatment.

YOUTH

The most important group to include in prevention activities is the youth. They must have access to all the important information about AIDS, and they must have the opportunity to ask questions and discuss things freely. According to the survey, most people begin to experiment with sex during the teenage years. Before one becomes sexually active, one should understand about sexual transmission of HIV as well as prevention. Most of those surveyed said that primary and secondary school students should learn about AIDS in school. It is necessary to train teachers about AIDS so that educational messages can be communicated from teachers to students in schools. Also, AIDS clubs in schools will give students the opportunity to discuss their concerns and to actively participate in the fight against AIDS.

Not to be forgotten are the out-of-school youth. Since they do not have contact with teachers in school, others that have an influence on young people should be involved in AIDS education. These people can include church leaders, traditional advisers, traditional healers, and others. Obviously, there is a need to train these people so that they can teach others. In addition to being able to adequately explain the facts about AIDS, they must be able to talk about sex and other sensitive issues and give encouragement to young people who are trying to take control of their sexual lives. Peer education is also extremely important for the youth since talking about sex with parents and other adults is neither common nor easy. Furthermore, some high risk behaviors in young people are actually the result of parental influence. For example, about three quarters of those surveyed thought that girls should be having premarital sex. Several women reported becoming sexually active because parents forced them to do so. Young people need support to continue good practices, and their peers can be very influential, so it is important that those peers be good sources of information Other than in schools, youth peer educators can be trained from churches, sports clubs, and drama groups. Young people both in and out of school can also be reached by methods such as drama, songs, and advertisements.

MESSAGE TARGETING

We have seen that radio, health workers, and friends have been the most effective means of delivering AIDS messages to the community. In order to take this one step further and actually encourage behavior change in people, the messages should be geared for particular groups of people. Many people seem unable to personalize the danger of AIDS. However, if they were exposed to messages which help them to identify the ways in which they are personally at risk of HIV infection, maybe they would be more likely to take steps to reduce their risk. For example, girls should know that infection rates are higher for girls than boys and the reason is that men are taking sex partners who are very young and spreading the virus among them. Women should know before they consider getting pregnant that an HIV-infected mother can pass the virus to her baby. Such specific messages can be delivered through both radio and health workers who have direct contact with

people. As more people hear and understand these messages, the more important friends will be as a means of relaying the information.

COMMUNITY SENSITIZATION

We have seen that while many of those surveyed have seen a person with AIDS, few would admit to having a relative or friend with AIDS. There is a need for sensitizing the community about the presence of AIDS. Denying that AIDS has affected an individual or a family will only allow the disease to spread. Only a community that is aware of the prevalence of HIV/AIDS and realizes the urgent need to stop its spread can work to erase the ignorance and behaviors which facilitate the spread of this disease. Community briefings must include village leaders and should stress the magnitude of the problem and the reasons why the situation is so advanced in Malawi and Nchalo in particular. These leaders must be aware of the facts and understand the reasoning behind them so that they can relay AIDS messages to their villagers continually, not only when an outsider has come to talk to them. A "red ribbon campaign" is another way to encourage people to admit that AIDS has affected their lives, and to make a personal statement about it.

CONDOM PROMOTION

Behavior change is not easy to bring about, especially involving sexual habits. However, condom use is a practice which people may be willing to adopt since it allows them to have sex while protecting themselves from HIV infection. Certainly, it is easier than abstinence, and it must be an integral part of the AIDS control project. The misconceptions about condoms resulting from lack of knowledge must be addressed. Many of the problems people report experiencing with condoms may be the result of improper usage. All those requesting condoms from health centers should be asked whether they would like a demonstration. Those distributing condoms in stores and bars should also be trained and asked to pass the knowledge to those requesting condoms, if necessary.

Men and women should know of the role condoms can play in child spacing. If condoms were considered useful in permanent relationships as well as for casual sex, the overall rate of usage would increase. In order for people to use condoms regularly, they must be easily accessible. Lack of free condoms at the regional level from the Ministry of Health often means that the supply to Nchalo is low. It is necessary to keep the Regional AIDS Coordinator informed of condom requirements as well as the shortages encountered. "Chishango" brand condoms should be supplied to retailers in the area for resale.

Table 1: Modes of Transmission

The percentages listed in Table 1 are for the following categories in the following order: married men, married women, unmarried females, female heads of households

MODE OF TRANSMISSION	AGREE	DISAGREE	DON'T KNOW
from man to woman through sexual intercourse	98.0% 100.0 84.8 96.3	2.0% 0.0 7.6 3.7	0.0% 0.0 7.6 0.0
from woman to man through sexual intercourse	100.0% 100.0 87.3 93.8	0.0% 0.0 2.5 6.2	0.0% 0.0 10.1 0.0
from mother to child inside womb	85.7% 84.8 59.5 71.6	8.2% 0.0 21.5 13.6	6.1 15.2 19.0 14.8
from mother to child through breastmilk	83.7% 93.9 59.5 80.2	10.2% 0.0 26.6 13.6	6.1% 6.1 13.9 16.2
by coughing/sneezing	39.6% 57.6 32.1 49.4	45.8% 39.4 55.1 35.8	14.6% 3.0 12.8 14.8
by shaking hands	26.5% 36.4 21.5 24.7	61.2% 63.6 64.6 53.1	12.2% 0.0 13.9 22.2
by eating from the same plate	28.6% 30.3 25.3 27.2	61.2% 69.7 64.6 58.0	10.2% 0.0 10.1 14.8
by donating blood at the hospital	69.4% 75.8 53.2 46.9	24.5% 21.2 30.4 37.0	6.1% 3.0 16.5 16.0
by mosquitoes	55.1% 48.5 34.2 67.9	28.6% 33.3 34.2 19.8	16.3% 18.2 11.4 12.3

Table 2: Attitudes about AIDS

The percentages listed in Table 2 are for the following categories in the following order: married men, married women, unmarried females and female heads of households (combined)

STATEMENT	AGREE	DIS-AGREE	DON'T KNOW
A man can prevent becoming infected with AIDS by changing his behavior.	89.8% 90.9 89.4	6.1% 9.1 9.4	4.1% 0.0 1.3
If a woman is infected with the AIDS virus she should not bear a child.	77.1% 57.6 61.9	16.7% 36.4 21.3	6.3% 6.1 16.9
A child (about 6 years old) can become infected with AIDS.	53.1% 36.4 32.5	34.7% 60.6 48.8	12.2% 3.0 18.8
An old person (about 70 years old) can become infected with AIDS.	75.5% 48.5 43.8	18.4% 51.5 41.3	6.1% 0.0 15.0
A person with AIDS can be cared for in the home.	83.7% 84.8 75.6	14.3% 15.2 20.6	2.0% 0.0 3.8
Primary school students should learn about AIDS in school.	91.8% 87.9 71.9	6.1% 9.1 20.6	2.0% 3.0 7.5
Secondary school students should learn about AIDS in school.	91.8% 93.9 74.4	6.1% 3.0 18.8	2.0% 3.0 6.9
A woman can prevent becoming infected with AIDS by changing her behavior.	93.9% 100.0 86.9	2.0% 0.0 10.0	4.1% 0.0 3.1
Sleeping with many different partners increases the risk of getting AIDS.	93.9% 100.0 77.4	2.0% 0.0 6.3	4.1% 0.0 16.4
Having sex when either person has open genital sores increases the risk of getting AIDS.	87.8% 93.9 74.2	6.1% 3.0 10.7	6.1% 3.0 15.1
There are some traditional healers who can cure AIDS.	14.3% 6.1 28.9	71.4% 90.9 65.4	14.3% 3.0 5.7
Women are primarily to blame for the spread of AIDS.	75.5% 36.4 52.2	20.4% 45.5 34.6	4.1% 18.2 13.2

Table 3: Sexual Behavior and Acceptability

The percentages listed in Table 3 are for the following categories in the following order: married men, married women, unmarried females and female heads of households (combined)

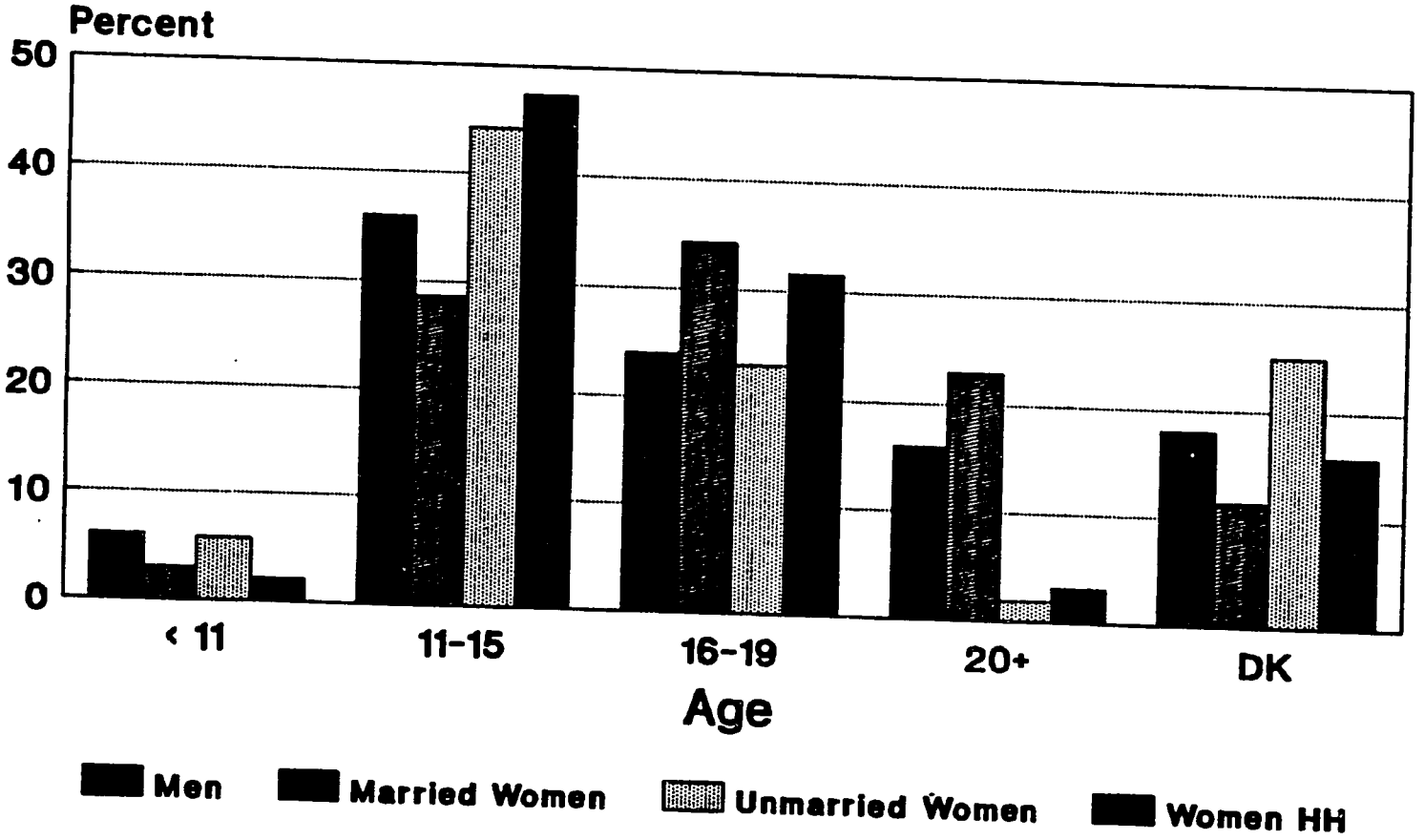
STATEMENT	AGREE	DIS-AGREE	DON'T KNOW
It is acceptable for a boy to experiment with sex before marriage.	20.0% 2.9 30.2	78.0% 97.1 67.8	2.0% 0.0 2.0
It is acceptable for a married man to have sex with women other than his wife.	0.0% 8.6 14.6	98.0% 91.4 82.4	2.0% 0.0 3.0
It is acceptable for a girl to experiment with sex before marriage	18.0% 5.7 23.6	82.0% 94.3 74.9	0.0% 0.0 1.5
Most married men have sex with women other than their wives	50.0% 61.8 63.6	48.0% 38.2 27.3	2.0% 0.0 9.1
If a girl is offered money or gifts by a man to have sex with him, she can easily refuse.	68.0% 28.6 41.4	24.0% 60.0 43.4	8.0% 11.4 15.2
It is acceptable for a married woman to have sex with men other than her husband	12.0% 5.7 14.1	84.0% 94.3 78.9	4.0% 0.0 7.0
Most married women accept that their husbands have girlfriends.	14.0% 5.7 18.1	78.0% 88.6 69.8	8.0% 5.7 12.1

Table 4: Feelings About Condoms

The percentages listed in Table 4 are for the following categories in the following order: married men, married women, unmarried females and female heads of households (combined)

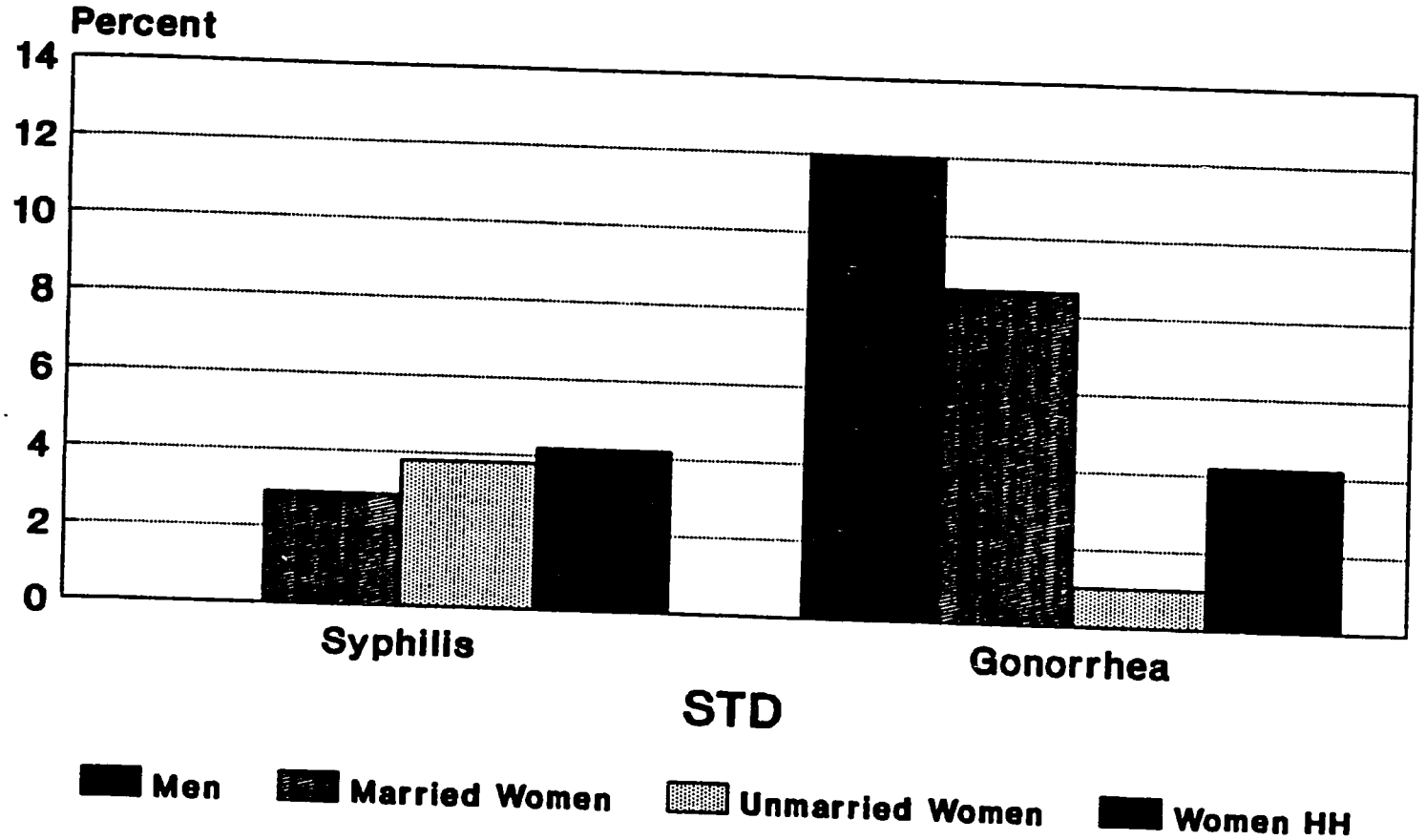
STATEMENT	AGREE	DISAGREE	DONT KNOW
Condoms can protect against syphilis/gonorrhoea.	90.0% 82.9 59.3	6.0% 0.0 14.1	4.0% 17.1 26.6
Condoms can protect against pregnancy.	86.0% 82.9 64.3	8.0% 0.0 15.1	6.0% 17.1 20.6
Condoms can protect against AIDS.	84.0% 85.7 69.2	8.0% 2.9 11.6	8.0% 11.4 19.2
Condoms are easy to obtain.	77.1% 74.3 52.3	18.8% 2.9 17.1	4.2% 22.9 30.7
A man cannot feel good if he uses a condom.	64.0% 25.7 40.9	28.0% 34.3 20.2	8.0% 40.0 38.9
Condoms are easy to use.	77.6% 42.9 44.2	18.4% 14.3 22.1	4.1% 42.9 33.7
Condoms can be used more than once	18.0% 25.7 23.2	76.0% 31.4 43.4	6.0% 42.9 33.3
Condoms can get lost in the womb.	64.0% 31.4 38.9	22.0% 17.1 27.8	14.0% 51.4 33.3
Condoms break easily during intercourse	79.6% 45.7 44.4	12.2% 14.3 20.2	8.2% 40.0 35.4
It is acceptable to advertise condoms on the radio	90.0% 82.9 67.3	4.0% 5.7 20.6	6.0% 11.4 12.1
If a man suggested using condoms with his wife she would suspect him of being unfaithful to her.	80.0% 48.6 58.3	8.0% 37.1 19.1	12.0% 14.3 22.6

Figure 1: Age at first intercourse
Kapachira Falls, Chikwawa District



IEF, March 1995

Figure 2: Incidence of STDs
Kapachira Falls, Chikwawa District



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Graduated with Honours, May 1990.
Grade Point Average: 3.6.

CURRENT WORK

JANUARY 1995 to present.
Drought Monitoring Supervisor, INTERNATIONAL EYE FOUNDATION, Chikwawa, Malawi.

- Supervising the monitoring of sentinel village sights in Chikwawa District as part of the drought relief programme, to facilitate the collection of information from health and agriculture extension workers, to help in targeting limited food aid from WFP and to disseminate information to communities being surveyed.
- Conducting anthropometric surveys on children being monitored with mid-upper-arm circumference tapes (MUAC) in the drought programme. Surveys will show chronic malnutrition not detected with MUAC measurements, as well as help determine the usefulness of MUAC as a longer-term monitoring indicator. Funded by UNICEF.
- Designing a surveillance and information strategy that bridges the drought monitoring begun in November with a more permanent community-based health and nutrition surveillance system.
- Involves continual contact with donor agencies such as UNICEF, FAO and WFP, as well as coordination with Ministries of Health and Agriculture at national, district and field level. Cooperating with other NGOs to improve existing programmes and to establish a national Food Security/Nutrition Network as part of UNICEF's National Plan of Action for Nutrition in Malawi.

WORK EXPERIENCE

APRIL 1994 to JANUARY 1995.
Researcher, REFUGEE STUDIES PROGRAMME, Oxford, UK & Malawi.

- Research into structures, operations and relationships between church organisations/individuals and beneficiaries. Involved extensive interviews with NGOs and refugees/returnees and frequent field visits throughout Malawi and Mozambique.
- Independently gathered funding through donations.

MAY 1994.
International Observer, UNITED NATIONS ELECTION ASSISTANCE SERVICE, with the Joint International Observer Group, Blantyre, Malawi.

- Investigated complaints of intimidation prior to elections. Observed election day proceedings including preparation of election sites, management of voting and counting of ballots in Mangochi District.

AUGUST 1993 to APRIL 1994.
Researcher & Assistant to the Director, MEDIA NATURA, London, UK.

- Research on gender in sustainable development, global environmental agreements, and ethical investment.
- Work involved organising book-collection campaign for library in Zambia, developing strategic media plans, writing/editing press briefings, proof reading, scheduling research trips, and researching new business options.
- Clients included Rockefeller Foundation, Global Environment Facility, Association to Aid the Refugees, and International Committee of the Red Cross.

NOVEMBER 1991 to JUNE 1992.
Researcher for Ann Taylor, MP, HOUSE of COMMONS, London, UK.

- Researched and handled correspondence for Shadow Minister of Environment Protection on Labour Party's Environment Protection Executive, Wild Mammals Protection Bill, Environmental Impact Assessment and Recycling.
- Assisted at Labour Party headquarters, Walworth Road during General Election.

NOVEMBER 1991 to MAY 1992.
Researcher for Rt. Hon, Lord Cocks of Hartcliffe, HOUSE of LORDS, London, UK.

- Conducted research for speeches and parliamentary questions; also collected information for book.

JANUARY to SEPTEMBER 1990.
News Intern, KUSA CHANNEL 9, Denver, CO, USA.

- Investigated stories and wrote news copy; helped in shooting and editing video for the 12 noon and 6pm newscasts.
- Full-time assistant to the News Director during summer.

MAY 1989 to MAY 1990.
Public Relations Director, UNIVERSITY of COLORADO STUDENT UNION, Boulder, CO, USA.

- Directed media relations of student government in writing press releases, negotiating advertising, drafting editorials for executives and co-ordinating press events.

MAY to AUGUST 1989.
Press Office Intern for Senator Tim Wirth, U.S. SENATE, Washington, D.C., USA.

- Assisted with research and writing press releases and news columns; co-ordinated satellite news conference.

• References available upon request. •

Dates	Participants					Facilitators			Subjects		Pre/Post Test		
	Cadre	MOH	Mtft	SUC	Oth	IEF	MOH	Mtft	Interv.	%	Min	Max	Mean
24/4/95 to 28/4/95	AIDS Volunteer				26	1	1	1	AIDS	100			
22/5/95 to 25/5/95	FWA Hosp Serv Pt Attend.	15 9 5				7 40%	3 60%		V/A EBF CDD Mat.Care FP AIDS PEC	11 17 9 11 17 17 17	12/40	77/95	55/80
2/6/95 to 23/7/95 (2 days each)	Trad Hlr				298	2 50%	1 50%		AIDS PEC	50 50			
12/6/95 to 16/6/95	HSA CHW	25 3	1 1			3 46%	4 58%	1 11%	VA EBF EPI CDD FP AIDS PEC Superv	9 17 9 6 11 17 17 9	33/60	83/98	
26/6/95 to 30/6/95	HSA CHW	22 2	4	1		4 42%	3 39%	2 19%	VA EBF EPI CDD FP AIDS PEC Hlth. Ed. Superv.	9 17 9 6 11 17 17 2 9	12/39	95/99	58/79

Mtft = Montfort Mission Hospital // SUC = SUCOMA // MLM = Mid-level Management

Dates	Participants					Facilitators			Subjects		Pre/Post Test		
	Cadre	MOH	Mtft	SUC	Oth	IEF	MOH	Mtft	Interv.	%	Min	Max	Mean
4/7/95 to 8/7/95	VHV VHC HSA	8			9 47	4 81%	1 18%		V/A EBF EPI CDD FP AIDS PEC Nutrition Sanitation	20 10 15 8 13 10 7 7 12		49 to 86	
10/7/95 to 14/7/95	VHV VHC HSA	4			10 41	2 24%	1 76%		V/A EBF EPI CDD FP AIDS Sanitation Nutrition Health.Ed.	20 10 15 8 13 10 7 7 12			
10/7/95 to 14/7/95	HSA CHW	26 1				3 24%	5 58%	1 18%	V/A EBF EPI CDD FP AIDS PEC SUPERV.	9 17 9 6 11 17 17 9	22/37	95/96	55/72

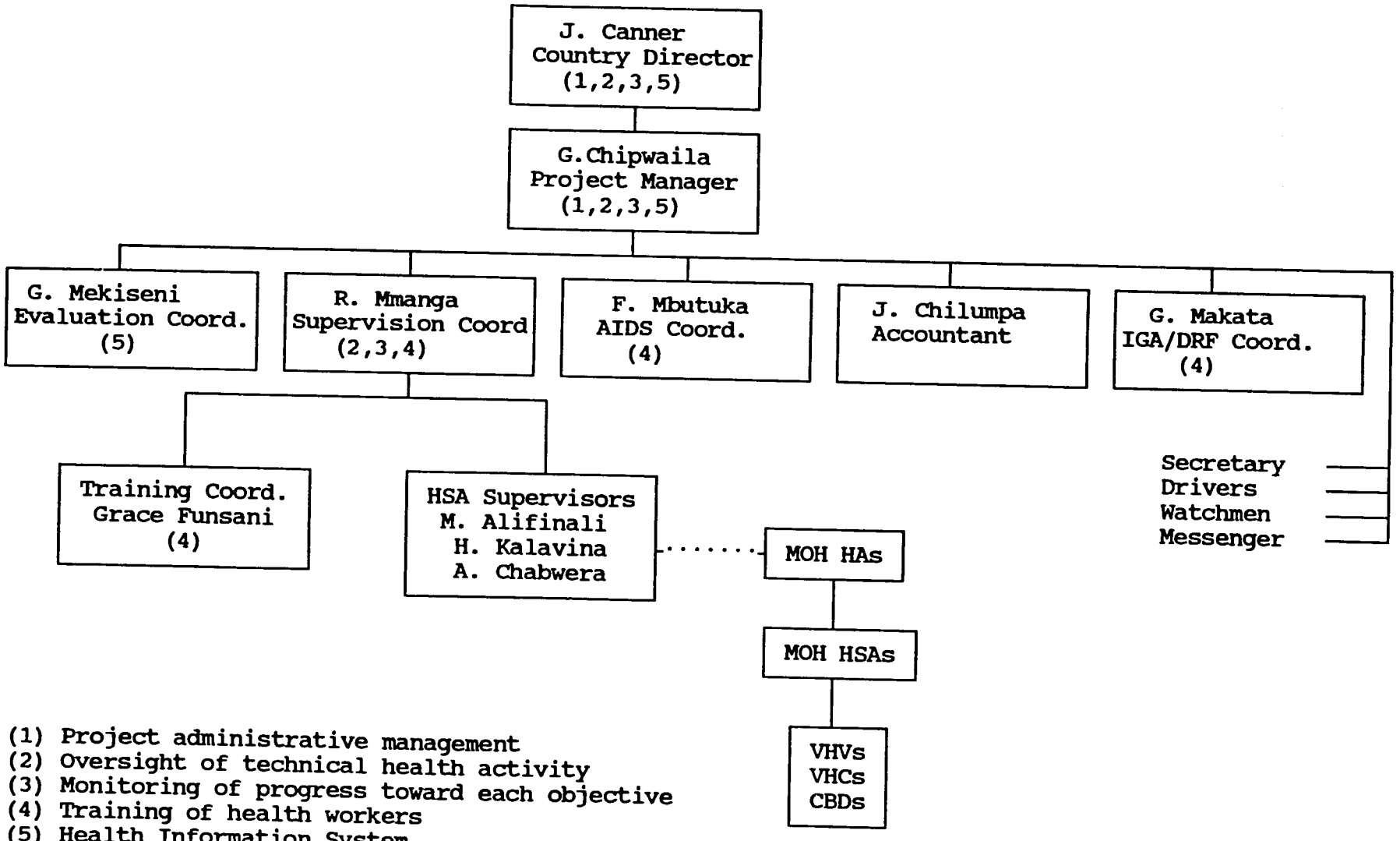
Dates	Participants					Facilitators			Subjects		Pre/Post Test		
	Cadre	MOH	Mtft	SUC	Oth	IEF	MOH	Mtft	Interv.	%	Min	Max	Mean
17/7/95 to 21/7/95	Volunteer	6				2 39%	1 21%	1 35%	DRF	100	43/84	80/100	
17/7/95 to 21/7/95	FWA Pt Attend Hosp Serv		12 3 3	4 3 5		4 44%	2 33%	2 22%	VA EBF CDD Mat Care FP AIDS PEC	17 17 6 11 9 17 17	24/49	90/100	64/76
12/8/95 to 1/9/95	TBA				12		5		Mat. Care VA EBF EPI FP AIDS	80 5 5 2 5 3	38/73	73/100	58/86
16/8/95 to 18/8/95	Nurse MA HA HI CO	6 6 3 1 1			1	2 30%	5 70%		VA EBF EPI CDD Mat Care FP AIDS PEC Superv.	6 12 6 6 12 6 12 12 28	28/45	45/100	70/86

Dates	Participants					Facilitators			Subjects		Pre/Post Test		
	Cadre	MOH	Mtft	SUC	Oth	IEF	MOH	Mtft	Interv.	%	Min	Max	Mean
16/8/95 to 18/8/95	Nurse MA HA HI CO	6 6 3 1 1			1	2 30%	5 70%		VA EBF EPI CDD Mat Care FP AIDS PEC Superv.	6 12 6 6 12 6 12 12 28			
23/8/95 to 25/8/95	MA Nurse HA	10 9 4			2	2 40%	7 60%		VA EBF EPI CDD Mat Care FP AIDS PEC Superv.	6 12 6 6 12 6 12 12 28			
30/8/95 to 1/9/95	MLM	25				2	5	1	V/A EBF EPI CDD Mat.Care FP AIDS PEC Superv	6 12 6 6 12 6 12 12 28	41/61	91/100	70/84
1/10/94 to 31/10/94 (1 day each)	Trad. Hlr.				125		1		PEC	100			
1/10/94 to 30/11/94 (2 days each)	TBA				180	3	2		AIDS	100			

Dates	Participants					Facilitators			Subjects		Pre/Post Test		
	Cadre	MOH	Mtft	SUC	Oth	IEF	MOH	Mtft	Interv.	%	Min	Max	Mean
21/10/94	AIDS Volunteer				20	1	1	1	AIDs	100			
20/12/94 to 23/12/94	VHC				40	1	1	1	General				

IEF/MALAWI CS/VA ORGANIZATION CHART CHIKWAWA DISTRICT

November, 1995

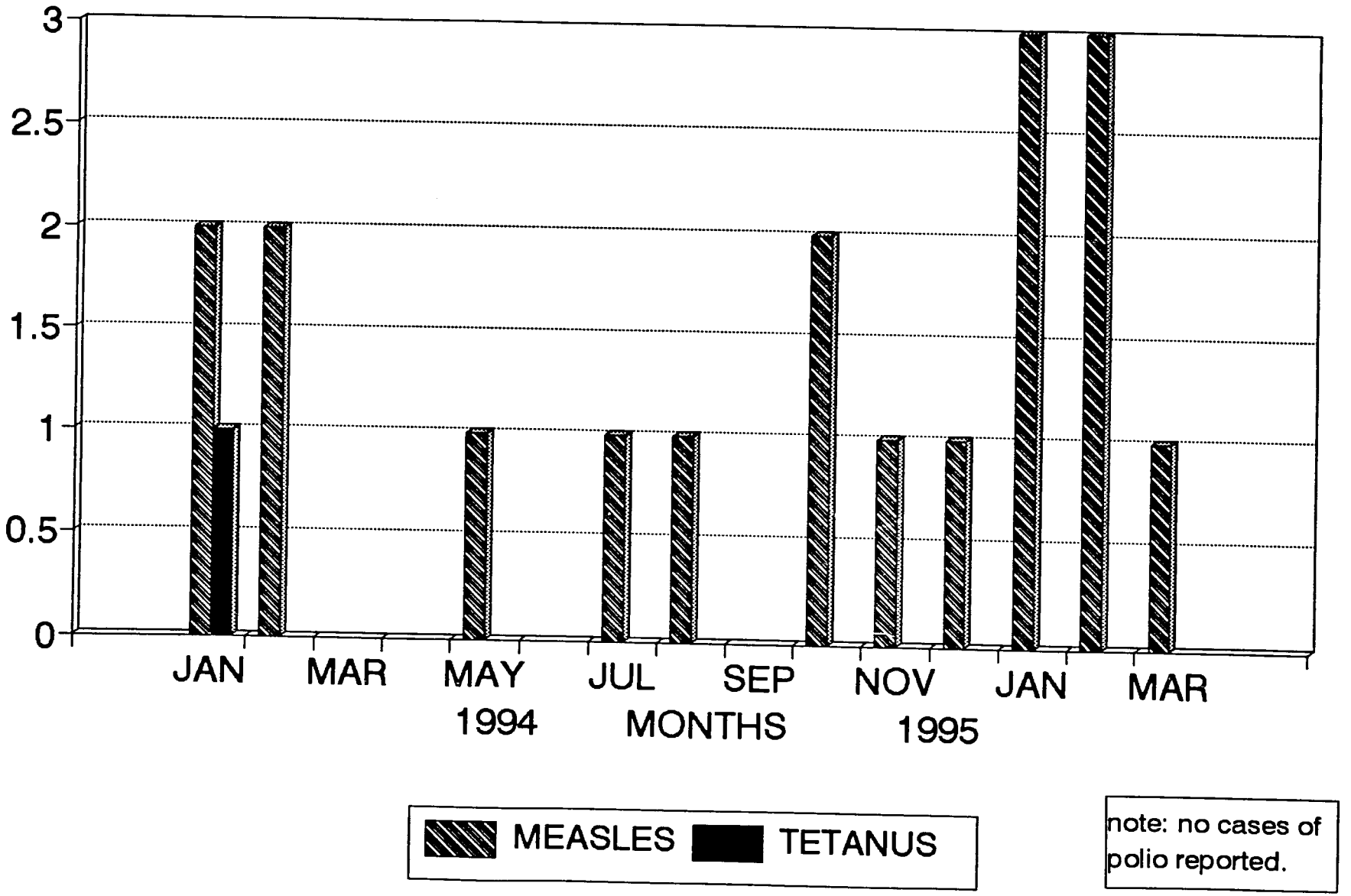


(1) Project administrative management
(2) Oversight of technical health activity
(3) Monitoring of progress toward each objective
(4) Training of health workers
(5) Health Information System
Malw-cs.2

Note: All staff are full-time, salaries nationals except for the expatriate Country Director

MEASLES, TETANUS AND POLIO CASES

CHICKWAWA DISTRICT, 1994-95



DATE SUBMITTED TO USAID 10/15/95

1995 COUNTRY PROJECT PIPELINE ANALYSIS: PART C - HEADQUARTERS/FIELD

		Actual Expenditures to Date 09/01/94 to 06/30/95			Projected Expenditures Against Remaining Obligated Funds 07/01/95 to 08/30/97			Total Agreement Budget (Columns 1 & 2) 09/01/94 to 08/30/97		
I. DIRECT COSTS		AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
A. PERSONNEL (salaries, wages, fringes)	1. Headquarters-wages/salaries	6,713	6,946	13,659	30,332	25,551	55,883	37,045	32,497	69,542
	2. Field, Technical Personnel-wages/salaries	36,628	2,153	38,781	152,564	44,234	196,798	189,192	46,387	235,579
	3. Field, Other Personnel-wages/salaries	5,629	5,629	11,258	0	0	0	5,629	5,629	11,258
	4. Fringes - Headquarters + Field	17,070	4,646	21,716	57,557	23,310	80,867	74,627	27,956	102,583
	SUBTOTAL - PERSONNEL	66,040	19,374	85,414	240,453	93,095	333,548	306,493	112,469	418,962
B. TRAVEL/PER DIEM	1. Headquarters - Domestic (USA)	0	0	0	0	4,725	4,725	0	4,725	4,725
	2. Headquarters - International	278	1,098	1,376	34,332	(1,098)	33,234	34,610	0	34,610
	3. Field - in country	1,737	294	2,031	4,263	(294)	3,969	6,000	0	6,000
	4. Field - International	1,596	469	2,065	13,854	16,331	32,185	15,450	18,800	34,250
	SUBTOTAL - TRAVEL/PER DIEM	3,611	1,861	5,472	52,449	21,664	74,113	56,060	23,525	79,585
C. CONSULTANCIES	1. Evaluation Consultants - Fees	0	0	0	6,250	6,250	12,500	6,250	6,250	12,500
	2. Other Consultants - Fees	73	707	780	5,927	9,293	15,220	6,000	10,000	16,000
	3. Consultant travel/per diem	0	0	0	5,000	5,000	10,000	5,000	5,000	10,000
	SUBTOTAL - CONSULTANCIES	73	707	780	17,177	20,543	37,720	17,250	21,250	38,500
D. PROCUREMENT (provide justification/explanation narrative)	1. Supplies									
	a. Headquarters	0	350	350	3,000	(350)	2,650	3,000	0	3,000
	b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)	164	3,461	3,625	0 (164)	0 21,539	21,375	0	25,000	25,000
	c. Field - Other	4,715	1,108	5,823	13,885	(1,108)	12,777	18,600	0	18,600
	2. Equipment									
	a. Headquarters	0	0	0	0	2,500	2,500	0	2,500	2,500
	b. Field	0	0	0	0	6,600	6,600	0	6,600	6,600
	3. Training									
	a. Headquarters	0	57	57	0	(57)	(57)	0	0	0
	b. Field	9,897	2,104	12,001	134,653	(2,104)	132,549	144,550	0	144,550
	SUBTOTAL - PROCUREMENT	14,776	7,080	21,856	151,374	27,020	178,394	166,150	34,100	200,250
E. OTHER DIRECT COSTS (provide justification/explanation narrative)	1. Communications									
	a. Headquarters	0	1,289	1,289	0	8,611	8,611	0	9,900	9,900
	b. Field	488	837	1,325	3,626	163	3,789	4,114	1,000	5,114
	2. Facilities									
	a. Headquarters	0	0	0	0	0	0	0	0	0
	b. Field	6,303	0	6,303	42,297	0	42,297	48,600	0	48,600
	3. Other									
	a. Headquarters	0	1,047	1,047	0	3,153	3,153	0	4,200	4,200
	b. Field	25,338	916	26,254	57,162	23,784	80,946	82,500	24,700	107,200
	SUBTOTAL - OTHER DIRECT	32,129	4,089	36,218	103,085	35,711	138,796	135,214	39,800	175,014
TOTAL - DIRECT COSTS		116,629	33,111	149,740	564,538	198,033	762,571	681,167	231,144	912,311
II. INDIRECT COSTS										
A. INDIRECT COSTS	1. Headquarters	20,783	5,297	26,080	89,566	27,434	117,000	110,349	32,731	143,080
	2. Field (if applicable)									
TOTAL - INDIRECT COSTS		20,783	5,297	26,080	89,566	27,434	117,000	110,349	32,731	143,080
GRAND TOTAL (DIRECT AND INDIRECT COSTS)		137,412	38,408	175,820	654,104	225,467	879,571	791,516	263,875	1,055,391