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INTERNATIONAL EYE FOUNDATION
BLANTYRE, MALAWI

VITAMIN A FOR CHILD SURVIVAL
CHIKWAWA DISTRICT, MALAWI

USAID CHILD SURVIVAL X
FINAL EVALUATION REPORT

COOPERATIVE AGREEMENT #FAO-0500-A-00-4041-00
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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CDD	Control of Diarrheal Diseases
CHAPS	Community Health Partnerships Project
CS X	Child Survival X Project
DHMT	MOHP District Health Management Team
DHO	MOHP District Health Officer
DIP	Detailed Implementation Plan
DRF	Drug Revolving Fund
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IEC	Information, Education and Communication
IEF	International Eye Foundation
IGA	Income-Generating Activity
KPC	Knowledge, Practices, and Coverage
M4E	Monitoring For Empowerment
MCH	Maternal and Child Health
MOA	Ministry of Agriculture
MOHP	Ministry of Health and Population
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PEC	Primary Eye Care
PVO	Private Voluntary Organization
STAFH	Support to AIDS and Family Health
TBA	Traditional Birth Attendant
TTV	Tetanus Toxoid Vaccine
U/5	Under 5
USAID	United States Agency for International Development
VHC	Village Health Committee
VHV	Village Health Volunteer

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1 EXECUTIVE SUMMARY

IEF has a long history of health programming in Chikwawa District, beginning in the early 198 's with a focus on tertiary eye care and continuing through the current Child Survival X (CS X) program that emphasizes community-based approaches to child health and prevention of blindness Funding support from USAID since 1985 has enabled IEF to develop and expand community infrastructure for child survival interventions in Chikwawa The current CS X project not only expanded the community-based health care system throughout the district, but also aimed to transfer ownership of that system over to the Ministry of Health and Population (MOHP) and the communities themselves IEF's role shifted from direct implementation to facilitation, with MOHP and a village-based health volunteer network as key partners While the project goal remained focused on reducing infant and child morbidity and mortality, the overriding strategy of CS X was to establish mechanisms to sustain the community health services

The CS X final evaluation was conducted from January 19-3 , 1998, by a 5-person core team composed of an external evaluator , IEF headquarters representative, IEF Malawi Country Director, District Ministry of Health Maternal/Child Health (MCH) Coordinator, and the IEF CS Program Manager The evaluation team met with virtually all groups with which IEF has worked during implementation of the CS X project to obtain information about approaches and impact of the project The team collected field data through a series of focus group discussions and semi-structured interviews and considered data from a variety of other sources including findings of quality assessments undertaken by IEF, training data, Knowledge/Practices/Coverage (KPC) surveys, and other project documentation Conclusions and recommendations were developed in a workshop setting with the core evaluation team and IEF CS staff

IEF has worked closely with MOHP in developing and implementing its programs The partnership has evolved from working side-by-side to supplement and complement each other's efforts and resources to a collaboration in planning and implementation This relationship will be strengthened further through the upcoming three-year, USAID-funded Community Health Partnerships (CHAPS) Project whereby IEF will be an integral member of an expanded District Health Management Team (DHMT) of MOHP The CHAPS Project is a logical follow-on to IEF's CS programs, enabling IEF and MOHP to address systemic constraints that have been beyond the scope of the CS projects

An extensive village-level health system has been established through IEF's CS program to enable increased coverage of target groups for immunization, Vitamin A, control of diarrheal disease (CDD), nutrition and exclusive breastfeeding, maternal care, primary eye care, and establishment of drug revolving funds and income-generating activities Cadres of village volunteers - Village Health Volunteers, Village Health Committees, Traditional Birth Attendants, Traditional Healers, Drug Revolving Fund Committees and Volunteers, and IGA Volunteers - have been trained to provide health education and to mobilize their communities to participate in preventive health activities MOHP staff have also received training to enable them to support the village-based health network Trainings were intervention-oriented, building technical capacity of participants As a result knowledge among health workers at all levels is high

Key Achievements of CS X

Knowledge has translated into practice on some key life- and sight-saving interventions Important achievements include

- The rate of fully-immunized children remains high at 87%
- The TTV2 rate for women of childbearing age has increased from 47% to 78%
- 64% of mothers know to exclusively breastfeed their -3 month old infants, an impressively high increase from the baseline figure of 21%, representing a major step toward positive behavior change
- There was a significant upward trend in the number of 6-71 month old children receiving Vitamin A, from 49% to 62%
- Traditional Birth Attendants (TBAs) know which cases should be referred to the nearest health facility and are doing so as intended
- Traditional healers have significantly changed their harmful practices for treating eye cases with traditional medicines and methods, indicating a positive trend toward use of "modern methods "
- Drug Revolving Funds (DRFs) were established in 6 isolated communities, providing a local source for essential drugs
- Functioning income-generating activities (IGAs) have been established in 7 communities, providing a source of cash income as well as food to participants
- All 14 IEF Health Surveillance Assistants (HSAs) were hired by MOHP - a major step in transferring ownership of the child survival program

All family planning and HIV/AIDS prevention objectives originally under CS X were shifted to the USAID-funded Support to AIDS and Family Health Project (STAFH), with USAID approval

Implementation Issues

Progress in some intervention areas has been less than anticipated due to overriding constraints, some of which were not within the budget and structure of CS X to address For example, health workers have not always transferred knowledge effectively, largely due to a gap in supervision and monitoring It was intended as part of the sustainability plan for CS X that MOHP would take over responsibility for supervision and monitoring of the village health workers along with the HSAs However, MOHP does not currently have capacity to supervise to the extent that was possible for IEF Transport is a major problem for all health supervisors, and supervisory systems are lacking There is no system of accountability for supervisors to ensure that they are providing adequate support and supplies to those who they supervise A comprehensive supervisory system is essential to sustainability of the community health care system, particularly since it relies on a volunteer work force to provide basic services, but development of such a system was not within the scope of CS X

Village-level workers have been unable to provide basic services for which they have been trained, largely due to shortages of supplies such as ORS, Vitamin A, and tetracycline eye ointment DRFs which have been set up to serve remote communities also suffer from gaps in the system for procuring drugs and supplies through MOHP There are adequate stocks of medicines and commodities at the district level but lack of transport and communication systems and mechanisms for coordination between the District Hospital and the Health Centers impedes a smooth supply route to the village level Procurement and stock control systems are needed in order to maintain the village health system that has been put in place MOHP capacity must be strengthened in these areas

Communication of MOH policy to the local level has also hindered efforts of health workers below the health center level to provide basic services at the community level TBAs and VHVs are often not providing Vitamin A and tetracycline ointment because their supervisors are unclear of policy and then withhold the drugs from the community level workers Efforts are needed to properly communicate policy to ensure full understanding and uniformity on all levels

IEF and MOHP have the opportunity to apply experience and lessons learned from CS X in the CHAPS Project The primary goal of the CHAPS Project is "to strengthen the capacity of the District MOHP to be more effective in its delivery of health care to the area's population " Priority needs identified for action under CHAPS include improving managerial and systems capacity in the following areas

- Financial, inventory, logistical, supervisory and health information systems
- Personnel management,
- Health planning and coordination,
- Information, Education and Communication

IEF has some unique expertise to offer MOHP in developing systems Quality assessments carried out by IEF staff have yielded useful information for program development and planning, but have not been shared widely or used to full potential to date Now IEF must work with MOHP to use such assessments in addressing priority needs under the CHAPS project IEF must involve MOHP in all phases of implementing quality assessments, including planning and conducting assessments, analyzing findings, and disseminating results Mechanisms must be established to ensure that findings are incorporated at an operational level

Summary of Lessons Learned and Recommendations for CHAPS

Virtually all of the lessons learned and recommendations emanating from the CS X final evaluation have been formulated in view of CHAPS, which is a natural progression in the MOHP/IEF partnership for community health programming Achievements, lessons learned and recommendations are detailed fully for each intervention in the sections of this report that follow Major lessons learned and recommendations from CS X which can be applied in CHAPS are

- Health workers have good knowledge about the key interventions but are not transferring it to target group members effectively Health education efforts of Village Health Volunteers (VHVs) do not appear to be supervised adequately by the HSAs and Village Health Committees (VHCs), as intended, due to the lack of supervisory systems and skills The MOHP does not have the capacity at present to provide supervisory support at the same level as IEF **Supervisory systems need to be developed that will strengthen supervisory capacity of MOHP The systems should build in training, including refresher programs, for all levels of health workers Supervisory checklists are needed to prompt each level of supervisor on what they must do to provide adequate supervisory guidance and support (e g , ensuring adequate supplies of Vitamin A and other supplies required to do the job) IEF, under the CHAPS program, will have an opportunity to work with MOHP at the district level to develop a comprehensive system This should be a priority activity**

- The final evaluation field survey results indicated that the VHVs and VHCs have a clearer idea about their respective roles and responsibilities, but that there are still problems related to skill differences and perceptions about who should be supervising who, specifically regarding VHC supervision of VHVs Both groups prefer to look to the HSAs as supervisors **Under CHAPS, the HSAs should**

be trained as facilitators to help these two groups focus on the overriding goal of improving the community health situation It may be in the interests of all concerned to make the HSAs the official supervisors rather than having community members responsible for supervising other community members, as in the current CS X structure

- The CHAPS program intends to continue training VHCs to solidify their role as community leaders for health, training for VHVs is less clear as a priority **It is recommended that IEF work closely with MOHP to plan the VHC trainings under the CHAPS project so that the already-trained VHVs are included as VHC members in any further training** This will perhaps slow down the VHV attrition rate by keeping them involved and interested It will also provide opportunities for refresher training, which is needed by any health workers to maintain knowledge and skills

- Findings from quality assessments have been a useful learning tool at the sites where they were undertaken, feedback from IEF staff to MOHP health workers at the service provision site helped point out shortcomings in service delivery The results have also been useful to IEF in planning health worker trainings **In the future, IEF should include MOHP in planning and conducting assessments so that 1) MOHP can be involved in deciding what will be assessed, 2) MOHP staff can develop skills and interest in quality assurance, 3) findings can be internalized more than by reading a report, possibly increasing chances that they will be incorporated into MOHP program planning Findings should be shared not only with senior MOHP officials and those staff involved in the assessment activity, but also with mid-level staff who are responsible for day-to-day planning and implementation**

- Village-level mobilization efforts by VHVs appear to have been successful in increasing immunization coverage However, coverage rates might have been even higher if there had been adequate supplies of vaccines and other supplies on a continuous basis Further increases in coverage may be stymied by the lack of transport and communication systems and clear drug procurement procedures needed to avoid shortages **Clear drug procurement policies need to be devised and communicated to health workers throughout the system, taking into account the special needs of various service point locations Though not within the scope of the CS X project, IEF should focus any future health programming efforts on resolving these root problems and avoid addressing acute needs**

- Inadequate teaching aids make health education efforts less effective **A revised approach to CDD should include close collaboration between IEF and MOHP in the development and implementation of an Information, Education and Communication (IEC) plan The plan should include the development of more IEC materials for CDD, training for health workers in how to use the materials and other teaching methods, and evaluation to assess results CDD messages should be reviewed to ensure that they are appropriate (e g , messages that promote homemade sugar-salt solutions should be eliminated) and reaching the right audiences Considering that men often serve as care givers of young children, IEC materials should be targeted to them as well as to mothers**

- Maternity ward workers appear to be effective agents not only for providing exclusive breastfeeding messages but also for encouraging good practices by not supplementing in the hospital, as shown by the maternity ward exit interviews However, they only reach mothers who are able to deliver in a hospital setting Most Malawian women deliver in the village It is important to have effective agents at the village level as well in order to achieve greater impact IEF and MOHP should continue exclusive breastfeeding promotion efforts through village-level health workers

- The number of Breastfeeding Promoters trained so far is too small to expect adequate coverage of the target group It would be premature to discontinue testing this approach until a sufficient ratio of Breastfeeding Promoters to target group members can be achieved **IEF should encourage MOHP to set a coverage ratio and to recruit and train the requisite number of Breastfeeding Promoters from among the VHVs This could be done on a pilot test basis in a sub-section of the district to see if it is worth pursuing on a district-wide scale**

- **Efforts should continue to try and change cultural practices surrounding breastfeeding** It would be worthwhile to experiment with exclusive breastfeeding messages aimed at fathers since they may be able to counteract incorrect advice from grandmothers This could be done through community health education sessions rather than sessions with individuals Raising knowledge of fathers and other community members about the benefits of exclusive breastfeeding may help develop the critical mass necessary to change behaviors **As with any IEC initiative, the concept and messages should be pilot-tested before widespread implementation**

- High knowledge levels about the benefits of Vitamin A among health workers and mothers are not translating into increased coverage rates at the expected levels The targets for Vitamin A objectives as well as other intervention areas, may have been overly ambitious given IEF's overall project goal of transferring ownership of the CS program to the MOHP and communities Inherent in such a transfer is the responsibility for policy support, supervision and monitoring of village-level health workers Significant changes in coverage rates may be unrealistic, an aim to maintain coverage may have been more in line with reality **In order not to lose gains made on Vitamin A coverage, IEF must work closely with MOHP under the CHAPS project to ensure that clear Vitamin A policy and strategy is developed and implemented**

- The lack of policy support at the regional level of MOHP to allow TBAs to administer Vitamin A has seriously affected IEF's strategy for increasing coverage of postpartum women **IEF must clarify the policy and, if necessary, lobby to change it Policy should be stated in writing so that health workers at all levels - as well as program partners like IEF - are clear about the parameters within which they must work.**

- Mothers of 24-71 month children may require special prompting and service delivery for Vitamin A supplementation since they may lose the habit of attending U/5 clinics after their children are fully immunized **Special instructions for health workers and clear advice for mothers need to be developed IEC messages should be developed and health workers trained in how to effectively deliver them to this special target group** IEF has had positive experience in combining Vitamin A promotion and supplementation with National Immunization Day campaigns Campaigns may be the most effective way to get the message across **IEF should explore with MOHP the possibility of institutionalizing Vitamin A supplementation as part of National Immunization Day campaigns, with special IEC messages aimed at 24-71 month children**

- Lack of coordination between IEF and MOHP resulted in a lost opportunity to train the full complement of TBAs budgeted under the project - a loss for MOHP and for the village-level health system This might have been avoided if a designated coordinator had been assigned to manage the TBA activities **Each major program intervention should be assigned to a specific coordinator who will be responsible for ensuring that program activities are carried out effectively and according to plans Job descriptions should clearly outline interventions for which each coordinator is responsible and work plans should be developed in line with intervention objectives**

- HSAs tend to ignore the maternal care side of the TBAs responsibilities when supervising possibly because some aspects are culturally awkward for male HSAs to address Awareness of HSAs needs to be raised about the critical importance of the maternal care aspects of the TBAs' job, and comfort level needs to be raised in discussing them **The HSA training curriculum should be reviewed and revised to emphasize these aspects Gender sensitivities related to male supervision of TBAs need to be considered when devising a revised curriculum to ensure that gender is not a barrier in providing support to the TBAs**

- Traditional healers have changed their practices significantly as a result of training but, as with exclusive breastfeeding, cultural practices are difficult to change within the three-year time frame of a project Given the reliance of communities on Traditional Healers as health providers and the apparent eagerness of the Traditional Healers to avail of training opportunities, **it is recommended that they continue to be a key target group for training by IEF and MOHP under the CHAPS project IEF and MOHP should consider developing separate two-day modules on priority topics so that each topic can be covered in greater depth Participatory techniques should be utilized, allowing time for participants to practice new skills**

- Communities clearly value the service provided by the DRFs, but do not feel a sense of ownership, they see the DRF as someone else's activity The handover process for the DRFs was negotiated between IEF and MOHP, community input was lacking in planning and executing handover **Communities should be involved in the handover process as a measure toward building their ownership of the DRFs It would also help identify skills needed by DRF Committees and Volunteers early on so that training can be more appropriately focused**

- Training given to the DRF Committees and Volunteers was too brief to develop the required skills for managing the DRFs More training is required for DRF Committee members and Volunteers to clarify their roles and responsibilities in greater detail and to develop their business management skills **MOHP, with assistance from IEF through the CHAPS program, should conduct a baseline survey/assessment of DRFs, building on the earlier assessment which was done, to serve as a training needs assessment A more thorough training should be developed for DRFs which includes pricing, cash management, drug procurement, and supervision**

- Health Center staff and HSAs, who facilitate drug procurement for DRFs, must understand their roles and responsibilities and be responsive to the needs of the isolated communities where the DRFs are located **Procurement procedures should be developed with a focus on ensuring a smooth flow of drugs Training for each and every level of volunteer, committee and health worker must clarify the guidelines and procedures and build commitment to ensuring consistent service Standard committee and volunteer selection guidelines, job descriptions and drug procurement procedures must be clearly written and adhered to by the various players who are involved in facilitating and managing the DRF**

- Results of the October 1997 DRF quality assessment should be shared with DRF Volunteers and Committees so that they have more information on which to base management decisions They will be better prepared to serve the community's interests if they know what motivates the community members to utilize the DRF - or not **It would be appropriate for IEF, with MOHP, to undertake a PRA activity with the DRF communities to broaden the understanding of how the DRF should operate and to enhance their ownership over the DRF**

- Decisions were made about which types of IGAs to implement without involvement of the community in choosing or in planning for implementation The process did not consider community capacity or interest to undertake the projects **As with the DRFs, the community should be brought into the process at the planning stage in order to develop their sense of ownership in the initiative and to assess their skills for taking on the project Customer needs assessments should be done through PRA and other appropriate techniques to assist in identifying possible projects from which the community can choose Before implementation, thorough planning should be done with the participants for all critical phases of the project so that they can help in developing implementation guidelines Basic financial skills training should be introduced and financial procedures put into place**

- IEF's decision to de-emphasize the VHV family register system and to instead build on the MOHP Monitoring For Empowerment (M4E) system was strategically correct given the sustainability goals for CS X The M4E training for HSAs was appreciated by MOHP staff and is perceived to have helped build capacity Building on an existing system rather than implementing a parallel one is not only a better use of limited resources but also enhances partnership - a necessary component of sustainability Providing training to the HSAs as a measure to improve the quality of data collected was much appreciated **Next steps should include training in use of data and how to feed back to the village level appropriately This will add further value to the efforts of health workers on the M4E**

- A major finding of the final evaluation was that MOHP does not have the resources required to maintain training at the level provided under IEF MOHP has qualified trainers, but lacks funding Health Center staff said that they have the manpower and willingness to train volunteer health workers and committee members in their respective villages rather than incurring costs associated with centralized, residential trainings, but that volunteers would still expect to be paid an "allowance" to attend the trainings, a cost for which there is no budget **It is recommended that IEF and other PVOs that have received CHAPS grants develop a common training allowance policy in collaboration with their District MOHP partners as a means to minimize this contentious issue**

2 INTRODUCTION

2 1 Background

The International Eye Foundation has been active in Malawi since the early 1980's This Child Survival project is based in the Lower Shire valley, District of Chikwawa (all-ages population 490,000 under-5 years 97,000), it targets over 500 villages including the worker townships of the SUCOMA sugar estate at the trading centre of Nchalo Over 80% of the predominantly rural population is estimated to be living below the absolute poverty line In 1994, the infant mortality rate for the District was estimated at 174 per 1000, 20% of children did not survive to the age of five years The under-5 mortality rate is worse than all other countries in Eastern and Southern Africa for which data are available Maternal mortality, at around 600 per 100,000, is also high

Major causes of childhood mortality are malnutrition, malaria, AIDS and AIDS-related diseases, diarrhea, and respiratory infections Around Nchalo trading centre and on the Sucoma sugar estate, HIV prevalence among pregnant women has been estimated at about 30% Unless there is some dramatic change, HIV-related mortality, along with explosive population growth (3 3% annual growth rate with less than 10% use of contraceptives, equivalent to a doubling of

population in 20 years) will reverse the potential gain to be achieved by Child Survival interventions On the other hand, the decrease in vaccine preventable diseases especially measles and polio is a striking success story No cases of polio have been reported in Chikwawa since 1992

The economy of Chikwawa District is overwhelmingly agricultural Two broad categories of the population are engaged in agriculture - smallholders whose main income comes from their landholdings, and agricultural laborers who work on a sugar estate (SUCOMA) Maize is the predominant crop among smallholders, yields are low The policies of the previous government created a dual economy by transferring land to the estate This left many smallholder families with plots of land too small to support their families and forced them to sell their labor to the estate There is little off-farm work and real wages for unskilled estate laborers are low Cotton is produced on smallholdings as a cash crop, yields and cash returns are usually low Apart from agricultural labor on the estate, small scale trading and casual labour on building projects, there is virtually no other paid employment There is only one all weather road, public transport is scarce Male literacy is below 50% and, at the start of the project, less than 20% of girls had attended school Chikwawa District contains a higher proportion of poorer households than many other Districts of Malawi

Overall, the lower Shire valley is characterized by food insecurity associated with recurrent drought Maize is the staple food Millet is also eaten, vegetables are used as a complimentary food eaten as a side dish and referred to as "relish", fruit including mango and papaya is available seasonally, goats and cows are kept in villages

Malnutrition is, as one would expect, a persistent as well as an acute problem Countrywide, wasting in under-5 children has increased from 2 8% in 1980 to 7 0% in 1995 There is marked seasonal, as well as annual, variation in malnutrition In 1994 in the project area, 3% of young children were acutely malnourished and half were stunted, a sign of chronic undernutrition In 1996, based on Monitoring for Empowerment (M4E) data, about a third of children seemed to be malnourished (WFP) Micronutrient malnutrition is also widespread and severe in the Lower Shire valley In the early 1980s, 4% of young children showed clinical signs of vitamin A deficiency (VAD), considerably in excess of the WHO threshold for a problem of public health significance There is no recent survey data on vitamin A status, anecdotal evidence suggest some improvement Iron deficiency anaemia, associated with malaria and low dietary intake, is prevalent in both young children and women of child bearing age Almost 60% of women at the District hospital antenatal clinic have been reported anaemic There are no figures for iodine deficiency But IDD is highly prevalent elsewhere in Malawi and iodized salt is little used in the Lower Shire valley

The health infrastructure in Chikwawa District consists of a District hospital, a mission hospital, a MOH rural hospital and 11 health centres with linked health posts SUCOMA estate has 7 health centres and a senior Clinical Officer At the time of the evaluation, there was only one doctor working in the District, at Montfort hospital The acting District Health Officer, a Clinical Officer, was not a medical Doctor, though well experienced in a range of surgical as well as medical interventions Each health unit operates monthly under-5 clinics at outlying villages, as well as other health care services such as antenatal care and delivery Health centres are understaffed and essential drugs are often out of stock Medical Assistants with three years

training work at major health centres Health Assistants, (10 in the District with two years training) staff health posts Health Assistants supervise Health Surveillance Assistants (120 in the District with eight weeks training) HSAs are directly responsible for the majority of activities at community level Two thirds of villages now have village health committees (VHC), as well as village health volunteers (VHV)

In 1994, about 100,000 Mozambican refugees were repatriated from Chikwawa District leaving behind a degraded environment, and taking with them considerable sources of donor aid The 1995 and 1996 rains were heavy, resulting in good harvests, improved household food security and greater availability of cash On the other hand, the prices of food and other essential commodities, such as maize flour, sugar, petrol, have risen steeply associated with three-fold devaluation of the Malawian Kwacha (MK) and structural adjustment

2 2 Project Description and Design

Beginning in September 1994, the International Eye Foundation was awarded a three-year Child Survival cooperative agreement (CS-X #FAO-0500-A-00-4041-00) for Chikwawa District with a total budget of $1,055,391 The Detailed Implementation Plan (DIP) called for extending the existing PHC infrastructure from health facilities into communities As a major design feature, it was intended to assist the public (Ministry of Health) and private sectors so that project activities would be absorbed and sustained at the end of the Child Survival cooperative agreement This system had been successfully pioneered by IEF in the same District under a previously funded Child Survival cooperative agreement

Specific interventions and activities targeted defined groups - immunization, vitamin A, control of diarrheal diseases, nutrition, Maternal Care, Eye Care, Drug Revolving Funds, Income Generation See Table 1 Objectives for each intervention, as given in the DIP, are detailed in Table 2

AIDS, STD work and Family Planning were initially part of the project But since February 1996, and with the agreement of the USAID, AIDS, STD and family planning-related activities have been shifted to a separate project - Services to AIDS and Family Health (STAFH)

The DIP set down that project staff should provide training to MOH and PVO staff in immunization, vitamin A, diarrheal disease control, and community based monitoring systems Traditional Birth Attendants (TBA) would be trained by IEF and the MOH, using a modified MOH curriculum including diarrheal diseases control and exclusive breast feeding messages TBAs would also be trained to deliver vitamin A to post-partum women

Traditional healers would be trained for Primary Eye Care A referral system would be developed between community health workers, such as traditional healers, village health volunteers, TBAs, and the MOH

Vitamin A should be provided by IEF as back-up to the District hospital and health facilities for supplementation and treatment of clinical VAD, including measles and severe malnutrition ORS and other family planning methods, including condoms, were to be obtained from the MOH and supplied to village health volunteers and community based distributors

IEF has a long term commitment to enabling communities to participate in improving their own health This Child Survival project aimed to form and train village health committees in over 100 communities where they were known not to exist VHCs would be empowered to choose and oversee the work of village volunteers, TBAs, and eventually drug revolving funds and income generating activities

The project aimed to train volunteers and Health Surveillance Assistants jointly with the MOH Village health volunteers (VHVs) should provide vitamin A, ORS, and nutrition education Volunteers should also maintain registers of children under six years, women of child bearing age, pregnant women and children under one to assist with vitamin A distribution and immunization efforts VHVs are to be supervised jointly by VHCs and HSAs Each HSA would be responsible for 5 - 10 villages and 8 - 15 VHVs

Table 1 Project Interventions, Activities and Target Populations

ntervention/Activity	Target Population
Immunization	Children 0 - 11 months Women 15 - 49 years
Vitamin A	Children 6-71 months Women 30 days post partum
ORT	Children 0 - 23 months
Nutrition	Children 0 - 5 years
Maternal Care	Women 15 - 49 years
Eye Care	All ages
Drug Revolving Fund	All ages
Income Generation	Villagers

3 EVALUATION METHODOLOGY

The evaluation was conducted from January 19-3 , 1998, by a 5-person core team composed of an external evaluator , IEF headquarters representative, IEF Malawi Country Director, District Ministry of Health MCH Officer, and the IEF Child Survival Program Manager The Evaluation Scope of Work and Schedule can be found in Annex 1 Four additional IEF Child Survival Staff members joined the core team as needed to assist during field data collection and to serve as information resources to the team A list of core evaluation team members and a copy of the team leader's c v are attached in Annex 2

The evaluation team met with virtually all groups with which IEF has worked during implementation of the CS X project to obtain information about approaches and impact of the project The team collected field data through a series of focus group discussions and semi-structured interviews Questionnaires used for the field data collection are attached in Annex 3 In all, the team conducted 24 interviews and discussions in 1 field sites during which approximately 116 people (54 men and 62 women) shared their views and knowledge about IEF's Child Survival program A complete list of individuals and groups interviewed is in Annex 4

The evaluation took place during the peak of the rainy season It was not possible to randomly choose interview sites due to the impassibility of some roads in Chikwawa District The team attempted to ensure that sites chosen were reasonably representative of program activities and geographically dispersed throughout the district

In addition to the field survey data, the evaluation team considered information from a variety of other sources including findings of quality assessments undertaken by IEF, training data, KPC surveys, and other project documentation A complete list of references used is found in Annex 5 The final KPC survey report is attached in Annex 6

Conclusions and recommendations were developed in a workshop setting with the core evaluation team and IEF CS staff This not only allowed the core evaluation team to tap the implementing staff as significant resources, but gave the staff an opportunity to consider what they have gained from their experience with CS X and how they can apply it most usefully in the CHAPS project

4 INTERVENTIONS AND ACTIVITIES

4 1 Immunization

Achievements

Final KPC survey results indicate that the rate of fully-immunized children remains very high at 87%, slightly above the baseline rate of 83% and more or less at the target of 9 % The TTV2 immunization rate for women of childbearing age has improved considerably from baseline (47%) to end-of project (78%), also reaching the target set in the DIP Indeed, the evaluation team observed an impressive number of women at an Under 5 (U/5) clinic in Patalao village receiving TTV3 and TTV4 vaccinations

Coverage objectives and findings for the baseline, mid-term and final surveys for immunization and all other interventions are shown in Table 2

Table 2 Coverage Objectives Baseline, Mid-term and Final Evaluation

Objective	Baseline (1994)	Mid-term (1996)	EOP (1998)
9 % of children 12-23 months fully immunized	83%	8 %	87%
75% of women of child bearing age received at least two doses TT	47%	76%	78%
75% of children 6-71 months received Vitamin A	49%	75%	62%
5 % of women received Vitamin A within one month of delivery	3 %	19%	2 %
9 % of children -23 months received ORT during diarrhoea episodes	83%	73%	73%
8 % of children -23 months received same amount, or more, breast mild during diarrhoea	75%	65%	62%
65% of children -23 months received same amount, or more, food during diarrhea	55%	42%	57%
25% of mothers exclusively breast feed their -3 month old children	21%	64%	64%
25% of mothers will use a modern contraceptive, assuming they have children under 24 months and do not want children in the next 2 years	2 %	19%	34%

Immunization continues to be a priority health program for the MOHP and efforts are made by a variety of agencies to increase coverage Though it is not possible to extract the impact of IEF's program from overall efforts, improvements in immunization coverage in Chikwawa are partly attributable to mobilization efforts of Village Health Volunteers (VHVs) All of the MOHP Health Center personnel who were interviewed praised the VHVs for their part in getting mothers and children to the U/5 clinics

825 VHVs throughout the district were trained during the course of the project, surpassing the target of 8 which was set in the DIP The 5-day basic VHV training included modules on immunization, Vitamin A, nutrition and exclusive breastfeeding, and diarrheal disease prevention and ORT The module on immunization aimed at enabling the VHVs to educate and mobilize communities to attend the monthly U/5 clinics, where they provide assistance to MOHP Health Center staff They were taught to use a family registration system whereby Vitamin A and TTV coverage of target group members children under 5 years and women of childbearing age - is recorded and U/5 cards are checked to ensure that they are up-to-date IEF has supplied all VHVs with a formatted notebook for this purpose 125 of the VHVs who received training have also received more intensive supervision from IEF staff in 6 villages where IEF has placed greater focus during the second half of the project

The evaluation team was unable to assess the degree to which VHVs follow the family registration system since none of the VHVs had their registers available during interviews In any case use of the family registration system has been de-emphasized by IEF in the interest of sustainability and capacity-building Instead IEF has begun to utilize data from the MOHP health information system Monitoring for Empowerment (M4E), which was initiated in January 1996 in response to widespread drought conditions suffered in Malawi Through this MOHP system, a variety of household-level data is collected monthly by HSAs on a random sample basis IEF uses this data to estimate coverage targets for various interventions This is a sensible approach given that responsibility for supervising the VHVs has been transferred to MOHP during CS X MOHP does not have the capacity to re-supply the VHVs with notebooks or to supervise the registration system to the same degree as IEF The M4E system is a much less labor intensive approach to gathering information needed for program planning and impact evaluation

IEF provided training to 138 HSAs in use of the M4E to help improve the quality and use of data collected There was general agreement among MOHP personnel interviewed during the evaluation that this training was a very useful contribution of IEF's CS X program HSAs reported that the VHVs have been very helpful to them in the data collection process Even if the VHVs do not maintain the family registers as envisioned originally, they have contact with their target groups by assisting with M4E data collection The M4E system is still trying to deal with basic problems in communication and feed-back (i e , the ineffectiveness of the feedback mechanism), but appears to be a useful method for ensuring that HSAs and VHVs work together in profiling their communities

Since 1996, IEF has conducted a series of "quality assessments" for specific interventions (Copies of assessment reports carried out since the CS X mid-term evaluation are attached in Annex 7) Quality assessments conducted by IEF field staff in the form of exit interviews of mothers at U/5 clinics and maternity wards have yielded important information about gaps in service delivery and program quality For example, U/5 exit interviews indicated that even though VHVs do a commendable job of mobilizing communities, they are not transferring knowledge to mothers about the importance of immunization

VHVs are expected to conduct health education on the key CS interventions to target group members, either during household visits or at group sessions, but there is no way to assess whether or not they actually carry out this job task due to a weak supervisory system VHVs are jointly supervised by the HSAs and Village Health Committees (VHCs), who are responsible to monitor VHV activities Interviews with VHVs, VHCs and HSAs during the evaluation revealed that none of these cadres have a clear concept of supervision - why it is necessary or how to do it Supervisory training has not been included in programs for the village-based health workers There are no supervisory systems or checklists in place to guide supervisors in providing support for workers in accounting for their activities Lack of an adequate supervisory system for VHVs, which includes accountability for conducting health education, makes it difficult to measure the effectiveness of the health education component of the village health scheme

The quality assessments also found that MOHP health personnel are not explaining immunization procedures properly to mothers Following each quality assessment IEF staff give immediate feedback on findings to the clinic and ward personnel as part of a program strategy to enhance health service provision Results are also used by IEF as the basis for planning trainings for health workers

Even though immediate feedback is given to clinic and village-based staff at U/5 clinics and reports are sent to and welcomed by senior district officials about results of quality assessments, the information is not flowing down to district-level implementing staff Information is shared at the top and with a limited number of staff at the bottom, but not at the mid-level where coordination should be taking place This represents a missed opportunity to use the findings of assessments for program planning and implementation on a wider scale within the district According to current policy, Health Center Officers-In-Charge are supposed to meet

together monthly to communicate and coordinate on health issues and initiatives These meetings could serve as a forum for sharing quality assessment results and planning follow-up action but they are not convened regularly

There are generally adequate supplies of vaccines at the district level However vaccine shortages, among other drugs and medical supplies, do occur at Health Centers and U/5 clinics in spite of the priority placed by MOHP on immunization coverage This problem has been pointed out through the quality assessments, the mid-term evaluation, and the final evaluation field survey One Health Center visited by the evaluation team had recently run out of vaccines and had suffered delays in obtaining re-supplies through the MOHP system Staff at two Health Centers interviewed by the evaluation team said that stock shortages, primarily caused by a lack of adequate transport and communication systems to facilitate distribution throughout the district, were common

Additionally, the evaluation team noted a lack of clarity about drug procurement procedures On several occasions during the evaluation the district-level MOHP representative on the team had to explain proper procurement procedures to Health Center and village-based health workers It was particularly noticeable at the village level that drug procurement procedures differ depending on the location and distance to the nearest health center or district hospital Given the frequency with which health workers are transferred from one area to another, it is not surprising that they may be confused about which procurement procedures to follow in any given place

IEF has provided significant logistical support to MOHP during National Immunization Day campaigns IEF transport has been used to distribute MOHP supplies of vaccines and Vitamin A to Health Centers to ensure adequate quantities are available at all sites IEF field staff have also provided assistance to specially publicize the public health campaigns This much-appreciated assistance has addressed some acute needs of the MOHP

The MOHP in Chikwawa did not have U/5 cards, on which vaccinations are recorded, at the time of the final evaluation The cards are currently on order, but officials were concerned that the amount would not be sufficient to meet needs In general the MOHP suffers shortages of stationery needed for keeping accurate records, requisitioning supplies, and other tasks with which health workers are charged The frequent shortages of drugs and other supplies experienced at all levels of the district health system are affected by larger problems of supervision, coordination, transport and communication These problems are beyond the scope of IEF's CS X program to address at the level needed

Lessons Learned/Recommendations

Health workers have good knowledge about the key interventions but are not transferring it to target group members effectively Health education efforts of VHVs do not appear to be supervised adequately by the HSAs and VHCs due to the lack of supervisory systems and skills, thus, VHVs do not receive supervisory support for this aspect of their job, nor are they accountable Supervision is an essential part of sustaining the village-level health system that has been established IEF must work with the MOHP/Chikwawa to devise a supervisory system that will ensure accountability of health workers to undertake their key responsibilities and ability of supervisors to provide adequate support to workers A supervisory system should include clear written procedures, lines of authority and checklists and a training program to clarify roles and responsibilities of supervisors and workers

Findings from quality assessments have been a useful learning tool at the sites where they were undertaken, feedback from IEF staff to MOHP health workers at the service provision site helped point out shortcomings in service delivery The results have also been useful to IEF in planning trainings In the future, IEF should

include MOHP in planning and conducting assessments so that 1) MOHP can be involved in deciding what will be assessed, 2) MOHP staff can develop skills and interest in quality assurance, 3) findings can be internalized more than by reading a report, possibly increasing chances that they will be incorporated into MOHP program planning Findings should be shared not only with senior MOHP officials and those staff involved in the assessment activity, but also with mid-level staff who are more involved in day-to-day planning and implementation

IEF, in consultation with MOHP/Chikwawa, could devise a distribution list and system to ensure that quality assessment findings reach appropriate staff IEF should encourage MOHP to activate monthly coordination meetings for Health Center Officers-in-Charge, where findings could be presented and considered for action by this key level of service providers

IEF's decision to de-emphasize the VHV family register system and to instead build on the MOHP M4E system was strategically correct given the sustainability goals for CS X The M4E training for HSAs was appreciated and is perceived to have helped build capacity by MOHP staff Building on an existing system rather than implementing a parallel one is not only a better use of limited resources but also enhances partnership - a necessary component of sustainability Providing training to the HSAs as a measure to improve the quality of data collected was much appreciated Next steps should include training in use of data and how to feed back to the village level appropriately This will add further value to the efforts of health workers on the M4E

Village-level mobilization efforts by VHVs appear to have been successful in increasing immunization coverage However, coverage rates might have been even higher if there had been adequate supplies of vaccines and other supplies on a continuous basis Further increases in coverage may be stymied by the lack of transport and communication systems and clear drug procurement procedures needed to avoid shortages Clear drug procurement policies need to be devised and communicated to health workers throughout the system, taking into account the special needs of various service point locations Though not within the scope of the CS X project, IEF should focus any future health programming efforts on resolving these root problems and avoid addressing acute needs

4 2 Diarrheal Diseases Control (CDD)

Achievements

The project approach for effecting CDD has been to rely on trained HSAs and VHVs to provide health education and ORT to mothers CDD was included in the 5-day basic training for the 138 HSAs and 825 VHVs who were trained under CS X VHVs with who the evaluation team met had good knowledge regarding treatment and referral of diarrheal cases

As was discussed in section 4 1 above, quality assessments conducted by IEF found that health workers are not communicating health messages effectively to mothers, but did not provide the depth of information needed to understand why Maternity ward exit interviews found that health talks by hospital workers discussed CDD less frequently than any other health topic In addition, health talks by VHVs are not monitored for quality, frequency or attendance Thus, it is not possible to assess how many mothers are actually being reached with CDD messages IEF staff believe that the lack of appropriate IEC materials for use by health workers may also be a factor in the low impact the project has had on CDD targets

Representatives of 428 Village Health Committees (VHCs) have been trained by IEF through the CS X project The VHCs perceive their key role as mobilizers for community health initiatives especially for sanitation and water Those with who the evaluation team met believe their efforts on sanitation have positively affected the health of the community by lowering the incidence of diarrhea Other health workers and community members also perceive the VHCs are doing a good job in this regard

Despite achieving training objectives, final survey results indicate that the number of children -23 months receiving ORT during diarrheal episodes decreased from baseline (83%) to final (73%) Likewise, fewer children were receiving the same amount, or more, of breastmilk, dropping from 75% to 62% The number of children receiving the same amount or more food during an episode remained more or less the same at around 57% None of the targets for this intervention were met

Following their training in the early phase of CS X, IEF distributed 3 sachets of ORS to VHVs to give them an initial supply for distribution in their respective villages The VHVs were instructed that future supplies should be procured through their supervisors, the HSAs, from the MOHP supplies However, the evaluation team found numerous instances during the field survey where health workers did not have ORS supplies, including at the Health Centers, despite adequate supplies at the district level The evaluation team only found ORS at the village level in the two villages visited with Drug Revolving Funds (DRFs), ORS supplies for the DRFs were procured by IEF to date, but future supplies will be through MOHP channels

As with vaccines, these shortages are affected by problems with transportation, communication, procurement and supervisory systems (see section 4 1 recommendations above) Resolution of these problems requires resources and/or policy initiatives beyond the scope of the CS X project, which was focused on strengthening and then handing over the village-based health system Specifically, MOHP commitment, demonstrated through establishment of policies and procedures which are backed by budget provisions, is required to put new systems into place Funding for transportation and communication systems is required to enable Health Center staff to involve in coordination with the district level and to ensure a continuous flow of information and supplies from the district to the Health Centers and down to the village level

It is notable that Government of Malawi is currently dependent on UNICEF for supplies of ORS sachets, a precarious source of a vital commodity at best IEF staff reported to the evaluation team that a Malawian pharmaceutical company, Pharmanova, produced ORS in the past but stopped due to poor quality control Sustainability of objectives under CDD are thus dependent on foreign supplies of ORS

Lessons Learned/Recommendations

Health workers are not effectively transferring knowledge to target group members about CDD VHVs are not receiving adequate supervision by the HSAs to ensure that they are carrying out their health education responsibilities See recommendations in section 4 1 above regarding supervision

Inadequate teaching aids are also likely to make health education efforts less effective A revised approach to CDD should include close collaboration between IEF and MOHP/Chikwawa in the development and implementation of an IEC plan The plan should include the development of more IEC materials for CDD, training for health workers in how to use the materials and other teaching methods, and evaluation to assess results CDD messages should be reviewed to ensure that they are appropriate (e g , messages that promote homemade sugar-salt solutions should be eliminated) and reaching the right audiences Considering that men often serve as caregivers of young children, IEC materials should be targeted to them as well as to mothers

Village health workers are dependent on MOHP supervision, supplies and training to carry out their roles and responsibilities as established through CS X However MOHP/Chikwawa does not currently have requisite systems or resources to sustain the village-level health care system IEF must focus future efforts on capacity-building at the district level aimed at strengthening health services provided by the Health Centers and village-based HSAs, particularly the ability of those levels to support and supervise the village health workers

IEF should investigate the potential to revive an indigenous source of ORS through Pharmanova by contacting donors who may be interested to support such a capacity-building initiative

4 3 Nutrition/Exclusive Breastfeeding

Achievements

The final KPC survey indicated that 64% of mothers know to exclusively breastfeed their infants -3 months of age, an impressively high increase from the baseline figure of 21% Exclusive breastfeeding messages are, thus, reaching at least two-thirds of mothers

All VHVs have received training on the importance of exclusive breastfeeding Of those, 116 VHVs, selected and supervised by MOHP, were given extra training by IEF as Breastfeeding Promoters They are scattered throughout the district Thus, this intervention received extra input in the form of these special health education agents with the intention that they would be able to give more attention to the target group

IEF conducted a quality assessment through maternity ward exit interviews in August 1997 and found that exclusive breastfeeding is one of the most frequently delivered health talks for mothers by ward health workers The same assessment also learned that 99% of children were not given supplements of water or food while in the hospital

However, an exclusive breastfeeding assessment conducted by IEF in May 1997 found that 54 % of mothers had been given breastfeeding advice by a health worker at a health center, but only 4% reported to have ever been visited by a Breastfeeding Promoter The ratio of Breastfeeding Promoters to target women is extremely small and is likely a key reason that so few women have ever been visited

The assessment also indicated that most Breastfeeding Promoters were not visiting their target mothers at the expected frequency of once a week So, while breastfeeding messages are reaching mothers through some mode, it is not clear to what extent the Breastfeeding Promoters are effecting the increase in mothers' knowledge Since the Breastfeeding Promoters are directly supervised by MOHP, IEF has not monitored their activities regularly but has relied on the quality assessment to gain information about their level of activities

The high knowledge level of mothers about exclusive breastfeeding is a giant first step toward behavior change, but closing the gap between knowledge and behavior still presents a challenge Cultural beliefs surrounding breastfeeding have proven very difficult to overcome The older women who ' advise" mothers on infant feeding practices are a formidable cultural force, and husbands, who also have a vested interest in their children's health, are usually left out of IEC initiatives

Lessons Learned/Recommendations

Maternity ward workers appear to be effective agents not only for providing exclusive breastfeeding messages but also for encouraging good practices by not supplementing in the hospital as shown by the maternity ward exit interviews However, they only reach mothers who are able to deliver in a hospital setting Most Malawian women deliver in the village It is important to have effective agents at the village level as well in order to achieve greater impact IEF and MOHP should continue exclusive breastfeeding promotion efforts through village-level health workers

The number of Breastfeeding Promoters trained so far is too small to expect adequate coverage of the target group It would be premature to discontinue testing this approach until a sufficient ratio of Breastfeeding Promoters to target group members can be achieved IEF should encourage MOHP to set a coverage ratio and to recruit and train the requisite number of Breastfeeding Promoters from among the VHVs This could be done on a pilot test basis in a sub-section of the district to see if it is worth pursuing on a district-wide scale

Quality assessments should continue to be used as a tool for evaluating effectiveness but supervision and monitoring of the Breastfeeding Promoters should be an essential aspect of the approach as well A supervisory system should be developed that supports and encourages performance levels of Breastfeeding Promoters (i e , they are visiting and educating target group members as expected) See recommendations for sections 4 1 and 4 2 regarding establishment of supervisory systems

Efforts should continue to try and change cultural practices surrounding breastfeeding It would be worthwhile to experiment with exclusive breastfeeding messages aimed at fathers since they may be able to counteract incorrect advice from grandmothers This could be done through community health education sessions rather than sessions with individuals Raising knowledge of fathers and other community members about the benefits of exclusive breastfeeding may help develop the critical mass necessary to change behaviors As with any IEC initiative, the concept and messages should be pilot-tested before widespread implementation

4 4 Vitamin A

Achievements

Vitamin A is an intervention area for which IEF is well-known in Chikwawa Virtually all of the health workers with who the evaluation team met identified IEF with Vitamin A programming Strategies to improve coverage have included providing nutrition education to mothers about the importance and sources of Vitamin A and mobilizing attendance at clinics where Vitamin A is administered to 6-71 month old children and postpartum mothers In addition, TBAs were trained so that they could also serve as a service point for Vitamin A supplementation for postpartum mothers

Vitamin A was emphasized as a key area of basic training for HSAs and VHVs so that they could deliver key messages to mothers in health talks VHVs were taught to track target group members through use of their family registers and to encourage attendance at U/5 clinics where Vitamin A capsules are given Members of 428 VHCs also received some training in Vitamin A so that they could support the VHVs in mobilizing communities to attend clinics

The main strategy for improving Vitamin A coverage of postpartum women was to train TBAs so that they could administer Vitamin A to their clients After training, conducted by MOHP/Chikwawa, IEF provided TBAs with an initial supply of Vitamin A capsules to give to postpartum women within 1 month after delivery 37 TBAs were trained under CS X, less than the 5 targeted due to problems in coordinating a training schedule with MOHP/Chikwawa According to IEF staff, TBA activities did not receive adequate attention because no specific IEF staff coordinator was assigned to manage them, TBA activities were assigned on an *ad hoc* basis among CS staff Thus, they did not receive as much attention as other program activities The MOHP District TBA Coordinator also acknowledged that this hampered coordination between IEF and MOHP on TBA activities

Knowledge about the benefits of and food sources for Vitamin A is high among the target group, as shown in the final KPC survey 75% of mothers know at least one benefit and 91% can name at least two food sources There was a significant upward trend in the number of 6-71 month old children receiving Vitamin A from 49% to 62%, though the target of 75% was not reached The number of women receiving Vitamin A within one month of delivery has decreased from 3 % at baseline to 2 % at end-of-project, well below the 5 % target set in the DIP

District-level supplies of Vitamin A are adequate to meet the needs of Chikwawa's target population, according to the District MOHP MCH Officer (who was a member of the evaluation team) In general, the U/5 clinics have Vitamin A capsules in adequate supply to meet the needs of those who attend the clinics, though the Health Centers reported that they sometimes run out As with vaccines and other supplies, they appear to have difficulty in managing stock levels due to unclear procurement procedures, transport and communication problems

These problems carry over to the HSAs, who are charged with ensuring that the TBAs have Vitamin A to give postpartum mothers U/5 exit interviews carried out by IEF showed that only 4% of postpartum mothers had received Vitamin A The TBA with whom the team met had not been supplied with Vitamin A for almost 2 years, she reported that she had never been visited by the HSA who is supposed to supervise her While she may have been an extreme example of supervisory neglect, it is probable that other TBAs suffer the same circumstances given the lack of supervisory skills and systems and inadequate supplies observed by the evaluation team at all levels of the health system (IEF's maternity ward exit interviews showed that 59% of mothers were not receiving Vitamin A while in the hospital, a serious deficiency in service provision at another key point of contact, but not strictly within the scope of IEF's CS X project to address)

The strategy to increase coverage of postpartum women has been further constrained by confusion over policy regarding distribution of Vitamin A by TBAs The MOHP/Chikwawa DHMT, during a briefing with the evaluation team, stated willingness to collaborate with IEF on this initiative, but that this requires permission from the Regional MOHP to go forward They asked that IEF request a policy modification from the Regional MOHP that would enable village-level health workers to serve as Vitamin A distributors The TBAs represent an important point of contact with postpartum mothers The impasse over allowing them to distribute Vitamin A misses an important opportunity to impact on this objective

In spite of the fact that VHVs are supposed to follow-up with Vitamin A target members, most U/5 clinics are in the words of the MOHP MCH Officer, "really Under 2 clinics " The evaluation team observed this phenomenon at the Patalao U/5 clinic the vast majority of clinic attenders were women, infants and toddlers Many women stop attending the U/5 clinics after their children are fully immunized at around 2 years, at which point visits to the clinic are only required every six months solely for Vitamin A It is easy to understand how a typical mother in a village setting might forget to take her child for supplementation unless

she is prompted or given an easier option for obtaining it Mobilization of mothers of children in the 24-71 month age group may require different techniques than are currently in the VHVs' repertoire MOHP does not currently have special instructions for health workers or mothers on how to manage Vitamin A supplementation for children in this age group

Lessons Learned/Recommendations

There has been a notable increase in Vitamin A coverage for children 6-71 months, but high knowledge levels about the benefits of Vitamin A among health workers and mothers are not translating into increased coverage rates at the expected levels The targets for Vitamin A objectives, as well as other intervention areas, may have been overly ambitious given IEF's overall project goal of transferring ownership of the CS program to the MOHP and communities Inherent in such a transfer is the responsibility for policy support, supervision and monitoring of village-level health workers Significant changes in coverage rates may be unrealistic, an aim to maintain coverage may have been more in line with reality In order not to lose gains made on Vitamin A coverage, IEF must work closely with MOHP to ensure that clear Vitamin A policy and strategy is developed and implemented

The lack understanding of the MOH policy at the regional level has adversely affected TBA administration of Vitamin A and has affected IEF's strategy for increasing coverage of postpartum women IEF must clarify the policy and, if necessary, lobby to change it Policy should be stated in writing so that health workers at all levels - as well as program partners like IEF - are clear about the parameters within which they must work

The MOHP does not have the capacity at present to provide supervisory support at the same level as IEF Supervisory systems need to be developed that will strengthen supervisory capacity of MOHP The systems should build in training, including refresher programs, for all levels of health workers Supervisory checklists are needed to prompt each level of supervisor on what they must do to provide adequate supervisory guidance and support (e g , ensuring adequate supplies of Vitamin A and other supplies required to do the job) IEF, under the CHAPS program, will have an opportunity to work with MOHP at the district level to develop a comprehensive system This should be a priority activity

Low coverage rates for postpartum women were indicated through the U/5 clinic and maternity ward quality assessments carried out by IEF The assessments provided information about Vitamin A service delivery that pointed to problems needing further investigation Problems, such as the confusion over policy discussed above, might have been detected and acted on earlier Although the quality assessments provide valuable information about gaps in service delivery, regular monitoring is also needed to "catch" problems earlier Although it would not have been appropriate for IEF to continue monitoring the VHVs directly, monitoring HSAs' supervisory performance on a sample basis might have yielded information about both the HSAs and the VHVs that could be used to strengthen the intervention

Mothers of 24-71 month children may require special prompting and service delivery for Vitamin A supplementation since they may lose the habit of attending U/5 clinics after their children are fully immunized Special instructions for health workers and clear advice for mothers need to be developed IEC messages should be developed and health workers trained in how to effectively deliver them to this special target group IEF has had positive experience in combining Vitamin A promotion and supplementation with National Immunization Day campaigns Campaigns may be the most effective way to get the message across IEF should explore with MOHP the possibility of institutionalizing Vitamin A supplementation as part of National Immunization Day campaigns, with special IEC messages aimed at 24-71 month children

4 5 Maternal Care

Achievements

IEF's objectives for maternal care, as stated in the CS X Detailed Implementation Plan, were to train 5 TBAs to provide antenatal care and to train and deploy 16 Community-based Distributors of family planning methods Additionally, 25% of mothers of children less than 2 months of age who desire no more children in the next 2 years would use a modern contraceptive method ***IEF received a grant under USAID/Malawi's Support to AIDS and Family Health Project which began in February 1996, at which time all of the CS X AIDS prevention and family planning activities transferred to that project, approved by USAID*** The antenatal care activities - training the TBAs - remained under the rubric of CS X

37 TBAs were trained under the project using the MOHP curriculum As a rule, IEF relies on MOHP to provide trainers for most health worker trainings, IEF serves as co-trainer for specialized sessions as well as providing funding The Health Center staff who were interviewed during the evaluation field survey stated that these trained TBAs have helped increase the capacity of the centers by extending maternal care services to distant villages They reported that TBAs recognize high-risk deliveries and correctly make referrals to the MOHP health centers The TBA with who the team met correctly answered questions related to safe delivery practices, Vitamin A and breastfeeding, indicating a good general knowledge in her field of service delivery Training appears to have been effective in increasing TBA knowledge in safe delivery and maternal care

Fewer TBAs were trained than planned due to scheduling difficulties with MOHP, as mentioned in section 4 4 above IEF did not assign a specific coordinator to manage TBA program activities, thus, the TBA activities tended to be managed on an *ad hoc* basis by the IEF staff The lack of a designated coordinator may have been a factor in problems scheduling TBA trainings with MOHP IEF staff reported that MOHP/Chikwawa did not request the full training schedule which was budgeted, while the MOHP District TBA Coordinator told the evaluation team that she did not know there was any budget to conduct further trainings This misunderstanding might have been avoided had a staff coordinator been specifically accountable for TBA activities and objectives

Supervision of TBAs has been problematic, as mentioned in Section 4 4 above Most HSAs who are charged with supervising TBAs are men According to project staff, men tend to focus supervision, when provided, on the hygiene and sanitation aspects of the TBA's responsibilities rather than on aspects of maternal care such as Vitamin A, iron supplementation, immunization, and breastfeeding These may be aspects which a male HSA feels uncomfortable discussing with a female TBA The TBA interviewed by the evaluation team had a TBA kit with basic equipment but she was lacking Vitamin A iron tablets, and gloves in spite of requests to her supervisor for more supplies of these expendable items Her capability to apply skills and knowledge she had learned through training was limited as a result

Lessons Learned/Recommendations

Misunderstandings between IEF and MOHP resulted in a lost opportunity to train the full complement of TBAs budgeted under the project - a loss for MOHP and for the village-level health system This might have been avoided if a designated coordinator had been assigned to manage the TBA activities Each major program intervention should be assigned to a specific coordinator who will be responsible for ensuring that program activities are carried out effectively and according to plans Job descriptions should clearly outline interventions for which each coordinator is responsible and work plans should be developed in line with intervention objectives

Recommendations regarding the need to develop a comprehensive supervisory system have already been presented in sections 4 1 through 4 4 above they are pertinent to the maternal care objective as well Until such time as a system is in place and health workers are trained accordingly, HSAs will not know how to appropriately supervise the village health volunteers including the TBAs Such supervision will necessarily include providing support to the TBAs in the form of supplies they need to do the job for which they have been trained Otherwise, supervising the TBAs will become an empty exercise

HSAs tend to ignore the maternal care side of the TBAs' responsibilities when supervising, possibly because some aspects are awkward for male HSAs to address Awareness of HSAs needs to be raised about the critical importance of the maternal care aspects of the TBAs' job, and comfort level needs to be raised in discussing them The HSA training curriculum should be reviewed and revised to emphasize these aspects Gender sensitivities related to male supervision of TBAs need to be considered when devising a revised curriculum to ensure that gender is not a barrier in providing support to the TBAs

4 6 Primary Eye Care (PEC)

Achievements

Eye care services are sorely lacking throughout Malawi Eye care specialists are almost all hospital-based, most villagers cannot access their services easily IEF's objectives for PEC were to train village-level health workers - all VHVs and 4 traditional healers - to recognize certain eye conditions and refer them appropriately VHVs were also trained to recognize and treat conjunctivitis with tetracycline eye ointment These training objectives were far surpassed all 825 VHVs received some PEC training, 53 traditional healers were given a two-day training which included PEC, among other topics, and 33 of those received refresher training as well

Traditional healers are often the first recourse for villagers seeking medical assistance and are considered a significant health resource in their communities IEF began a training program for traditional healers in 1996 in order to tap this resource and build capability to offer appropriate (i e , not harmful) care at the village level Traditional healer training included PEC and HIV/AIDS, among other primary health care topics The evaluation team interviewed 11 traditional healers during the final evaluation field survey, all of who had undergone IEF's training All of those interviewed expressed their satisfaction with the training they had received and said that they would welcome further training opportunities They reported that the IEF trainings had increased their knowledge on PEC and AIDS and has raised their interest in learning more about "modern methods" in the future

Several topics in addition to PEC were also covered during the two-day training for traditional healers This time frame allowed only brief coverage to each topic, although PEC was emphasized A quality assessment of Traditional Healers training carried out by IEF in May 1997 indicated that up to 53% were still using traditional treatments, such as blowing medicine into the eye, for eye problems, 22% are still using traditional eye drops on their patients All of the healers who were interviewed by the evaluation team said that they only refer cases after they fail to cure a patient, then they refer to the nearest health center While these results indicate that harmful practices are still an issue of concern it represents a significant improvement since the beginning of the traditional healer training program The IEF trainings have not only raised knowledge of traditional healers but also their interest in learning more They appreciate IEF s efforts to legitimize their role in the village level health care system Their enthusiasm to receive more training in primary health care is a positive sign toward changing harmful practices

The IEF PEC Coordinator resigned in June 1997, shortly after the above-mentioned quality assessment was conducted This left a gap in the management of PEC activities, there was no follow-up on assessment results to address issues which were raised Other staff were assigned to take over PEC activities in addition to their other program responsibilities, but it was not given the full attention it required

It is not possible to assess the impact of VHV training in PEC, there is no data on the number of cases they treat or refer IEF provided tetracycline eye ointment to VHVs and TBAs in the early phase of CS X so that they could treat conjunctivitis, but this program activity was discontinued when MOHP disapproved village-level health workers administering the ointment Thus, although the VHVs and TBAs have been trained, they are unable to practice the skills they were taught due to policy constraints Tetracycline eye ointment is currently available in those communities where a community-managed Drug Revolving Fund (DRF) is established, but the vast majority of communities do not have a DRF

Lessons Learned/Recommendations

Given the reliance of communities on Traditional Healers as health providers and the apparent eagerness of the Traditional Healers to avail of training opportunities, it is recommended that they continue to be a key target group for training by IEF and MOHP under the CHAPS project

Traditional healers have changed their practices significantly as a result of training but, as with exclusive breastfeeding, cultural practices are difficult to change within the three-year time frame of a project IEF and MOHP should consider developing separate two-day modules on priority topics so that each topic can be covered in greater depth Participatory techniques should be utilized, allowing time for participants to practice new skills Increasing depth of coverage may not only improve knowledge and awareness, but may lead to more significant behavior change as well

Quality assessments should continue to be regularly carried out in order to discover to what extent practices are changing, which practices are changing or not, and what are the barriers to change IEF should supplement these assessments by regularly monitoring trends in the number of eye cases seen at the District Hospital and/or selected Health Centers as means to measure overall impact of this intervention

The PEC program lost some momentum due to the resignation of the PEC Coordinator on staff As was learned with the TBA program, each major intervention needs a designated coordinator in order to ensure activities are managed effectively IEF should appoint a PEC Coordinator to manage activities under the CHAPS program One responsibility of a PEC Coordinator should be to follow-up with MOHP to regarding the policy barrier that prohibits village-level health workers from administering tetracycline eye ointment The objective would be to find out the basis for this policy and to seek options that will improve villagers' access to appropriate treatment

4 7 Drug Revolving Funds (DRFs)

Achievements

IEF established 6 Drug Revolving Funds, as planned, in isolated communities of Chikwawa during the CS X project DRF Committees, village headmen, and 2 DRF Volunteers in each of the six communities were given brief basic training by IEF and MOHP in management of the DRF HSAs, VHCs and Health Assistants have also received limited training about DRFs in the areas where they have been established Two DRFs have been fully handed over to MOHP for monitoring and supervision it is planned that the remaining four DRFs will be phased over before the completion of the project in February 1998

Communities consider the DRF to be a valuable service A DRF assessment undertaken by IEF in October 1997 found that 78% of mothers feel that the DRF is important to their village, 96% of mothers said that they seek medicine through the DRF as a first resort before going to a traditional healer These mothers prioritized *availability* of drugs in the DRF as more important than being able to buy drugs cheaply or for free The District Health Team and Health Center staff interviewed during the final evaluation also said that they consider the DRF to be an important mechanism for extending health services to communities in distant locations

IEF has procured drugs as needed for the DRFs up until the point of handover, at which time the DRF Volunteers are expected to procure either through MOHP or from commercial sources Of the two DRFs reviewed by the evaluation team, one which had not yet been handed over to MOHP was actively utilized by the community while the phased-over DRF had been dormant for a period of 5 months due to problems in the drug procurement system From interviews with DRF Volunteers, a DRF Committee, and HSAs, the evaluation team gathered that handover of the DRFs had not included clear procedures for procurement It also appeared that MOHP procurement procedures differ from one location to the next depending on proximity of the DRF to a Health Center or District Hospital Procedures are not standard and are very unwieldy, resulting in confusion

Lack of understanding about roles and responsibilities coupled with inadequacy of management skills presents a major constraint to operation of the DRFs on a sustainable basis The DRF Committee was not able to specify job roles and responsibilities other than "to monitor the DRF Volunteer's activities " They are unclear about how to supervise the DRF Volunteers Although DRF Volunteers were elected by their communities, selection guidelines were not provided by IEF or MOHP, volunteers were chosen on the basis of "good character "

It was felt by the evaluation team that lack of supervision of the DRF Committee and Volunteers by the responsible HSA was a major factor in the disruption to DRF operations since handover to MOHP The HSAs were as unclear about procedures as the DRF Committee and Volunteers who were interviewed by the evaluation team One HSA indicated that he resented having a DRF in the community because it had taken away one of his key job responsibilities, that is, administering basic drugs He felt he had lost some prestige as a result

The DRF Volunteers Committee and HSAs all expressed some dissatisfaction about the handover process There was general agreement that the handover process should have been carried out with much greater public ceremony by IEF and the MOHP, involving the whole community There was an expectation that both IEF and MOHP should have been more inclusive in planning and executing the handover to the DRFs

The DRF Volunteers and Committees have relied on either IEF or MOHP for supply of drugs rather than taking initiative to buy drugs from other sources They seem to view the DRF as an IEF or MOHP activity rather than a community initiative Their sense of ownership in the DRF is lacking, also indicated by the lack of active management and decision-making about the DRF contents and maintenance

Basic management skills to manage the DRFs are lacking among the DRF Volunteers, Committees and HSAs So far, pricing has not been an issue, but the recent devaluation of the kwacha will cause an inevitable increase in drug prices The DRF Committee and Volunteers who were interviewed did not seem to have either the knowledge, skills or experience to set prices Other management decisions, such as utilizing DRF funds to replace pens and stationery for record keeping or to buy a flashlight to provide DRF services at night, were never considered by those responsible for such decisions Such simple decisions have the potential to stall the operations of the DRF if those responsible for decision making are not equipped to take appropriate action

Lessons Learned/Recommendations

Communities clearly value the service provided by the DRF, but do not feel a sense of ownership, they see the DRF as someone else's activity The handover process for the DRFs was negotiated between IEF and MOHP, community input was lacking in planning and executing handover Involving communities in the process could have been a measure toward building their ownership of the DRFs It would also have helped identify skills needed by DRF Committees and Volunteers early on so that training could have been more appropriately focused

Training given to the DRF Committees and Volunteers was too brief to develop the required skills for managing the DRFs More training is required for DRF Committee members and Volunteers to clarify their roles and responsibilities in greater detail and to develop their business management skills MOHP, with assistance from IEF through the CHAPS program, should conduct a baseline survey/assessment of DRFs, building on the earlier assessment which was done, to serve as a training needs assessment A more thorough training should be developed for DRFs which includes pricing, cash management, drug procurement, and supervision

If guidelines and procedures are unclear, accountability falters and the DRF system may disintegrate IEF and MOHP should build on the experience gained during CS X to enhance DRF programs under the CHAPS project, utilizing lessons learned to involve the communities in planning and management, to develop appropriate training programs, and to establish clear guidelines and procedures for managing the DRFs Standard committee and volunteer selection guidelines, job descriptions and drug procurement procedures must be clearly written and adhered to by the various players who are involved in facilitating and managing the DRF Health Center staff and HSAs, who facilitate drug procurement, must understand their roles and responsibilities and be responsive to the needs of the isolated communities where the DRFs are located Procurement procedures should be developed with a focus on ensuring a smooth flow of drugs Training for each and every level of volunteer, committee and health worker must clarify the guidelines and procedures and build commitment to ensuring consistent service

Results of the October 1997 quality assessment should be shared with DRF Volunteers and Committees so that they have more information on which to base management decisions They will be better prepared to serve the community's interests if they know what motivates the community members to utilize the DRF - or not It would be appropriate for IEF, with MOHP, to undertake a PRA activity with the DRF communities to broaden the understanding of how the DRF should operate and to enhance their ownership over the DRF

4 8 Income Generating Activities (IGAs)

Achievements

The community-based health care system set up by IEF is highly dependent on volunteers and turnover rates of volunteers has been a concern from past experience A key issue affecting turnover rates has been the fact that, in a country where per capita income is among the lowest in the world, communities have great difficulty in supporting their volunteers with material incentives Under CS X, IEF initiated a pilot program to establish 1 IGAs with the aim of providing a source of income for health volunteers Of the 1 which were set up, 7 were still functioning at the time of the final evaluation A total of 3 VHVs and VHC members were trained to undertake IGA projects

IGAs are a program area with which IEF has little institutional experience With this limitation in mind, technical assistance was sought from the Ministry of Agriculture (MOA) to help in developing project ideas Vegetable gardening, rabbit raising, and poultry projects were introduced in the pilot locations by IEF involvement of communities was limited to deciding which individuals would participate The criteria that participants should be a VHV or a VHC member was de-emphasized over the course of the project and, ultimately, participation was open to any interested individuals Though some volunteers did participate, the original concept of offering an income source to volunteers was lost

Though not by design, the particular projects that were introduced - rabbit raising, poultry raising and vegetable gardening - have provided participants with a source of food as well as income Those with who the evaluation team met indicated that this was a very important, if not primary, motivation for participating in the activity

In the IGAs which have met with success, participants were very enthusiastic about their activities in discussions with the evaluation team The rabbit raising and vegetable gardening participants indicated to the evaluation team that they are satisfied with their projects and intend to keep them operating, even with the prospect of no longer receiving technical assistance after the conclusion of CS X However, their experience is limited and basic literacy skills which are needed for business planning and management are lacking It was not possible within the scope of the final evaluation to look in great depth at the financial management of the IGAs, but responses from participants when asked about financial status of and planning for their projects indicated that skills are quite limited and systems for accountability are lacking These deficiencies severely limit chances for sustainability of the IGAs unless participants can develop the necessary skills and systems, for which continued technical assistance is needed

Three poultry projects were introduced as a cooperative venture at a time when Malawi was suffering drought conditions, which were then followed by floods This had a disastrous affect on the poultry projects due to difficulties in procuring feeds In addition, some participants dominated and took advantage of less literate members of the groups This led to dissension and, finally, disintegration of the poultry projects The IEF staff felt that the infusion of cash into the community, generated by the project, had a divisive effect which eventually caused the downfall of the poultry scheme

On the other hand, group solidarity appears to be a strong factor for success of the vegetable gardening projects The gardening group with which the evaluation team met was composed completely of women The group had discussed some ideas for use of earnings, which are banked and accounted for by their elected treasurer All of the members work together daily to maintain the garden, decisions regarding the project

have been based on group consensus, without notable problems to date Continued technical assistance in gardening and training in basic management would be well-invested given the positive group dynamic on which the project is founded, but such assistance would need to be intensive in order to address the growing needs of the group over time There are few, if any, resources for providing this level of assistance after completion of CS X

IEF has linked project participants with the MOA for some technical assistance The MOA provided some basic training to participants of each type of IGA during the start-up phase of the projects, in total, 3 participants were trained fewer than the planned 1 trainees MOA technicians have been fairly consistent in providing follow-up assistance to the rabbit raising IGA participants, but the vegetable gardening participants have not received the same level of MOA support Technical assistance linkages are tenuous at best, and there has been little input of management training

IEF staff voiced a general belief that the IGA projects have required too many inputs and too much effort with too little impact They have had difficulty in identifying appropriate technical resources to assist in implementing this intervention, and do not feel they were equipped to provide the necessary support

Lessons Learned/Recommendations

Decisions were made about which types of IGAs to implement without involvement of the community in choosing or in planning for implementation The process did not consider community capacity or interest to undertake the projects In particular, the health volunteers were not involved in these key steps in the process, so the original objective of implementing IGA projects to benefit the community volunteers was lost over time As with the DRFs, the community should be brought into the process at the planning stage in order to develop their sense of ownership in the initiative and to assess their skills for taking on the project Customer needs assessments should be done through PRA and other appropriate techniques to assist in identifying possible projects from which the community can choose Before implementation, thorough planning should be done with the participants for all critical phases of the project so that they can help in developing implementation guidelines Basic financial skills training should be introduced and financial procedures put into place

Infusing cash into the community proved to be divisive in the poultry projects, though the gardening groups have so far avoided friction over finances between members Future IGA project planning should include a structured session whereby the participants must consider the implications of a cash infusion They must be asked to answer questions such as

- What if my neighbor earns a lot of money and I earn only a small amount?
- Who will keep track of money earned by the project, and how will those who are illiterate stay informed of earnings?
- What are the criteria for deciding who can access group savings?
- How will the group decide what to do with earnings?
- How will we resolve differences of opinion among group members?

It will be important for a skilled facilitator to have the community consider various scenarios and plan for contingencies

The current level of management and technical skills of participants is inadequate to ensure sustainability of the IGA projects Further training is needed along with continued technical support In the future - if IGA activities are undertaken - IEF should consider implementing them through a partnership with an experienced

vide the required training and technical assistance to project participants on a long term NGO linkages with the appropriate Ministry should be established Given that it is too late to take basis, nded actions for the CS X IGA projects, IEF should consider continuing to provide technical these ough its Food Security Program so that participants have a source of technical assistance while assis in the nascent stage of their projects they

5 LEMENTATION ISSUES

mmunity Education and Social Promotion

lth Worker Training

aining for village-based health care providers has been a key activity under CS X, with the goal of instilling wnership over and responsibility for health care firmly with the community, supported by MOHP Training has been largely targeted at village volunteers and committees to increase their knowledge of the child survival interventions and their capacity to mobilize communities and deliver some basic services Training has also been provided to MOHP personnel to enhance their capacity to support the village health care system Training data is presented in Table 3

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TABLE 3
TRAININGS CONDUCTED DURING CS X

TRAINING TARGET GROUP		INTERVENTIONS	# PLANNED PARTICIPANTS	# ACTUAL PARTICIPANTS	NOTES
I	VHVS	Vitamin A, ORT, CDD, Nutrition, EPI, PEC	8 VHVs	825 VHVs	Target surpassed
II	Breastfeeding Promoters (from among VHVs)	Exclusive breastfeeding	Chosen by MOHP	116	Training participants were selected by MOHP from among trained VHVs
III	VHCs	Vitamin A, ORT, CDD, Nutrition, EPI	57 VHCs	428 VHCs	75% of target met, during second half of CS X, IEF placed special focus on 6 villages
IV	HSAs	Vitamin A, ORT, CDD, Nutrition, EPI	1 HSAs	138 HSAs	Target surpassed
V	HSAs	PEC	1 HSAs	16 HSAs	16% of target met, less than planned due to limited referral sites for HSAs
VI	HSAs	DRF Management	12 HSAs who provide supervisory support to DRFs	6 HSAs	1 % of available HSAs trained This was less than planned due to only 1 HSA responsible for each DRF village
VII	MOHP mid-level managers	Vitamin A, ORT, CDD, Nutrition, EPI, Supervision and Management	3 MOHP mid-level managers	14 MOHP mid-level managers	47% of target met
VIII	Health Assistants, Medical Assistants Nurses	Vitamin A, ORT, CDD, Nutrition, EPI	75 HAs, MAs, Nurses	7 HAs, MAs, Nurses	93% of target met

TRAINING TARGET GROUP		INTERVENTIONS	# PLANNED PARTICIPANTS	# ACTUAL PARTICIPANTS	NOTES
IX	Health Assistants at Health Centers covering DRF communities	DRF Management	6 HAs	5 HAs	83 % of target met (100% of Has involved)
X	MOHP Support Staff (ward and patient attendants)	Vitamin A, ORT, CDD, Nutrition, EPI	100 support staff	111 support staff	Target surpassed
XI	Community Health w orkers	Vitamin A, ORT, CDD, Nutrition, EPI	5 CHW s	13 CHW s	87% of target met
XII	Traditional Healers	PEC, AIDS	400 traditional healers	530 traditional healers	Training target surpassed
XIII	Primary School Teachers	PEC, vision screening	2 per each school in district	12 teachers	Program discontinued after this activity was picked up by a German NGO, CBM
XIV	Traditional Birth Attendants (TBAs)	Maternal care and safe delivery	50 TBAs	37 TBAs	74% of target met due to lack of coordination on training schedule between IEF and MOHP
XV	DRF Volunteers	DRF Management	6 DRF Volunteers	12 DRF Volunteers	Target met 6 additional volunteers were selected after the mid-term evaluation to serve as "back up" support to original volunteers
XVI	DRF Committees	DRF Management	12 DRF Committee members from 6 DRFs	12 DRF Committee members	Target met
XVII	IGA participants - VHVs and VHC members	IGA training	100 VHVs and VHC members	30 VHVs and VHC members	30% of target met in terms of the number of VHV & VHC members trained for IGAs All 10 planned IGAs were established

A major finding of the final evaluation was that MOHP does not have the resources required to maintain training at the level provided under IEF MOHP has qualified trainers, but lacks funding Health Center staff said that they have the manpower and willingness to train volunteer health workers and committee members in their respective villages rather than incurring costs associated with centralized, residential trainings, but that volunteers would still expect to be paid an "allowance" to attend the trainings, a cost for which there is no budget There is some funding budgeted for traditional healers and VHCs under the CHAPS project, but MOHP does not have resources to support further training for VHVs This leaves sustainability of the village health care system in question since this is the largest cadre of volunteers conducting mobilization activities

It is recommended that IEF and other PVOs that have received CHAPS grants develop a common training allowance policy in collaboration with their District MOHP partners as a means to minimize this issue

The VHVs need continued attention in the form of supervision and training by MOHP in order to ensure that they fulfill their intended role in the community-based health care system It is recommended that IEF work closely with MOHP to plan the VHC trainings under the CHAPS project so that the already-trained VHVs are included as VHC members in any further training This will perhaps slow down the VHV attrition rate by keeping them involved and interested It will also provide opportunities for refresher training, which is needed by any health workers to maintain knowledge and skills

Health Education for Target Groups

Despite considerable training and high knowledge levels, quality assessments carried out by IEF found that village volunteers are not effectively transferring health messages to intervention target groups The assessments did not, however, provide depth of information needed to understand why this is the case One possibility is that VHVs are not carrying out health education sessions as intended, but health education activities have not been strictly monitored to date

Under CHAPS, a supervisory system should be devised that will include at least a minimal level of monitoring of volunteer activities to ensure that they are conducting activities for which they have been trained, including health education

Community Mobilization

VHCs have been activated to induce them to lead their communities in health initiatives, representatives of 428 VHCs have received training to enable them to supervise VHV activities and assist in mobilizing communities for child survival activities In 6 villages that have received extra attention since the mid-term of the CS X project, IEF field supervisors have worked with the VHCs and VHVs to address problems pointed out in earlier evaluations regarding tensions between them

The final evaluation field survey results indicated that the VHVs and VHCs have a clearer idea about their respective roles and responsibilities, but that there are still problems related to skill differences and perceptions about who should be supervising who Both groups prefer to look to the HSAs as supervisors Under CHAPS, the HSAs should be trained as facilitators to help these two groups focus on the overriding goal of improving the community health situation It may be in the interests of all concerned to make the HSAs the official supervisors rather than having community members responsible for supervising other community members

5 2 Human Resources for Child Survival

An extensive network of health workers has been established by IEF through the CS IX and CS X projects, reliant on village-based volunteers as the foundation IEF has provided considerable training to each category of volunteer to ensure skills and knowledge are adequate to provide expected mobilization service delivery and referrals to communities For a full listing of the different categories of volunteers and health workers who have been trained under the health care network, see Table 3

Of the 825 VHVs who were trained, IEF estimates that 125 are actively conducting activities for which they are responsible Specific data in this regard is unavailable since supervisory responsibility for VHVs was transferred to MOHP during the project, there is no supervisory system currently in place to provide insights into the actual activity levels of VHVs As mentioned in many places throughout this evaluation report IEF should work with MOHP under the CHAPS program to institute a comprehensive supervisory system that includes accountability of each level of worker to conduct specific job tasks Monitoring by supervisors to ensure job responsibilities are being fulfilled and to address problems that may arise is essential to measuring effectiveness of health strategies, particularly one that heavily emphasizes volunteer education and mobilization activities

The volunteer network relies on support provided by MOHP health workers, particularly the community-based HSAs and the Health Center staff HSAs, specifically, play a major supervisory or advisory role to the VHVs, VHCs, TBAs, DRF Committees and DRF Volunteers Training under CS X for the MOHP staff was intended to give them the requisite knowledge and skills to support CS interventions

All of the MOHP health workers who met with the evaluation team were well aware of the CS X project activities and had a fair understanding of their supporting role However, numerous interviews revealed that they are not able to fulfill that role because of logistical constraints in providing supervisory support and assistance in procuring commodities Health Center staff cited the need for motorcycles to be able to cover their large outreach areas (Over 5 villages are covered by one District Hospital, one sub-district hospital, and 11 Health Centers) HSAs, expressed their difficulty in covering anywhere from 5-1 villages without transport, though most HSAs have been provided bicycles, many are in disrepair due to lack of maintenance funds from MOHP This is a serious constraint requiring considerable resources (i e , funding) to overcome

However, more pertinent to the MOHP support role is the lack of supervisory skills and systems, problems which do not rely entirely on expensive solutions Measures could be taken to devise a supervisory system within the limitations set by available transport, communication, and manpower A crucial component of the system should be job descriptions for each level of health worker, MOHP or volunteer Each level should be well-oriented to their job roles and responsibilities through training, training should emphasize the supervisory role and use of checklists to monitor and pinpoint problems in performance

IEF's CS X staffing structure has shrunk slightly since the mid-term of the project due to some staff resignations (See CS X Organogram in Annex 8) Some positions were restructured to collapse responsibilities The former Training Coordinator was promoted to Program Manager in January 1997 Training and Evaluation were then combined into one position The Community Health Coordinator took on the responsibilities of one of the field supervisors who was chronically ill The PEC Coordinator resigned in June 1997 and her responsibilities were re-assigned to the Training and Evaluation Coordinator The newly-combined positions are logical in terms of staff skills and expertise, but the additional job responsibilities have placed a strain on staff and have affected their ability to give adequate attention to all interventions

5 3 Supplies and Materials for Local Staff

Several of IEF's objectives were severely constrained by the MOHP policy that disallows volunteers administering drugs Affected objectives included increasing Vitamin A coverage treatment of conjunctivitis, and control of diarrheal disease with ORS After VHVs were trained IEF supplied them with tetracycline eye ointment, Vitamin A, and ORS Likewise, TBAs were provided with an initial supply of Vitamin A to give to postpartum women These volunteers were instructed to obtain further supplies from their nearest Health Center through their HSAs The health volunteers with who the final evaluation team met, however, had not been able to re-stock as instructed due to the policy constraint

Some volunteers complained that their HSAs were unresponsive to requests for supplies, but interviews with HSAs and Health Centers indicated that they did not understand procurement procedures, they also reported stock outages of some commodities and drugs due to problems in transporting supplies from the District Hospital District MOHP supplies were reported to be adequate to meet needs throughout the district Persistent problems in the MOHP procurement and supply systems impede the chances for sustaining the village health care system

IEF inherited a lot of older equipment (e g , photocopiers and vehicles) from the CS IX project There have been constant maintenance problems, particularly with vehicles, which have hindered efficiency at times

5 4 Quality Assurance

IEF staff have undertaken an impressive number of quality assessments to gather information about service delivery issues Quality assessments carried out since the mid-term evaluation are attached in Annex 7 Assessment results have been used to plan appropriate trainings for health workers, and feedback has been given to health workers at the sites where assessments were conducted Assessment results have also been shared with the DHO through reports

Quality assessment results could be applied on a much wider scale, however To date, information is shared at the top of the district-level MOHP structure and with a limited number of staff at the bottom who have been directly involved in the assessment, but not at the mid-level - between district-level and the Health Centers - where coordination should be taking place Information from the assessments is not flowing down to district-level implementing staff This represents a missed opportunity to use the findings of assessments for program planning and implementation on a wider scale within the district

IEF has an opportunity through the CHAPS project to expand use of quality assessments Since the assessments require a considerable amount of staff time to conduct, they should be planned strategically, in collaboration with MOHP, and results must be circulated and used on a wider scale than has been done to date IEF should include MOHP in planning and conducting assessments so that 1) MOHP can be involved in deciding what will be assessed, 2) MOHP staff can develop skills and interest in quality assurance, 3) findings can be internalized more than by reading a report possibly increasing chances that they will be incorporated into MOHP program planning Findings should be shared not only with senior MOHP officials and those staff involved in the assessment activity but also with mid-level staff who are more involved in day-to-day planning and implementation

IEF, in consultation with MOHP/Chikwawa, could devise a distribution list and system to ensure that quality assessment findings reach appropriate staff According to current policy, Health Center Officers-In-Charge are supposed to meet together monthly to communicate and coordinate on health issues and initiatives These

meetings could serve as a forum for sharing quality assessment results and planning follow-up action, but they are not convened regularly IEF should encourage MOHP to activate monthly coordination meetings for Health Center Officers in-Charge, where findings could be presented and considered for action by this key level of service providers

5 5 Supervision and Monitoring

Supervision and monitoring are the most serious needs to ensure sustainability of the CS health initiatives, as was pointed out in the mid-term evaluation The recommendations from that report are still pertinent

- Supervision should be used to assess progress towards objectives and improve quality of services
- Simple checklists for supervisory visits should be devised and routinely used by MOHP staff

In addition to these, it is recommended that a comprehensive training program must be developed to cover every level of health worker MOHP staff and volunteers alike Sessions should cover clarification of job roles and responsibilities (inferring the development of job descriptions), supervisory skills, and use of supervisory checklists Performance evaluations, linked to job descriptions and achievement of specific objectives, should be incorporated into the supervisory system as well

The supervisory system must be developed within the constraints of limited transportation and communication Training must build a sense of personal commitment and accountability to minimize the sense of powerlessness that the lack of transportation and communication has caused IEF should explore the possibility of establishing awards and incentives for good performance Since it is unlikely that MOHP would have funds for such awards, private sources (e g , SUCOMA and/or other local sponsors) could be sought

HSAs and VHVs have gained some skills in data collection as a result of IEF training and experience in gathering data for M4E reports These health workers appear to find job satisfaction from their role in the M4E system even though they do not receive feedback as planned IEF should continue to work with MOHP to strengthen the M4E system at the district level, focusing on developing analysis skills of health workers and feedback mechanisms Although it is doubtful that MOHP/Chikwawa can influence the M4E system beyond the district, better use of data could be used to monitor impact on key initiatives that are planned for the CHAPS program Making better use of this system is recommended over developing a new monitoring system for CHAPS

5 6 Headquarters Support

The IEF/Malawi field office reportedly has very close links with headquarters staff, maintained largely through e-mail, fax and telephone IEF headquarters staff have made regular visits to the Malawi program during the course of CS X the headquarters-based CS Coordinator participated in both the mid-term and final evaluations and the Director of Programs has visited twice The Country Director, Dr Christine Witte, believes that the support provided by the headquarters staff has been appropriate to meet the needs of the field program

5 7 PVO's Use of Technical Support

IEF has not procured or received any technical assistance since the mid-term of the project except for training of the senior CS program officers in EPI-INFO by a local consultant Prior to the mid-term, technical assistance was acquired in the following areas analysis of data, use of EPI-INFO, M4E, data collection and information systems, primary eye care, strategic planning, quality assurance and computerized accounting IGA-specific training

5 8 Assessment of Counterpart Relationships

IEF's key partner is MOHP and efforts have been appropriately focused on developing this relationship MOHP staff have been involved in all IEF-sponsored trainings, providing technical input The District MCH Officer has participated in both the mid-term and final evaluations of the CS X project and has also provided valuable assistance in the process of handing over the HSAs and DRFs to MOHP It is planned that IEF will sit on the expanded District Health Management Team upon commencement of the CHAPS project, ensuring an even closer working relationship and opportunity to assist in building MOHP capacity to support community-level health initiatives

Building the relationship with MOHP has been hampered by frequent turnover of the District Health Officer position Three DHOs have been assigned during the course of CS X The DHO is the key local authority in a highly centralized structure IEF has had to start from scratch in orienting each new DHO on its programs, slowing down the process of implementation and program development

Relationships with other key health agencies in Chikwawa are good, but they have not been particularly relevant or useful for CS X activities since the focus of the project was on building MOHP capacity to take over the village-level health program A Program Advisory Committee, composed of representatives from MOHP, IEF, SUCOMA Health Clinic, and Montfort Hospital, met regularly each quarter during the first half of CS X, but have not been as frequent during the second half due to the frequent turnover of the DHO

5 9 Referral Relationships

When and where to refer have been part and parcel of training for all of the community health volunteers All of the volunteers interviewed during the final evaluation demonstrated awareness of this as part of the protocol they were trained to follow Only the traditional healers voiced resistance to the idea of referring to MOHP facilities, stating that they only refer after they fail to cure a patient

Health Center staff with who the evaluation team met expressed that village health volunteers TBAs in particular, are aware of when cases should be referred and that they do actively refer cases to the Health Centers The referral linkage seems to have been strengthened in spite other barriers, such as lack of supervisory systems and supplies, that have constrained the relationship between the Health Centers and village-level health workers Distance from health facilities and absence of transport also present barriers to building the referral linkages

5 10 PVO/NGO Relationships

There has been little networking or contact with other PVOs or NGOs for Child Survival except of an informal nature As mentioned in section 5 8, the focus has been on building a constructive working relationship with MOHP IEF has had more substantive formal contacts with other PVOs for the STAFH project, which is funded directly by the USAID/Malawi mission

Networking and coordination with other PVOs is anticipated to occur at a significant level during the CHAPS project, also a USAID/Malawi-funded project

5 11 Budget Management/Pipeline Analysis

No major budget revisions have been made since the DIP was submitted and approved The financial pipeline analysis is attached The monthly burn rate is $25,221 (combined AID/IEF) This is very close to the estimated burn rate ($25,128 combined AID/IEF) calculated on the budget

At the mid-term it was noted that the project was underspent The IEF has taken measures to correct the underspending which was in part due to the fall of the local currency The changes from the previous Country Director to the new CD also contributed to an increase in activities and a corresponding increase in spending It is anticipated that the program will close out activities having spent the budget

5 12 Sustainability

Achievements

Refer to Table 4 - Sustainability and Capacity-Building and Sustainability Plans and Outcomes, for details on sustainability achievements and outcomes

The overall goal of CS X was focused on sustainability of the village-level health care system by transferring ownership to communities and MOHP Indeed, responsibility has been transferred, but the requisite skills and resources to maintain program momentum and quality are not yet fully in place The overriding constraints related to of lack of supervisory skills and systems, transportation, communication and coordination systems within MOHP are critical to address for the purposes of sustainability However, these are large issues that must be addressed not only at the Health Center and village levels, where the CS X project has focused efforts, but at the district and regional levels of MOHP It was not within the scope of IEF's project to address these issues There is a much greater opportunity to address these issues within the context of the CHAPS project The CHAPS project is the logical "next step" for IEF and the MOHP in forging a stronger partnership and strengthening the community health care system

Communities' participation in child survival activities has been largely through the VHVs, VHCs and other village volunteers All of the volunteers have welcomed training opportunities offered through CS X and would like to participate in others (although there is some question about whether they are motivated by the per diems they have received to attend trainings in the past) The VHCs interviewed during the final evaluation indicated that they had been active in mobilizing their communities to undertake health initiatives, which was corroborated by the HSAs VHVs have been active in promoting attendance and assisting Health Center staff at U/5 clinics Sustaining this interest at the same level will be a challenge for MOHP given the many constraints already enumerated throughout this report

DRFs have been established in 6 communities Although there was some confusion for communities and village-based health staff due to unclear handover, MOHP is committed to continuing support for DRFs This bodes well for sustainability of the DRFs There is scope for strengthening the DRFs under the CHAPS project as well

It is less likely that IGAs will sustain since they do not have the same possibility for long-term linkages with the appropriate Ministry or NGO

TABLE 4
CAPACITY-BUILDING AND SUSTAINABILITY PLANS AND OUTCOMES

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
A To transfer responsibilities and recognition from IEF to the MOHP and Montfort Mission Hospital so that all HSAs are seen as belonging to the MOHP and all VHVs to their respective communities	1 Train MOHP staff in vitamin A, CDD, nutrition AIDS and supervision/management	The following MOHP staff were trained 138 HSAs (target - 100) • 14 mid-level managers (target - 30) 70 Health Assistants, Medical Assistants Nurses (target - 75) 111 Support Staff (target - 100) 13 Community Health Workers (target 15)	MOHP staff at all levels were familiarized with the CS interventions but skills in supervision require further strengthening to be able to implement them on a sustained basis More training is needed in supervision and trainings should be focused less on theory and more on practical application supplemented with supervisory systems and checklists which must also be developed
	2 Improve community health care by training VHVs and VHCs in vitamin A CDD nutrition AIDS family planning EPI, and HIS	825 VHVs were trained (target - 800), of those, 125 received refresher training Representatives of 428 VHCs trained (target - 570)	Current VHVs and VHCs have good knowledge on CS interventions and procedures for referrals to MOHP health services However supervisory support for them is lacking (see 1 -Outcomes above) There is also a continued concern about drop-outs of volunteers due to lack of material incentives MOHP does not have the resources necessary to provide training for new volunteers to replace drop-outs or to provide refresher training to old volunteers Although MOHP has qualified and willing trainers resources are lacking for training support costs such as transport accommodations and allowances which trainees have come to expect

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
	3 MOHP hire all IEF HSAs	All IEF HSAs (14) were hired by MOHP	IEF HSAs have been fully integrated into the MOHP system Most were transferred from the sites they had covered for IEF and handover problems occurred Communities and health volunteers were not fully cognizant of the handover and some resisted the HSAs who took over the sites The HSAs were not as familiar with the CS program activities and did not provide the same level of supervision and monitoring as the IEF HSAs had provided Communities and MOHP have expressed the need for greater involvement in handover planning and implementation
	4 MOHP take over responsibility for supervision of HSAs doing project activities	Responsibility for supervising the IEF HSAs has been transferred from IEF to MOHP	Responsibility has been transferred but the requisite skills and resources needed to effectively supervise is lacking In addition to the need for supervisory skills and systems MOHP also needs transportation and communication systems to facilitate effective supervision Coordination mechanisms need to be put into place to ensure Health Centers and HSAs are adequately informed of initiatives and implementation procedures so that they can support and supervise health volunteers
	5 MOHP take over responsibility for training and support of VHVs and VHCs	MOHP has served as a co-trainer along with IEF in providing training to VHVs and VHCs, as well as other volunteer health workers such as TBAs	MOHP does not currently have the requisite funding for training VHVs There is a small level of funding available for training of VHCs drug revolving fund volunteers, and TBAs Training cannot currently be sustained at the same level as under CS X The IEF VHV/VHC training manual could be revised and shared with HSAs so that they can refer to it in village-level training of VHVs, as needed to deal with attrition

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
	6 MOHP maintains stocks of vitamin A condoms ORS and family planning methods	MOHP/Chikwawa maintains stocks of all drugs and commodities at the district level Most U/5 clinics have adequate supplies of vitamin A Approximately 75% of Health Centers (out of 12) have adequate supplies of ORS	Health Centers have frequent stock outages of basic supplies and are therefore unable to provide supplies through the HSAs to the village level volunteers This disrupts the village level health delivery system that has been established by IEF through CS X There is a breakdown in the system for requisitioning drugs between the Health Centers and district stores The MOHP stock control and procurement system should be reviewed to pinpoint the weak links and to devise solutions then a revised system with clear standardized written procedures put into place All staff and volunteers should be oriented on the revised system and their roles and responsibilities within it
	7 Trained traditional healers refer eye disease to MOHP facilities	530 traditional healers have been trained and 330 of those have received refresher training (target - 400) Training included PEC as well as other PHC topics	Harmful traditional practices of treating eye cases have decreased since IEF s training program for traditional healers was initiated A quality assessment found that 53% still use traditional treatments such as blowing medicine into the eye and 22% are still using traditional eye drops on their patients - a significant drop in harmful practices However of those interviewed for the final evaluation none refer cases unless they fail to cure Further training in greater depth is needed to continue eroding use of harmful practices by traditional healers
	8 Trained TBAs provide maternal care services	37 TBAs were trained by IEF and MOHP trainers using the MOHP TBA curriculum (target - 50)	TBAs have good knowledge of safe delivery practices and maternal care as a result of training provided Supplies of vitamin A and iron which they need to carry out CS X activities for maternal care have not been provided as planned however due to the lack of supervisory support for TBAs from HSAs (i e HSAs do not provide them with necessary supplies)

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
	9 Established Drug Revolving Funds (DRFs)	6 DRFs were established in isolated communities (target - 6) 2 of which have been fully handed over to MOHP , 12 DRF Volunteers and 12 DRF Committee members were trained as well as 6 HSAs and 5 Health Assistants	Training for DRF Volunteers and Committees lacked the depth needed to develop understanding about roles and responsibilities and management skills Problems in drug procurement have occurred due to lack of clear, written procedures, MOHP procurement procedures differ from one location to the next depending on proximity of the DRF to a Health Center or District Hospital resulting in confusion to the MOHP village level workers and the DRF volunteers and committees HSAs and Health Center based staff do not know their roles and responsibilities regarding supervision and support for the DRFs Communities do not demonstrate a sense of ownership of the DRFs they expected greater involvement in and public ceremony for handover
	10 Established IGAs	10 IGAs were initiated 7 of which are functioning at end-of-project 30 VHVs and VHC members were trained (target 100)	The criteria that participants should be a VHV or a VHC member was de-emphasized over the course of the project and ultimately participation was open to any interested individuals Community capacity or interest to undertake the projects was not considered in the planning process experience of participants is limited and basic literacy skills which are needed for business planning and management are lacking Technical assistance linkages with Ministry of Agriculture are stronger for some IGAs than others continued support is needed for all IGAs but is not likely to be forthcoming without IEF's continued assistance Participants of successful IGAs are keen to continue even without support

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
B Communities will sustain the village-based health care system by selecting and supporting the VHVs and VHCs, involving in health activities and supporting village based health care services	1 Communities will regard the VHVs as their own rather than perceiving that they belong to IEF or MOHP, demonstrated by their involvement in selecting VHVs and by the VHCs' supervision of VHVs	Representative of 428 VHCs were trained using the same curriculum as for VHVs to give them knowledge to supervise VHVs effectively	VHCs have gained knowledge on health interventions and a sense of ownership over the VHVs but the VHVs do not feel that the VHCs have adequate knowledge on health activities to supervise them VHCs express some jealousy of VHVs opportunities to receive more training Both VHCs and VHVs view the HSAs in a supervisory capacity Communities know who their health volunteers are and are involved in selecting them but look to HSAs to organize the selection process Further re-orientation on roles and responsibilities is needed
	2 VHCs will meet at least once a month with their VHC and HSA	Training for VHCs and VHVs	VHCs meet irregularly due to seasonal work loads and weather conditions They initiate community health activities particularly regarding bore hole maintenance, latrine and kitchen construction, and general sanitation
	3 Communities will contribute support of VHVs and VHCs	10 Income generating activities were initiated with the idea of providing a source of material support for volunteers	IGAs were set up but they have not provided the intended incentives for volunteers Communities show support for volunteers mainly by involving in health initiatives of volunteers
	4 Communities will demand health services particularly for condoms ORS, vitamin A and EPI	Village-level volunteers have been trained to mobilize and/or provide services	Vitamin A coverage for 6 71 month children has increased but coverage has decreased for postpartum women at least partly due to lack of Vitamin A supplies for the TBAs Communities have demonstrated a demand for ORS from VHVs but supplies are not available HSAs have not facilitated commodity supplies to the village-level volunteers as demanded Supervision and understanding of roles and responsibilities within the village-health care system need to be strengthened
C Collaboration between health care agencies will be strengthened	1 Trainings will be conducted in collaboration with one or more of the health care agencies in the district	All trainings were undertaken with MOHP	MOHP provided trainers and curricula for trainings while IEF provided funding and administrative support
	2 Health agencies will meet quarterly to coordinate activities and discuss common operational issues	A Program Advisory Committee (PAC) was established for regular meetings with MOHP SUCOMA, and Montfort representatives	The PAC meetings between health agencies became irregular when the MOHP District Health Officer position became unstable due to frequent transfers

GOAL	END-OF-PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
	3 A two-day workshop will be held at the end of year two of CS X to review results of the mid term evaluation and to formalize plans for the final transfer of activities and responsibilities to key sustaining organizations		Plans for the transfer of HSAs to MOHP were negotiated in year one of CS X between IEF and MOHP Communities and village based health workers, including HSAs, were not involved in the process and have expressed a need to be involved in handover planning and implementation so that they are aware of plans and procedures
D Responsibility for sustaining the village health care system will revert directly to MOHP	1 MOHP will provide direct supervisory and financial responsibility for IEF HSAs	IEF HSAs were transferred to MOHP at the end of year one	MOHP has assumed financial and supervisory responsibility for HSAs
	2 MOHP will take over responsibility for commodities procurement and transport by the end of year two	IEF relinquished responsibility for commodities procurement and transport to MOHP by the end of year two	MOHP does not have the requisite stock control systems and procurement policies in place to maintain the village health care system The necessary policy support from MOHP to allow TBAs and VHVs to administer vitamin A and ORS is lacking
	3 IEF assistance to DRFs and IGAs will diminish by the last quarter of the project	2 DRFs were handed over to MOHP during year three, 4 will be handed over by the end of the project Technical assistance was provided by Ministry of Agriculture (MOA) for the IGAs	Volunteers and village based health workers have suffered confusion regarding handover of the DRFs due to their lack of involvement in planning and implementation of handover While MOA was helpful in project start up and in providing technical support to some IGAs longer term technical assistance, particularly for developing management skills is needed by the IGA participants
E VHVs will receive some incentives from earnings of IGAs and DRFs	1 IGAs and DRFs will be established as a source of income for volunteers	6 DRFs were established 10 IGAs were initiated, 7 of which are functional at end-of project	The original intent of the IGAs was lost when participation was opened to any interested community members DRF committees and volunteers do not have the skills needed to make decisions on how to utilize profits earned on sales of drugs from the DRF The idea of providing an incentive to volunteers from earnings has not been activated thus far

Recommendations

Numerous recommendations regarding sustainability and capacity-building have been made throughout this report including

Lack of community involvement in the planning for and implementing phase over of the project resulted in many problems including resistance by communities and health workers at the Health Center and village levels Their sense of ownership was not developed adequately, nor were their management skills Communities must be integrally involved in each step of the phaseover process in the future Skills training must be focused on developing basic management capabilities as well as specific technical skills

The 5-day supervisory training for mid-level managers was not enough to develop the level of supervisory skills necessary to sustain the village health care system established through CS X, and supervisory systems are not in place A comprehensive system must be developed, including a training program, supervisory checklists, revision of job descriptions with an emphasis on supervisory responsibilities, and a system of supervisory accountability and evaluation

Although there are adequate supplies of stocks at the district level, they do not flow smoothly to the Health Centers and on down to the village level workers - where they are needed most MOHP policy support is lacking and procurement systems are not clear to the Health Center staff and HSAs, procedures are not standard, leading to confusion Standard procedures must be developed and instituted

Coordination between Health Centers and the District MOHP and among Health Centers should be strengthened in order to achieve greater impact of health initiatives Regular monthly coordination meetings should be activated to serve as a forum for sharing issues and experiences, coordinating on district-wide initiatives, informing Health Center staff about new and/or revised systems and procedures and, importantly, to include that key level of staff in planning health initiatives

ACKNOWLEDGEMENTS

Sincere gratitude is extended to Dr Christine Witte, IEF Country Director, the IEF CS X staff, and MOHP District MCH Officer Mr Nelson Gobede - all of who participated in the final evaluation with eagerness to learn from their experience and enthusiasm to apply lessons to future programming efforts They exhibited an extraordinary ability to take a critical look at achievements and to think about how to do it better next time Their high level of professionalism and teamwork is commendable IEF CS Coordinator, Lily Clement, was also a vital member of the evaluation team, she brought valuable perspective to the exercise from her global experience in child survival programming

The IEF drivers literally kept the evaluation team on track - despite the swamps and potholes created by the seasonal rains! The evaluation could not have been accomplished without them IEF Administrative Assistant, Mrs Mary Kachale, ensured that the team was accommodated in style, for which we are grateful

The evaluation team poked and prodded many community members and health workers with numerous questions They answered all of our queries without hesitation, only on the faith that we would do something useful with the information The team is grateful for the insights they gladly offered us, and it is our intent to ensure that what we have learned is not only documented in this report, but applied to future program efforts to benefit all of the communities of Chikwawa District

ANNEXES

ANNEX 1	Evaluation Scope of Work and Schedule
ANNEX 2	Evaluation Team Members and Team Leader's c v
ANNEX 3	Interview Question Guides
ANNEX 4	List of Individuals and Groups Interviewed
ANNEX 5	List of References
ANNEX 6	Final KPC Survey Report
ANNEX 7	IEF Quality Assessment Reports
ANNEX 8	IEF Child Survival Organogram
ANNEX 9	Pipeline Analysis

ANNEX 1

EVALUATION SCOPF OF WORK AND SCHEDULE

SCOPE OF WORK
FINAL EVALUATION
VITAMIN A FOR CHILD SURVIVAL PROJECT
CHIKWAWA DISTRICT, MALAWI
JANUARY 19 - 30, 1998

1 INTRODUCTION

The purpose of the Final Evaluation (FE) is to review the progress of the IEF-Malawi Child Survival for Vitamin A Project in Chikwawa District, Malawi The FE is a requirement of the United States Agency for International Development, Bureau for Humanitarian Response/Private and Voluntary Cooperation/Survival and Health funded Cooperative Agreement # FAO-0500-A-00-4041-00 The life of the project extends from September 1 through February 28, 1998

The FE is estimated to require 16 days from an external evaluator The dates for the field visit are tentatively scheduled from January 19-30, 1998

2 OBJECTIVES

The requirements of BHR/PVC for the final evaluation are

a A narrative report (English), addressing project progress towards achieving its goals and objectives as stated in the cooperative agreement (AID guidelines provided),

b A final financial pipeline analysis (completed with assistance from Bethesda headquarters in advance)

Additional requirements of IEF for the final evaluation are

c Assess the implementation process and identify common constraints that have impeded effective implementation,

d Assess technical appropriateness of interventions,

e Develop recommendations for developing other programming in the project area, including other health activities and income-generating activities

Specific guidelines are provided from USAID BHR/PVC/CSH for this purpose Additional questions for consideration will also be provided by IEF The final evaluation report will be made available to IEF (headquarters and country staff) and USAID (Washington and Mission)

3 ACTIVITIES

The evaluator will lead a team consisting of the IEF-Malawi staff (Country Director, Project Manager, Coordinators, other), the IEF-Headquarters Child Survival Coordinator, and an official(s) from the District Ministry of Health (to be designated) Major tasks are

a Review documentation (1 day)

Review all project related documentation (detailed implementation plan, mid-term evaluation report and evaluation guidelines) This information should be reviewed in advance of the evaluation

b Orientation, including interview forms (1 day)

Qualitative data will be collected through a combination of key informant interviews and focus groups To prepare for this "BHR/PVC Child Survival Final Evaluation Guidelines" will be used to develop a specific set of interview questions to interview 1) community members, 2) local leaders, 3) project volunteers, 4) project staff, and 5) Ministry staff

c Data Collection (4 days)

Team members will be divided into groups, each consisting of IEF staff paired with MOH representatives and/or the Team Leader In a sample of project communities (4-6), teams will complete structured interviews and focus groups with 1) community members, 2) local leaders, 3) project volunteers, 4) project staff and 5) Ministry staff Involvement of project staff in conducting interviews and focus groups will be limited to 1, 2 and 3 only, the Team Leader will conduct interviews of all of the above levels The total number of interviews and focus groups will be determined in-country

At the end of each day, findings will be summarized and presented to the entire team for discussion This will identify whether any changes in the questions or the interview methods, or new questions are required for the next day, and to identify response patterns

d Data Analysis (1 day)

One day is required to process major findings from all interviews and focus groups following the AID guideline headings

e Findings/Recommendations & Lessons Learned (2 days)

Two days are required to review the findings and process major recommendations and

lessons learned from all interviews and focus groups by the evaluation team following the AID guideline headings

g Debriefing (1 day)

Presentations to the MOH and USAID will be conducted (and if time allows other institutions may also be included) The debriefing will consist of a review of the evaluation process, and the draft findings and recommendations

h Report Writing (5 days)

i The Team Leader will write a *first draft report in English* (conclusions and recommendations) for debriefing and for presentation to IEF foi comments and suggestions prior to departure Preparation of the report will be a continuous daily process of typing interview forms, interviewee lists findings and recommendations lists

ii The *second draft in English* will incorporate staff comments from the first draft and will be submitted to IEF/Malawi by February 3, 1998 A diskette of the word processing file (Wordperfect 6 0) will be delivered to IEF along with a hard copy of the draft IEF staff will have the opportunity to make final comments on the second draft before the final report in English is completed

iii The *final draft in English* will incorporate comments from the second draft It will be forwarded to IEF/HQ (hard copy plus Wordperfect 6 0 file) by February 11, 1998 This report will be submitted to BHR/PVC/CSH by IEF/HQ once all modifications have been finalized

4 SCHEDULE

See attached

5 REQUIREMENTS

IEF has identified Ms Lisa Krift as the external evaluator She has proven skills in Child Survival project evaluation and is familiar with the USAID Child Survival program, private voluntary organizations, and Malawi

REPORT OUTLINE (Preliminary)

i Acknowledgements
ii Acronyms
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- 2 2 Project Description and Design

3 Evaluation Methodology

4 Interventions and Activities
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- 4 2 Vitamin A
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- 4 4 Nutrition
- 4 5 Maternal Care
- 4 6 Primary Eye Care
- 4 7 Drug Revolving Funds
- 4 8 Income Generating Activities

5 Implementation Issues
- 5 1 Community Education and Social Promotion
- 5 2 Human resources for Child Survival
- 5 3 Supplies and Materials for Local Staff
- 5 4 Quality Assurance
- 5 5 Supervision and Monitoring
- 5 6 Headquarters Support
- 5 7 PVO's Use of Technical Support
- 5 8 Assessment of Counterpart Relationships
- 5 9 Referral Relationships
- 5 10 PVO/NGO Networking
- 5 11 Budget Management
- 5 12 Sustainability

6 Summary of Intervention Recommendations

7 Lessons Learned and Recommendations for CHAPS

8 Attachments

- A Evaluation team
- B Scope of work
- C Evaluation schedule
- D Sources of information (lists of interviewees)
- E Interview guides (interviews focus groups)
- F List of documents used
- G List of individuals/institutions consulted
- H Financial pipeline analysis
- I KPC Survey
- J Summary of KPC Findings
- K Health Care Facilities in Chikwawa District
- L Organogram for IEF Child Survival Project X

Schedule - Malawi FE

Sun	Mon	Tues	Wed	Thur	Fri	Sat
January 18 Travel to Blantyre	19 Orientation, Forms development day 2	20 Data collection day 3	21 Data collection day 4	22 Data collection day 5	23 Data collection day 6	24 Data Analysis day 7
25 Findings day 8	26 Recommendations/ Lessons Learned day 9	27 Report writing (1st draft) day 10	28 Debriefing day 11	29 Report writing (2nd draft) day 12	30 Report writing (2nd draft) day 13	31 Travel to LLW (LK) day 14
February 1	2 Report writing (2nd draft) day 15	3 Send 2nd draft report/diskette to IEF/Malawi	4	5	6 Feedback from IEF	7
8	9 Report writing (final draft) day 16	10	11 Send final report/diskette to IEF/Malawi	12	13	14
22	23	24	25	26	27	28

Note days refer to the days worked by the external evaluator, day 1 has previously been spent on reviewing the documents

EVALUATION SCHEDULE

January 1998

Sunday 18	Arrival of External Evaluator IEF Office Blantyre Review key documents
Monday 19	Planning meeting with IEF Country Director, IEF Hdqtrs CS Coordinator and IEF CS Program Manager to review evaluation scope of work, methodology, and schedule Finalize field survey questionnaires
Tuesday 20	IEF office, Nchalo, Chikwawa District Briefing with IEF CS staff Finalize field survey schedule Field visit to Chabisala Village, community and health worker interviews
Wednesday 21	Field visits to Mangulenji DRF Center Ndakwera Health Center Lazaro Village
Thursday 22	Field visits to Chipwaila Health Center Mikalango Rabbit IGA Njovuyalema DRF Center
Friday 23	Field visits to Kakoma Health Center Njereza Vegetable IGA Chikwawa District Hospital Return to Blantyre
Saturday 24	Data tabulation
Sunday 25	Data analysis Preparation for staff workshop
Monday 26	Nchalo, Chikwawa Staff workshop to review data, findings and conclusions
Tuesday 27	Blantyre, Report writing
Wednesday 28	Chikwawa District Hospital Evaluation briefing for the District Health Management Team Blantyre - report writing
Thursday 29	Blantyre - report writing Travel to Lilongwe

Friday 30 Lilongwe report writing

February 1998

Monday 2 Lilongwe - report writing

Tuesday 3 Lilongwe - report writing

Wednesday 4 2nd draft to IEF/Blantyre

Monday 9 Lilongwe - report writing

Wednesday 11 Final draft to IEF/Blantyre

ANNEX 2

EVALUATION TEAM MEMBERS AND TEAM LEADER'S C V

EVALUATION TEAM

Lisa Lanier Krift, Consultant
External Evaluator/Team Leader
Lilongwe, Malawi

Liliana Riva Clemente, MPH
Child Survival Coordinator
IEF Headquarters
Bethesda, Maryland, USA

Christine Witte, PhD
IEF Country Director
Blantyre, Malawi

Nelson Gobede
MCH Coordinator
Ministry of Health
Chikwawa District, Malawi

Wellington Bisani
Child Survival Program Manager
IEF/Malawi
Nchalo, Chikwawa District

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agricultural production
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areas of family planning

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LISA LANIER KRIFT

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e-mail <krift@compuserve com>

SUMMARY OF PROFESSIONAL EXPERIENCE AND SKILLS

range of international development programs with broad responsibilities for program
y monitoring and evaluation proposal conceptualization and writing guidance of re-
opment of strategic partnerships staff training and team building representation and
ancies for program evaluations and assessments

EMPLOYMENT HISTORY (Long term Positions)

(US), INTERNATIONAL PROGRAMS WESTPORT, CT, USA (April 1984 Decem-
in a variety of increasingly responsible staff positions as follows

SSIA FIELD OFFICE/CIVIC INITIATIVES PROGRAM FOR DEMOCRATIC AND RM (10/96 - 12/96) Guided implementation of programmatic financial and adminis-
omplex USAID-funded civil society project including fiscal management and control and
ice of 8 project consortium member agencies and 180 US and Russian NGO subgran-
negotiated extension of project for additional (fourth) year and expansion of coverage
regions Assessed technical assistance needs of regional NGO resource centers sup-
ect and initiated phaseover to fully-indigenous management (Resigned position to join

RUSSIA FIELD OFFICE/CIVIC INITIATIVES PROGRAM FOR DEMOCRATIC AND RM (3/95 - 9/96) Managed programmatic aspects of 8-member US PVO consortium
d agency in implementing a 3-year $20 million USAID-funded civil society project fo
ning impact of indigenous NGOs on democratic and economic reform in three target
outhern Russia Central Russia) of Russia Directed design and implementation of 7
including provision of technical assistance and subgrants to over 180 Russian NGOs
ordinated design and delivery of technical assistance provided by consortium members
tees Represented consortium to various stakeholder groups including official USG
eing US foreign assistance programs in Russia USAID consortium member headquar-
and bi-lateral donors members of the Russian parliament and legislative committees
Russian NGOs actively involved in reform efforts Initiated and established donors fo-
regularly to share program information about and coordinate assistance to Russian

BANGLADESH FIELD OFFICE (6/93 - 2/95) Managed transformation of established
all-scale geographic focus to large-scale policy advocacy program focused on women s
gram beneficiaries increased from 45 000 to 2 5 million as result of new funded initia
d conducted staff development activities to enable local staff to execute new field office
ed direction to professional staff in implementing and monitoring diverse portfolio of 7
of Child Survival women s credit early childhood development STDs/HIV and disaster
response Guided design and implementation of action research program including
international researchers on women s empowerment and enhancement of staff research
ities Established SC/US as Secretariat for UNICEF sponsored inter agency working
ildhood Development Coordinated and co facilitated two SC/US South Asia regional
itoring and evaluation

RDINATOR - BANGLADESH FIELD OFFICE (2/92 - 5/93) Designed and facilitated
egic planning process through which transformative program directions and strategies
lished country program a key outcome of which was establishment of an action research
ice Provided follow up supervision in developing and implementing staff action plans to
plan

N OFFICER - WESTPORT, CT, U S A (8/90 - 1/92, part-time) Compiled materials and
phaseover of SC/US Pacific programs for use by SC program staff Drafted a compen-
ational Programs of Save the Children Federation to describe SC/US programs and
ersion was widely distributed to donors colleague agencies and development profes-

(11/20/97)

sionals Assisted Asia/Pacific regional office with proposal development and fundraising for new program initiatives and strategic planning processes covering 9 country programs

- ***CO-COORDINATOR - PACIFIC PROGRAMS, TUVALU AND KIRIBATI FIELD OFFICES (5/89 - 7/90)*** Managed programmatic aspects of SC s Kiribati and Tuvalu country programs including design and implementation of all training and program monitoring and evaluation activities Collaborated with appropri ate government offices to institutionalize community based development planning processes in both countries Coordinated program evaluations for UNDP- and USAID-funded grants in both countries Successfully phased over SC/US programs to subsequent donors and sponsoring agencies entailing developing phaseover strategies identifying and securing donor support and funding and clearing all programmatic financial and administrative obligations incumbent upon SC/US in those two countries

- ***TRAINING COORDINATOR - KIRIBATI FIELD OFFICE (6/88 - 4/89)*** Established training unit and developed field office capability to utilize participatory training methods in implementing community-based island development program Collaborated with appropriate government personnel on design production and field-testing of community development planning materials Developed and implemented program monitoring and evaluation system

- ***PROGRAM MANAGER - PHILIPPINES FIELD OFFICE/ILOCOS NORTE PROGRAM (6/85 - 5/88)*** In coordination with Project Director, established new SC/US impact area Recruited trained and supervised local staff in implementing community-based multi sectoral development program Managed programmatic aspects of USAID Co-Financing grant focused on health and nutrition Developed community-based program planning monitoring and evaluation system Prepared annual and multi-year program plans and budget proposals Developed collaborative linkages with local and regional Philippine Government officials and other agencies, resulting in provision of more regularized basic services to remote mountain tribal communities, immunization rates for under-fives increased from almost nil to 100% Coordinated design and conduct of staff and community-level skills training and planning workshops

- ***PROGRAM ASSOCIATE - ASIA-PACIFIC REGIONAL OFFICE, WESTPORT, CT, U S A (4/84 - 5/85)*** Performed broad range of liaison duties involving program budget and finance, administration and fundraising in support of 12 Asia and Pacific country programs in preparation for field-based management assignment Analyzed and monitored field office financial reports and sponsorship programs Assisted in development of field office budgets and funding proposals and in orientation of field office staff to Asia/Pacific regional operations

U S PEACE CORPS, PLARIDEL, BULACAN, PHILIPPINES

- ***COOPERATIVES LOAN PROGRAM TECHNICAL ADVISOR (4/82 - 8/83)*** Managed local-level implementation of joint Ministry of Agriculture/USAID pilot project to extend low-interest loans to two farmers cooperatives for income generation projects Completed feasibility studies baseline surveys and other documentation required for loan approval Developed project recordkeeping and accounting systems and trained cooperative officers in use of them
- ***RURAL CREDIT ADVISOR (6/81 - 3/82)*** Developed membership education program for provincial-level Cooperative Rural Bank Assessed social factors and members needs affecting financial operations of bank through a survey of 280 member farmers' cooperatives and designed membership development scheme based on results

AURORA ASSOCIATES, WASHINGTON, D C

- ***PROGRAM DEVELOPMENT OFFICER (12/80 - 5/81)*** Assistant to the vice-president of International Division Recruited and maintained skill bank of professionals for consulting assignments in Africa Developed orientation program for newly-contracted consultants Served as liaison on financial program and administrative issues between overseas contractors and headquarters management Conducted contract negotiations and project development meetings with international development agencies Assisted in corporate planning and budgeting for international division and in internal evaluation of division operations

AFRICA BUSINESS AND ECONOMIC REVIEW, WASHINGTON, D C

- ***ASSOCIATE EDITOR (3/80 - 11/80)*** Edited articles for publication in bi-weekly business and economic affairs newsletter focused on sub-Saharan Africa Supervised technical and clerical staff in all aspects of production including research writing layout and design and distribution Wrote business and economic analyses risk assessments and investment studies, including special reports on request from newsletter clients Assisted in coordinating newsletter-sponsored trade conference bringing together representatives of US banks and businesses and African governments and private sector leaders
- ***STAFF ASSOCIATE (7/79 - 2/80)*** Assisted in all aspects of establishing newsletter including development of office management systems and staff resource library recruitment and orientation of technical and clerical staff, and marketing Researched and wrote articles analyses and features

PACIFIC CONSULTANTS, WASHINGTON, D C

- ***ADMINISTRATIVE ASSISTANT (11/78 - 6/79)*** Assisted in recruitment of personnel for international development projects concentrating on Women in Development and small farmer agricultural production Conducted research for and assisted in production of project proposals Provided administrative back stopping in support of international development projects

CONSULTANCIES (Short term assignments)

John Snow, Inc , Support to AIDS and Family Health Project (JSI-STAFH), Malawi (September 1997 on-going) Principal Investigator for case study research to determine the impacts of grant management respon sibilities on the institutional development of Malawian NGO recipients of JSI STAFH grants

Project HOPE/Malawi, Child Survival X Program (July 1997) Team leader for final evaluation of Project HOPE s USAID-funded Child Survival program

John Snow, Inc , Support to AIDS and Family Health Project (JSI-STAFH), Malawi (May-June 1997) Served as Coordinator for Annual Coordination Meeting of STAFH Project Partners Prepared meeting back ground paper designed working sessions provided orientation and guidelines to facilitators and wrote report of proceedings for distribution to meeting participants and other agencies working in the areas of family planning and HIV/AIDS

Save the Children/US, Caucasus Regional Program (November 1994) Member of 4-person team to con duct mid-term assessment of USAID-funded 2-year humanitarian assistance grant to SC/US for relief and development projects implemented by US PVO sub-grantees in the Caucasus republics of Armenia Georgia and Azerbaijan Results of evaluation led to re-direction of the program from emphasis on humanitarian assistance toward community development utilizing local NGOs as key players in the transition (*Report of the Mid-Term Evaluation of the SC/US Caucasus Program* January 1995)

Save the Children/US, Philippines Field Office (May 1993) Team leader and report author of study to assess degree of sustainability of program activities and impact two years after phaseover of SC/US program in Ilocos Norte province (*SC/US Working Paper An Assessment of Impact Sustainability in Adams Ilocos Norte* May 1993)

Save the Children/Australia, Bangladesh Program (April 1992) Served as member of 3-person evaluation team tasked to assess and recommend options for phaseover of SC/Australia s Jamalpur Project The report outlined a program phaseover strategy which was subsequently implemented by SC/Australia (*An Assessment of Jamalpur Project* May 1992)

EDUCATION AND TRAINING

Master of Arts, 1978 with specialization in International Commerce and Economics Patterson School of Di plomacy and International Commerce University of Kentucky Lexington

Visiting Scholar, Summer 1977 University of Kentucky International Summer Program University of Cluj Romania

Bachelor of Arts (with Honors), 1976 in International Studies Southwestern at Memphis (now Rhodes Col lege) Tennessee

Training of Trainers Workshop, February 1985 Save the Children Federation Westport CT Two week workshop in participatory training methods

Peace Corps In-Service Training, February 1982 Philippine Rural Life Center Dasmarinas Cavite Philip pines One-week hands-on technical training in animal husbandry and tropical gardening

Peace Corps Pre-Service Training, June-September 1981 various locations in the Philippines Intensive professional training on Philippine rural banking system and rural credit programs specialized lectures by Cen tral Bank and USAID staff on the operation and management of agricultural credit and marketing cooperatives Tagalog language and cross-cultural training

HONORS AND AWARDS

Fulbright Travel Grant Summer 1977
Patterson Fellowship 1976 77
Southwestern Scholar Award and Scholarship 1972 76
Dean s List Southwestern College 1973 76

LANGUAGES AND TRAVEL

Working knowledge of Tagalog (Pilipino) Proven ability to manage professional programs in a variety of lan guage and cultural contexts including Russia, the Pacific Bangladesh and The Philippines Extensive travel throughout the US Europe the former Soviet Union Asia and the Pacific

References available upon request

ANNEX 3

INTERVIEW QUESTION GUIDES

INTERVIEW WITH MOHP DISTRICT LEVEL

Date of interview
Location of interview

Interviewer s

Name/Designation of persons interviewed
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1 Are you familiar with the IEF Child Survival project? (Yes/No)

2 What activities are you aware of? (List activities mentioned)

3 Has the project assisted or enhanced the capacity of MOHP to provide health services in Chilwawa? Explain

4 What CS X activities have been most helpful or successful in enhancing capacity of MOHP and or improving health services in Chilwawa? Explain

5 What activities have been the least helpful? Explain

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INTERVIEW WITH MOHP DISTRICT LEVEL

Date of interview
Location of interview

Interviewer s

Name/Designation of persons interviewed
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1 Are you familiar with the IEF Child Survival project? (Yes/No)

2 What activities are you aware of? (List activities mentioned)

3 Has the project assisted or enhanced the capacity of MOHP to provide health services in Chikwawa? Explain

4 What CS X activities have been most helpful or successful in enhancing capacity of MOHP and/or improving health services in Chikwawa? Explain

5 What activities have been the least helpful? Explain

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6 Which CS X activities do you feel should be continued or sustained

7 Is it feasible for these activities to be continued or sustained?

8 What are the major constraints to sustaining the activities?
(If transport is mentioned as a major constraint probe for other constraints if transport were not an issue)

9 Will training for HSAs VHVs VHCs and TBAs continue at current levels? If no why?

10 Have supplies of commodities for Child Survival interventions - Vitamin A ORS condoms tetracycline eye ointment - been consistent and adequate to meet the needs of the target population in the district? If not what are the limitations/constraints?

11 What type of support would be most helpful in enhancing capacity of MOHP to deliver health services in Chikwawa District?

SPECIFICALLY FOR DEHO

12 In what ways has the project assisted with IEC activities?

13 What further support would be useful for IEC activities?

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QUESTIONS FOR HSAs

Date of interview
Location of interview

Interviewer/s

Name Designation of persons interviewed

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1 What are your main job responsibilities? (List those mentioned.)

2 What is your coverage area? (# of villages)

3 Do you provide health education to mothers? When/where?

4 How many VHVs do you supervise?

5 How often do you visit each VHV?

6 What is the purpose of a supervisory visit?

7 What do you do when you make a supervisory visit to a VHV?

8 Who is your supervisor? How often do you [illegible]

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6 Which CSX activities do you feel should be continued or sustained

7 Is it feasible for these activities to be continued or sustained?

8 What are the major constraints to sustaining the activities?
(If transport is mentioned as a major constraint probe for other constraints if transport were not an issue)

9 Will training for HSAs VHVs VHCs and TBAs continue at current levels? If no why?

10 Have supplies of commodities for Child Survival interventions - Vitamin A ORS condoms tetracycline eye ointment been consistent and adequate to meet the needs of the target population in the district? If not what are the limitations/constraints

11 What type of support would be most helpful in enhancing capacity of MOHP to deliver health services in Chikwawa District?

SPECIFICALLY FOR DEHO

12 In what ways has the project assisted with IEC activities?

13 What further support would be useful for IEC activities?

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QUESTIONS FOR HSAs

Date of interview
Location of interview

Interviewer/s

Name Designation of persons interviewed
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1 What are your main job responsibilities? (List those mentioned.)

2 What is your coverage area? (# of villages)

3 Do you provide health education to mothers? When/where?

4 How many VHVs do you supervise?

5 How often do you visit each VHV?

6 What is the purpose of a supervisory visit?

7 What do you do when you make a supervisory visit to a VHV?

8 Where do you supervise? How often do you [illegible]

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9 How many VHCs do you work with?

10 What is your relationship with the VHCs? Describe

11 What factors do you feel influence the relationship with the VHCs? (List)

12 Do the VHCs assist in supervising the VHVs? Why/why not?

13 What are the key constraints you face in carrying out your job responsibilities?

14 What support have you received from IEF to enable you to do your job?

15 Do you have a bicycle supplied by IEF? Do you use it for your work?

16 What support do you receive from MOHP to enable you to do your job?

17 Do you receive adequate supplies of ORS, tetracycline eye ointment, Vitamin A and condoms? From what sources?

18 What further support do you need to enable you to do your job? (Probe for prioritized answers, not a wish list.)

19 Do you submit reports to the District for the Monitoring [illegible] Empowerment HIS system? How often?

20 Do you receive feedback from the District [illegible] the communities [illegible] the HIS system? If yes, how often? [illegible]

21 Do you use the information you collect for [illegible]

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QUESTIONS FOR HEALTH CENTERS (MOHP HEALTH CENTERS, SUCOMA)

Date of interview
Location of interview

Interviewer/s

Name/Designation of persons interviewed

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1. Are you familiar with the IEF Child Survival project? (Yes/No)

2. What activities are you aware of? (List activities mentioned.)

3. Has the project assisted or enhanced the capacity of the Health Center to provide health services in Chilwawa? Explain.

4. Has the VHCs, VHVs, TBAs and traditional healers contributed in any way to improved health services? How so? (Specify by type of health worker.)

5. Does the Health Center receive referrals from VHVs, TBAs and/or traditional healers? What types of referrals? Have referrals increased since Child Survival started?

6. [illegible] training for HSAs, VHVs, VHCs and [illegible] traditional [illegible] If so [illegible]

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7 What CS activities have been most helpful or successful in enhancing capacity of the Health Center and/or improving health services in this area? Explain

8 What activities have been the least helpful? Explain

9 Which CS activities do you feel should be continued or sustained?

10 Is it feasible for these activities to be continued or sustained?

11 What are the major constraints to sustaining the activities?
(If transport is mentioned as a major constraint probe for other constraints if transport were not an issue)

12 Have supplies of commodities for Child Survival interventions - Vitamin A, ORS, condoms, tetracycline eye ointment - been consistent and adequate to meet the needs of the target population in the district? If not what are the limitations constraints?

13 What further type of support would be most helpful in enhancing capacity of the Health Center to deliver health services in this area?

QUESTIONS FOR VILLAGE HEALTH COMMITTEES (VHCs)

Date of interview
Location of interview

Interviewer/s

Name/Designation of persons interviewed
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1 What are the VHC's job roles and responsibilities? (List answers)

2 Have you received training to enable you to carry out your job?

3 What type of training have you received? From who?

4 How did you become VHC members?

5 What is your motivation to be a VHC member?

6 How often does the VHC meet together?

7 Why do you meet? What do you discuss or do at meetings?

8 What is the VHC s relationship with the HSAs?

9 With the VHVs?

10 With local leaders?

11 What does the VHC do to "supervise" the VHVs and DRF Volunteers? Explain what is meant by supervision '

12 Has the DRF provided needed drugs for your village on a continuous basis? Are drugs can be replenished when needed? Why/why not?

13 What support do you receive to help you carry out your VHC roles and responsibilities? From where does support come from?

14 Does the community offer any type of support to the VHC and VHV? Specify

15 What further support would be helpful to the VHC?

16 Have you seen any changes - positive or negative - in the health condition of your community as a result of the efforts of the VHC or VHVs? Specify

QUESTIONS FOR VILLAGE HEALTH VOLUNTEERS (VHVs)

Date of interview
Location of interview

Interviewer/s

Name/Designation of persons interviewed
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1 What are your key roles and job responsibilities? (List)

2 What training have you received to enable you to carry out your job roles and responsibilities?
From who/which agency?

3 How many mothers and children are you currently covering?

4 How do you know you are covering all eligible women? (What is your system for identifying target groups?)

5 Who supervises your work?

6 How often do you see your supervisor/s?

7 What do your supervisor/s do when they are "supervising' you?

8 What are the main constraints you face in carrying out your job?

9 What type of supervisory or other support would be helpful to you in doing your job?

10 What motivates you to be a VHV?

11 What do you tell a mother whose child has bloody diarrhea?

12 Do you provide health education to mothers? How? When?

FOR VITAMIN A VHVs

13 When should a woman receive Vitamin A?

14 When should a woman NOT receive Vitamin A?

15 Which foods are rich in Vitamin A?

16 What is the amount of Vitamin A a child should receive?

FOR BREASTFEEDING PROMOTERS/VOLUNTEERS

17 Do you recommend water for infants under 3 months? Is it good or bad?

18 At what age should mothers start feeding their children supplementary foods?

QUESTIONS FOR TRADITIONAL BIRTH ATTENDANTS

Date of interview
Location of interview

Interviewer/s

Name/Designation of persons interviewed
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1 Have you received training under the IEF CS X project? (Yes/No)

2 Who/which agency provided the training?

3 In what topics have you received training? (Tick answers mentioned

Vitamin A ___
Exclusive breastfeeding ___
Nutrition ___
AIDS ___
Maternal care ___
Sterile delivery practices ___
Other (Specify) ___

4 When do you give women Vitamin A?

5 How soon should a woman begin breastfeeding a newborn?

6 What are safe delivery practices?

7 Do you wear gloves when delivering? If not what do you do?

8 Do you ever refer patients? For what reasons do you refer them?

9 Where do you refer patients?

10 Do you provide Vitamin A to your patients?

11 Where do you get your Vitamin A supplies?

12 Do you have a TBA kit? (Yes/No)

13 If yes where did you get it?

14 What is in your TBA kit? (List)

15 How do you replace supplies in your TBA kit?

16 Who is your supervisor? How often do you see your supervisor?

17 What does your supervisor do during a supervisory visit?

18 If your supervisor is a male does it affect the support or supervision you receive? In what way?

19 What constraints do you face in your work?

20 What further type of support would be helpful to you in your job?

QUESTIONS FOR DRUG REVOLVING FUND VOLUNTEERS

Date of interview
Location of interview

Interviewer/s

Name/Designation of persons interviewed
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1 When did you begin the DRF?

2 Who advised and trained you in setting up the DRF?

3 Who procures the medicines kept in the DRF?

4 From where are medicines procured?

5 Are you able to cover the costs of maintaining the DRF? Are you able to provide a continuous supply of drugs?

6 What problems or constraints do you have in managing the DRF?

INTERVIEW TEAM SHOULD CHECK THE DRF BOX AND RECORDS TO SEE IF INVENTORY RECORDS AND CASH RECORDS INDICATE PROPER MANAGEMENT OF DRUGS AND CASH

QUESTIONS FOR COMMUNITY LEADERS

Date of interview
Location of interview

Interviewer/s

Name/Designation of persons interviewed
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1 Who are the VHC members in your community?

2 What does the VHC do?

3 Who is the VHV in your community?

4 What does your VHV do?

5 Have you ever sought assistance for a health problem from your VHV? Why/why not?

6 Do you feel your VHC and VHV are fulfilling their responsibilities? What services do they provide to the community?

7 Do you think the VHC and VHVs deserve any support for their services?

8 What type of support would you be willing to provide?

QUESTIONS FOR TRADITIONAL HEALERS

Date of interview
Location of interview

Interviewer/s

Name/Designation of persons interviewed
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1 What trainings have you received?

2 From who/which agencies?

3 What topics were covered in trainings?

4 Were the trainings helpful? Which were most helpful?

5 In what ways have trainings been helpful?

6 What recommendations would you suggest to make trainings more helpful?

7 Do you refer patients?

8 What cases do you refer?

9 Where do you refer cases?

QUESTIONS FOR COMMUNITY MEMBERS

Date of interview
Location of interview

Interviewer/s

Name/Designation of persons interviewed
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1 Who are your VHC members?

2 What does the VHC do?

3 Do you have children under the age of 2 years?

4 Who is your VHV?

5 How often do you see your VHV? (How often does she visit you?)

6 What does your VHV do?

7 Have you ever sought assistance for a health problem from your VHV? Why/why not?

8 Do you feel your VHC and VHV are fulfilling their responsibilities? What services do they provide to the community?

9 Do you think the VHC and VHVs deserve any support for their services?

10 What type of support would you be willing to provide?

QUESTIONS FOR IGA VOLUNTEERS

Date of interview
Location of interview

Interviewer/s

Name/Designation of persons interviewed
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1 When did you begin your IGA project?

2 What is your project? Describe

3 What do you gain from doing this IGA?

4 What motivates you to do the IGA?

5 What problems or constraints have you encountered in doing your IGA project?

6 Would you recommend others to do this type of IGA? Why/why not?

7 Is this IGA something you plan to continue? If yes why? If no why not?

ANNEX 4

LIST OF INDIVIDUALS AND GROUPS INTERVIEWED

INDIVIDUALS/GROUPS INTERVIEWED

International Eye Foundation

Christine Witte, PhD Country Director
Liliana Riva Clement, CS Coordinator

IEF Child Survival Project, Malawi

Wellington Bisani, Program Manager
George Mekiseni, Training and Evaluation Coordinator
Golden Makata, IGA/DRF Coordinator
Mathews Alifanali, Community Health Coordinator
Henry Kalavina, Community Health Supervisor

Chikwawa District Hospital

Mrs E Nyaude, Community Health Nurse
Mr S B Gwaza, District Environmental Health Officer
Mr D D Semu, District Health Education Officer
Mr N Gobede, District MCH Coordinator

9 Staff at the Ndakwera, Chipwaila, and Kakoma Health Centers
4 HSAs at Njovuyalema, Mangulenji, and Chabisala villages
8 Community leaders in Lazaro village
19 Community members in Chabisala and Lazaro villages
15 Village Health Committee members in Lazaro and Chabisala villages
4 Drug Revolving Fund Committee members in Mangulenji village
3 Village Health Volunteers in Chipwaila and Chabisala villages
11 Traditional Healers in Lazaro and Ndakwera villages
1 Traditional Birth Attendant in Mangulenji village
33 IGA Volunteers in Mikalango and Njireza villages
4 Drug Revolving Fund Volunteers in Mangulenji and Njovuyalema villages

ANNEX 5

LIST OF REFERENCES

LIST OF REFERENCES FOR EVALUATION

1 Child Survival IX Final Evaluation Report
2 Child Survival X Detailed Implementation Plan
3 Child Survival X Mid-Term Evaluation Report
4 IEF Quality Assessment Reports
5 Child Survival X Project Training Data
6 Child Survival X Project Files
7 Community Health Partnerships (CHAPS) Proposal

File information supplemented the field survey interviews and staff briefings

ANNEX 6

FINAL KPC SURVEY REPORT

International Eye Foundation Child Survival Project

Report on the results of final 1997 Project Survey conducted from 1st through 12th December, 1997

Compiled by

George Mekiseni
Evaluation/Training Coordinator
International Eye Foundation
Child Survival Project
P O Box 142, Nchalo

Wellington Bisani
Project Manager
International Eye Foundation
Child Survival Project
P O Box 142 Nchalo

Presented to

The Country Director
International Eye Foundation
P O Box 2273
Blantyre

Copy to

Pitt R Kangoni
Malaria Reseach Project
P O Box 30096
Chichiri
Blantyre 3

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TABLE OF CONTENTS

1 0 Introduction/ Background

2 0 Demographics

3 0 Project Objectives/ Present assessment

4 0 Results in Table Forms

5 0 Comments on the objectives and relevant results

1 0 Introduction / Background

This was the previous knowledge and practice questionnaire which was administered last year between June 13th and July 4th as part of a mid term evaluation Due to pressurre of work and the more rains we had in March of this year our activities were slowed down This year's actual exercise was from 1st to 12th December

30 villages were randomly selected Refer appendex 1 for the names of selected clusters 300 mothers of child bearing age were interviewed The interviewed women were only those who had children less than 24 months of age

The interviews collected data on basic demographic information which included
- Breastfeeding (including weaning and food supplementation),
- Provision of Vitamin A -importants,rich foods and implication of Vitamin A deficiency,
- Control of Diarrheal Diseases,
- Immunizations and Vitamin A supplementation for themselves and thier children,
- Ante- natal care during the pregnancy for the child concerned,
- Malaria transmission and prevention and
- Family planning

Demographics

The demographic variables are summarized in Table 1 (page 5) The average age of the interviwed mothers was 27 Their ages ranged from 15 to 49 The average age of the children was 10 months - ranging from 0 to 25 months

Sena and Mang'anja women were fairly represented 48% and 30% respectively with 22% hailing from other tribes The majority of the women who were interviewed were illiterate (62%) Only 4 women attended secondary school thus 1% 21% did primary school but could not write whereas 15% were literate 5 women, (2%) said they were involved in general work from which they could obtain cash whilst 98% reported engaging themselves in specific cash -generating activities

Project objectives

Objectives of IEF Child Survival project with pertinent results from the 1997 Final Project Survey

<u>OBJECTIVES</u>

BREASTFEEDING
A 25% (up from 21%) of mothers will excluxively breastfeed their 0-3 months old infants

DIARRHOEA
B 90% (up from 83%) of children 0-23 months will receive appropriate ORT during diarrhoea episode(s)

C 8O% (up from 75%) of children 0-23 months will receive some amount or more breastmilk during diarrhoea episode(s)

D 65% (up from 55%) of children 0-23 months will receive same amount or more solid food during diarrhoea episode(s)

IMMUNIZATION
E 90% (up from 83%) of children 12-23 months old be fully immunized*

F 75% (up from 47%) of women will receive two or more TTV doses

VITAMIN A
G 50% (up from 30%) of women will receive Vitamin A supplementation within 1 mointh of delivery

H 75% (up from 49%) of the children 0-71 months will receive vitamin A supplementation

FAMILY PLANNING
I 25% (up from 20%) of mothers will receive use a modern contraceptive, assuming they (a have children under 24 months, and b want no child in the next 2 years

PRESENT ASSESSMENT RESULTS

BREASTFEEDING
A Of 300 women, only 23% believe supplement food should be given before 4 months Of 83 children in the ≤ 3 mo age group,28% appear to have been exclusively, breastfed

DIARRHOEA
B Only 73% of the children in this age group are gettting ORS or sugar salt solution

C Of 103 children in this age group who had diarrhoea within 2 weeks of the survey,62% were receiving the same or more breastmilk during thge episode

D Of 103 children inthis age group who had diarrhoea wihin 2 weeks of the survey,57% were receiving the same or more of solid foodduring the episode

IMMUNIZATION

E Only 87% of the 241 children in this age range were fully immunized NB fully immunized assumes at least three OPV,three DPT, one measles and one BCG

F Of 222 women with confirmed TTV inf, 37% have had ≥ 2 doses of TTV whilst 56% receive > 3 doses of TTV

VITAMIN A
G 60 women(20% if 300)were confirmed as having received any Vit A Of these 35 (58%) received their dose at or within 1 month of delivery

H 62% of the children in the age group 3-25 months have received any vitamin A supplementation as recorded About three quarter of these received 1 dose only

FAMILY PLANNING
1 Of women meeting in this creteria 34% are using a modern FP method 94% could correctly identified condom but only 2% reported to have used it sometimes with their husbands or friends

Comments on the objectives and relevant results

Breastfeeding There was no actualy question directly asking if the mothers were exclusively breastfeeding However, among women currently breastfeeding children of 3 months or less an average of 43% of the women did notreport giving their child any of the items queried in question 6 of KPC questionnaire(e g tea,cowmilk phala,etc)

Diarrhoea Salt sugar solution (SSS) was presumed as sufficient as ORS 73 % of the children were getting at least actual ORS Only 2 9 approximately 3% of children received SSS without also ORS

Of 62% of the children received the same amount or more breastmilk during the recent or ongoing diarrhoea episode,the number of children in each group was alternatively divided between "same amount" and "more" amount (53 children or 51 % of 103) and 73 children or 71% of 123 19 other children (18% of 103) received less breast milk Only 11 children stopped feeding Of the 57% of children receiving the same amount or more solid during a recent or ongong episode, most (69 children, or 67 % of 103) received more foods as comparded to same amount (47 children, or 46 % of 103 21 children (20%) received less food, and 2 (2 %) stopped eating Only 21 mothers limited the amount of food given

Immunization Only 87% of children between 3 and 25 months were fully immunized - - meaning they had had 3 vaccinations each of OPV and DPT, and 1 each of measles The level of immunization is still lower than 3% as compared to our objective From last years' baseline survey, it shows an improvement by 7% thus from 80% to 87% However 86 % of these 3-25 months children had received 3OPV shots,and 85 % had received 3DPT shots The lowest levels of vaccination were for measles Only 45% of the children who had their under-5 cards had been immunized for this disease BCG levels were impressing with 96%

As for mothers,the supposition that those without TTV cards or some other documentation of TTV immunization, had not been vaccinated, is safely assumption It is certainly impossible that some of those without cards may have been vaccinated The target of having 75% of mothers vaccinated was not observed The highest record of those receiving 3 or more was 56%

Fammily Planning Family planning use has tremendously improved since the time of our last years' Mid project survey results 34% of women with children under 2 years who did not want more children in the next two years were using family planning It was 29% on our last years' mid- term project survey results On this survey,methods mentioned by women include vasectomy, injection, pills, condom, billing, abstinence and other There were no couples with tubal ligation,IUD,foam/jelly, EBF and coitus interruptus Natural methods were also mentioned,especially abstenence,which was at 8% Only 7 out of 85 "abstaining" women reported abstenence due to lactation

Vitamin A This years' of vitamin A supplementatation in women is lower than the projected 50% Only 44% of women reported to have received vit A supplementation at child birth, while (2%) within 2 months of delivery and 7% before delivery Vitamin A supplementation in children appeared to have been lower than the projected 75% An overall of 63% had received vit A For children over 6 months of age (n=169), 53% have received vit A supplementation Less than a third of these children (31%) have have had two or more doses

Results in Table Form 5

TABLE 1 Demographic information for the 300 participants

DEMOGRAPHIC INFORMATION

	MEAN	(S D)
Age of youngest child (months)	3	(6)
Mother's age (years)	27	(8)
Ethnic Group	%	
Sena	48	
Mang'anja	30	
Other	22	
Highest level of school completed		
None	62	
Primary, cannot read	21	
Primary, can read	15	
Secondary or higher	1	
Work		
None	5	
Handcraft	<1	
Harvest,picking fruits	6	
Casual labour	23	
Selling farm products	70	
Selling food $ milk	6	
Servant/household services	1	
Storekeeper	3	
Full time employed	5	
Other	24	

TABLE 2 Breastfeeding and nutritional knowledge and practices The approximate sample size from which each set of calculations is made and provided below

BREASTFEEDING/NUTRITION	%	(n)
Mother is breastfeeding youngest child	100	(300)
If no, Mother has ever breastfed child	<1	
Hrs post- delivery mother started breastfeeding		
One hour	52	(300)
1 to 8 hours	37	
After 8 hours	10	
Don't remember	2	
Does mother give child any of the following		
Water and tea	87	
Cow's milk or formular	28	(300)
Soft food such as phala	77	
Fruit or fruit juice	45	
Mango or papaya	61	
Green leafy vegetables	68	
Meat or fish	61	
Peas, groundnuts or beans	57	
Egg or yoghurt	35	

Mother put the following in child's food	
Green leafy vegetables	62 (300)
Honey or sugar	51
Lard or vegetable oil	45
What should the mother do [re breastfeeding] for the first 3 to 4 days of child's life?	
Mother doesn't know	21 (300)
Breastfeed the baby with colostrum	29
Avoid bottle feeding	05
Frequent sucking	64
Should a mother stop breastfeeding once pregnant?	57 (300)
Mother should start suppementary feeding	
At 4-6 months	28 (300)
Before 4 months	23
After 6 months	42
Doesn't know	04
Other	04
Additional foods that can be given	
Mother doesn't know	05 (300)
Banana	23
Pawpaw	27
Other	53

TABLE 3 Vitamin A knowledge and its application The approximate sample size from which each set of calculations is made Some questions concern only a sub set of the population

VITAMIN A	% (N)
Vitamin A is good for	
Mother doesn't know	25 (300)
Prevention of blindness/night blindness	13
Prevention of diarrhoea	23
Prevention of ARI	00
Prevention of malaria	16
Vitamin A no use	01
Other	38
These foods contain Vitamin A	
Mother doesn't know	05 (300)
Grean leafy vegetables	84
Yellow fruits or fruit juice	30
Meat or fish	28
Breastfeeding	11
Egg yolk	21
No foods contain Vitamin A	<1
Other	39
Mother should recieve Vit A	
Soon after delivery	44
Within two months after delivery	02 (300)
During ANC(before delivery)	21
Mother doesn't know	26
Other	07

Consequences of Vit A deficiency	
Blindness	20 (300)
Stunted growth in children	34
Polio	26
Other	44

TABLE 4 knowledge and management of diarrheal disease Aproximate sample size for calculations is provided as some questions concern only a sub- set of the population _

DIARRHOEA	% (N)
Child suffer from diarrhoea in the last 2 weeks?	34 (300)
If yes,When child had diarrhoea,did mother	
Breastfeed more than usual	70
Breastfeed same as usual	52 (103)
Breastfeed less than usual	34
Left breastfeeding	13
Child stopped feeding	01
Liquids given when the child had diarrhoea	
More than usual	67 (103)
Same as usual	46
Less than uaual	20
Left completely	02
Exclusive breasteeding only	34
Medication given for diarrhoea	
None	02 (103)
ors	73
Sugar salt solution	10
Fruit or fruit juice	31
Rice juice	02
Pills or tablets	14
Other	43
When child had diarrhoea,mother sought treatment	
District hospital	07 (103)
Health centre	59
Mission hospital	06
Store	26
Village health volunteer	12
Traditional healer	20
Friends or relatives	10
TBA	00
Other	05
Signs/symptoms which would lead mother to find assistance for child with diarrhoea are	
Mother doesn't know	02
Vomiting	22
Fever	12 (300)
Dry mouth,sucken eyes, decreased urination	33
Diarrhoea for more than 2 weeks	52
Blood diarrhoea	04

95

Loss of appetite	09
Tiredness	80
Other	06

Most important thing(s) to do after child has recovered from diarrhoea are	
Mother doesn't know	05 (300)
Give little food more frequently	71
Feed more food more than usual	21
Give high energy foods	47
Other	44

TABLE 5 Knowledge of immunizations and supplementation Records ofreceiving vaccinations and Vit A supplements exist only as confirmed by presence of an ANC,an under-5's or other documentation Approximate sample size for each set of calculations is provided, as some questions concern only a sub-set of population

IMMUNIZATIONS/VITAMIN A SUPPLEMENTATION

	% (N)
Child has received any immunizations	94 (300)
Nunber of times a mother should receive TTV to protect her and the child	
Once	02 (291)
Twice	07
Three or more times	86
None	00
Mother doesn't know	05
Child has an "Under-5" card?	90 (300)
Children receieved BCG vaccination	96 (271)
Number of OPV vaccination	
At least 1	97 (271)
At least 2	85
At least 3	75
Number of DPT vaccination	
At least 1	97 (271)
At least 2	84
At least 3	73
* Measles vaccination	45
Number of doses of Vit A received	
At least 1	48 (271)
At least 2	14
At least 3	33
At least 4	<1
* Vit A to mother	22

Avg age(months) child should receive measles vaccination?

TABLE 6 Ante-natal knowledge and ANC attendance Approximate sample size for each set of calculations is provided, as some questions concern only asub- of the population

ANTE-NATAL CARE	%	(N)
When expectant mother went to ANC	96	(299)
Mother has an ante-natal card?	42	(300)
Number of ante-natal visits (from card)		
One	04	(126)
Two or more	34	
Four or more	62	
Never attended	00	
During what month of pregnancy should a mother make her first visit to the ante-natal clinic?		
1-3 months	39	(127)
4-6 months	54	
7-9 months	06	
No reason of going to ante-natal clinic	00	
Mother does not know	00	
Mother has TTV card with TTV information	73	(300)
Number of TTV vaccination received		
One	06	(222)
Two	37	
Three or more	56	
None	<1	

TABLE 7 Malaria knowledge and management Approximate sample size for each set of calculations is provided, as some questions concern only a sub- set of the population The entry with a star under "other medicines" commonly used to treat malaria notes the large number of women who give analgersiccs to children suspected of having malaria

MALARIA	%	(N)
Mother consider malaria as a major problem	97	(300)
One can get malaria from		
Bite of housefly	17	(300)
Bite of mosquito	52	
Germs	05	
Plasmodium	07	
Other	19	
Signs and symptoms of malaria,as reported		
Fever	84	(300)
Swollen glands	03	
Aneamia	01	
Painful joints	25	
Headache	71	
Other	24	
Medicines are commonly used to treat malaria		
Fansidar	79	(299)
Chloroquine	09	
Bactrim	07	
Quinine	01	

Other medicine	83	
*aspirin cafenol paramol or Panadol		
To protect herself from malaria		
Using net	07	(300)
Using coils doom or dug	38	
Using wire mesh	03	
Disrupting breeding sites or spraying	38	

Number of Fansidar(S/P) tablets mother would give, by age group

	Medium	(N)
Under 4 years	1	(264)
4 to 8 years	1	(250)
9 to 14 years	2	(239)
Greater than 14 years old	3	(259)

TABLE 8 Family planning knowledge and practices of the mother Approximate sample sizes for each set of calculations is provided, as some questions concern only a sub- set of the population

FAMILY PLANNING	%	(N)
Is mother pregnant now?	05	(300)
If no, woman wants another child in the next 2 yrs		
Yes	17	(290)
No	73	
Doesn't know	10	
If mother does not want (or D K) children in next 2 yrs, Is mother currently using a FP method?		
Yes	34	(245)
Among women using a method		
Proportion of women using		
Tubal ligation	00	(85)
Vasectomy	02	
DPV (injection)	52	
Oral (pill)	25	
IUD	00	
Condom	07	
Foam/jelly	00	
EBF	00	
Billing	01	
Abstinence	08	
Coitus interruptus	00	
Other	05	
CONDOMS		
Woman can correctly identify a condom	94	(300)
Frequency of condom use w/husband or partner?		
Never use	92	(300)
Sometimes use	05	
Most of the time	02	
Always	01	

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ANNEX 7

IEF QUALITY ASSESSMENT REPORTS
(SINCE PROJECT MID-TERM EVALUATION)

1 Report on DRF Assessment, 10/17-23/97

2 Report on Maternal Ward Exit Interviews at Ngabu, St Montfort and Chickwawa District Hospital, 7/23-8/29/97

3 Traditional Healers Assessment

4 Traditional Healers & AIDS Control in Chikwawa District

5 Mid-Project Survey Report on DRFs & IGAs

6 Assessment of Knowledge and Practice on Breast Feeding and Exclusive Breast Feeding

7 Report on DRF Refresher Course, 5/15-17/97

8 Detailed Report of U/5 Clinic Exit Interviews, 5/14-27/97

9 Report of the Focus Group Discussion on VHCs

10 Focus Group Discussions with VHCs and the Community on M4E

11 Report of 2nd Initial M4E Training Held at Mitole Residential Training, 10/7-11/97

TRUE COPY

REPORT ON DRF ASSESSMENT CONDUCTED FROM 17TH THROUGH 23RD OCTOBER 1997

FOR THE PERUSAL OF

THE ACTING PROJECT MANAGER
IEF(CS) PROJECT
P O BOX 142
NCHALO

COMPILED BY

GEORGE MEKISENI
EVALUATION /TRAINING
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18 12/97

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6 0 RECOMMENDATIONS

SECTION D

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[illegible]

SECTION [illegible]

[illegible]

*Drug # mothers responded [illegible]

[illegible]

* On other drugs sold by th volunteer women mentioned Of Penicillin [illegible] Panadol [illegible] Paramo chloroquine and Tetracycline

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QUESTIONNAIRE RESPONSES	# MOTHERS RESPONDED	%

QUESTIONNAIRE RESPONSES	# MOTHERS RESPONDED	%
	11	

QUESTIONNAIRE RESPONSES	# MOTHERS RESPONDED	%

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[illegible] DEFAULT [illegible]

[illegible]

[illegible]

[illegible]

- At most DRF centres the volunteers [illegible] simple shelter which could be used as a house to sleep and perform their duties

- Since [illegible] when the volunteers go to [illegible] Mt Malata was doing hand over [illegible]

- The amount [illegible] DRF centres [illegible] the task [illegible] helpful [illegible]

[illegible]

[illegible]

[illegible]

- [illegible] dimba cultivation [illegible]

6.0 RECOMMENDATION

[illegible] Population should [illegible] down

MOHP should find another way [illegible] their [illegible]

7.0 [illegible]

[illegible] Messrs [illegible] and [illegible] chairman [illegible] assistance [illegible] Mr Michael [illegible] and tabulation [illegible] thanks to Mr Michael [illegible] The [illegible] Community Health [illegible] assisted [illegible] with the [illegible]

8.0 APPENDICES

[illegible]

[illegible]

- [illegible]

[illegible]

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IEF CHILD SURVIVAL PROJECT

DRF KNOWLEDGE ATTITUDE AND PRACTICE ASSESSMENT

NB All questions to be administered to 20 selected mothers at random with children less than 10 years

Name of DFF [illegible]

Date [illegible]

Name of the interviewer

Name of the children [illegible]

Name of the mother

[illegible]

[illegible]

(Probe and [illegible] all answers [illegible])

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10) H[illegible] TF

(NB I the mother says she does not know put a question mark)

1 [illegible]

2 [illegible]

TF

[illegible]

[illegible]

3 Ferrous Sulphate

[illegible]

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ASSESSMENT OF DRF ACTIVITIES THROUGH FOCUS GROUP DISCUSSIONS WITH VILLAGE HEADMAN, VILLAGE HEALTH COMMITTEE AND THE VOLUNTEER

INTRODUCTION

- [illegible]

  and [illegible]

- Self introduction

- Tell the members the purpose of the FGD we want to discuss the success and problems [illegible] Further [illegible] to discuss [illegible] and [illegible] sustainability of DRF and IGF funds [illegible]

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- [illegible]

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BEST AVAILABLE COPY

shall [illegible]

4 days

(NB Open ended guiding questions)'

[illegible]

[illegible]

[illegible]

[illegible]

3 If some members [illegible]

Number [illegible]

Reason [illegible] they [illegible]

BEST AVAILABLE COPY

REPORT ON MATERNAL WARD EXIT INTERVIEWS CONDUCTED AT NGABU, ST MONTFORT AND CHIKWAWA DISTRICT HOSPITAL FROM 23RD JULY THROUGH 29TH AUGUST 1997

FOR THE PERUSAL OF

THE PROJECT MANAGER
IEF (CS) PROJECT
P O BOX 142
NCHALO

COMPILED BY

GEORGE MEKISENI
EVALUATION/TRAINING COORDINATOR
IEF (CS) PROJECT
P O BOX 142
NCHALO

COPY TO

THE COUNTRY DIRECTOR
IEF
P O BOX 2273
BLANTYRE

THE DISTRICT HEALTH OFFICER
P O BOX 32
CHIKWAWA

SENIOR MEDICAL OFFICER
ST MONTFORT HOSPITAL
P O BOX 68
NCHALO

CLINICAL OFFICER
NGABU RURAL HOSPITAL
P O BOX 15
NGABU

DATE 1ST NOVEMBER, 1997

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1 0 INTRODUCTION

International Eye Foundation has sponsered a number of trainings to different cadres of Ministry of Health Personal in order to boost Child Survival Interventions in Chikwawa District since 1989
This include Clinical Officers Nurses, Health Assistants Health Surveillance Assistants not forgetting Female Ward Attendants Hospital Servants and Patient Attendants

In order to evaluate the success and development areas, a questionnaire which is in our appendix I was developed by the IEF Training /Evalaution Coordinator and later polished by the Project Manager and The IEF Country Director in July 1997

SECTION A

2 0 ASSESSMENT METHODOLOGY.

Three big hospitals viz Ngabu St Montfort and Chikwawa were selected for this assessment Two Enumerators were hired for this task Since there were three hospitals, one IEF Community Health Supervisor was also involved in this task Refer appendix II for the names of two hired Enumerators, one IEF Supervisor and the stations they were assigned

These three people were trained fully by the Evaluation and Training Coordinator how they could conduct In-Depth Interviews on 22nd July, 1997

Our Community Health Supervisor started the work on 23rd July, 1997 whilst the two Enumerators commenced on 11th August, 1997

3 0 DEMOGRAPHIC

A total of 146 mothers were interviewed 46 from Chikwawa District Hospital 82 from St Montfort and 18 from ngabu Rural hospital

- The sum total of their ages was 3759 00
  Mean = 25 75
  Standard Deviation = 8 15

4 0 RESULTS IN A TABLE FORM.

1) Did you receive Vitamin A since the birth of this child

	FREQ	PERCENT	CUM
Yes	60	41 1%	41%
No	86	58 9%	100 0%

ii) (a) Did you/Health Worker give the Child water?

Yes	1	0 7%	0 7%
No	145	99 3%	100 0%

(b) Did you/Health Worker give the child any food?

Yes	1	0 7%	0 7%
No	145	99 3%	100 0%

iii) Did any H/Worker ever given you H/Talk?

Yes	94	64 4%	64 4%
No	52	35 6%	100 0%

iv) Who taught you?

CO	1	1 1%	1 12%
CO, FWA,HSA	1	1 1%	1 1%
FWA	3	3 2%	5 3%
FWA,HSA	6	6 4%	11 7%
HA	1	1 1%	12 8%
HA,HSA	2	2 1%	14 9%
HSA	5	5 3%	20 2%
MA	1	1 1%	22 3%
MA,FWA	1	1 1%	23 4%
MA,FWA,HSA	1	1 1%	24 5%
MA,NS HSA	1	1 1%	25 6%
NS	20	21 3%	45 7%
NS FWA	11	11 7%	57 4%
NS,FWA,HSA	13	13 8%	71 3%
NS FWA HSA			
OTHER	1	1 1%	72 3%
NS,FWA, OTHER	1	1 1%	73 4%
NS HA	1	1 1%	74 5%
NS HA HSA	5	5 3%	79 8%
NS HSA	18	19 1%	98 9%
NS, OTHER	1	1 1%	100 0%
TOTAL	94	100 0%	

* <u>ABRFVIATIONS</u>

MA = Medical Assistant
CO = Clinical Officer
NS = Nurse
FWA = Female Ward Attendant
HSA = Health Surveillance Assistant
HA = Health Assistant

What was taught?	FREQ	PERCENT	CUM.
BF	3	3 2%	3 2%
BF CDD FP	3	3 2%	6 4%
BF CDD FP OTHER	1	1 1%	7 4%
BF, EBF	2	2 1%	9 6%
BF EBF CDD FP	1	1 1%	10 6%
BF, EBF, FP	6	6 4%	17 0%
BF EBF FP OTHER	1	1 1%	18 1%
BF, EBF, OTHER	2	2 1%	20 2%
BF EBF SN	7	7 4%	27 7%
BF, EBF, SN FP	1	1 1%	28 7%
BF EBF SN FP OTHER	1	1 1%	29 8%
BF, EBF SN, OTHER	3	3 2%	33 0%
BF, SN	4	4 3%	37 2%
BF, SN, FP	9	9 6%	46 8%
BF SN, FP OTHER	1	1 1%	47 9%
BF, SN, HIV/AIDS	1	1 1%	48 9%
BF NS OTHER	2	2 1%	51 1%
BF, CDD, FP, OTHER	1	1 1%	52 1%
EBF, FP	4	4 3%	56 4%
EBF, HIV, OTHER	1	1 1%	57 4%
EBF, OTHER	1	1 1%	58 5%
EBF, SN	7	7 4%	65 9%
EBF, SN FP	4	4 3%	70 2%
EBF, SN, FP OTHER	3	3 2%	73 4%
EBF, SN OTHER	1	1 1%	74 5%
FP	5	5 3%	79 8%
HIV/AIDS FP	1	1 1%	80 9%
OTHER	2	2 1%	83 0%
SN	1	1 1%	84 1%

6 0 Do you have U/5 card of this child?

Yes	132	90 4%	90 4%
No	14	9 6%	100 0%

7 0 (a) Date of BCG Vaccines	23/07/97	2	1 6%	1 6%
	28/07/97	2	1 6%	3 1%
	31/07/97	3	2 3%	5 5%
	06/08/97	1	0 8%	7 0%
	10/08/97	1	0 8%	7 0%
	11/07/97	32	25 0	32 05
	12/07/97	1	0 8%	32 8%
	13/08/97	4	3 1%	35 9%
	15/08/97	10	7 8%	43 8%
	18/08/97	23	18 0%	61 7%
	19/08/97	8	6 3%	68 0%
	20/08/97	9	7 0%	75 0%
	21/08/97	1	0 8%	75 8%
	22/08/97	4	3 2%	78 9%
	25/08/97	15	11 7%	90 6%
	26/08/97	5	3 9%	94 5%
	27/08/97	3	2 3%	96 9%
	28/08/97	1	0 8%	97 7%
	29/08/97	3	2 3%	100 0%
		---	---	
	TOTAL	128	100%	
(b) Dates when mother was given Vitamin A	23/07/97	2	1 5%	1 5%
	28/07/97	2	1 5%	3 0%
	31/07/97	3	2 3%	5 3%
	06/08/97	1	0 8%	6 1%
	08/08/97	1	0 8%	6 8%
	10/08/97	2	1 5%	8 3%
	11/08/97	29	22 0%	30 3%
	12/08/97	1	0 8%	31 1%
	13/08/97	4	3 0%	34 1%
	14/08/97	4	3 0%	37 1%
	15/08/97	11	8 3%	45 5%
	18/08/97	27	20 5%	65 9%
	19/08/97	4	3 0%	68 9%
	20/08/97	8	6 1%	75 0%
	21/08/97	1	0 8%	75 8%
	22/08/97	5	3 8%	79 5%
	25/08/97	15	11 4%	90 9%
	26/08/97	5	3 8%	94 7%
	27/08/97	2	1 5%	96 2%
	28/08/97	2	1 5%	97 7%
	29/08/97	3	2 3%	100 0%
		---	---	
	TOTAL	132	100 0%	
8 Do you have a TIV card?	Yes	131	89 7%	89 7%
	No	15	10 3%	100 0%

9	Number of TTVs received on their cards	TTV 1	20	15 3%	15 3%
		TTV 2	66	50 4%	65 6%
		TTV 3	21	16 0%	81 7%
		TTV 4	9	6 9%	88 5%
		TTV 5	15	11 5%	100 0%
		TOTAL	131	100 0%	

Sum of TTVs - 326 00
MEAN = 2 49
STANDARD DEVIATION = 1 18

SECTION B.

5 0 OBSERVATION

From the interviews and results below are my observations

- Approximately 59% of the mothers were not receiving Vitamin A while they were in the hospitals with their newly kids An action was taken by our Community Health Supervisor and the two Enumerators

- 99% of the children were not given either water or any food while they were lin the hospital

- 64% of the mothers were given Health Talks by Health Workers while they were pregnant and in the hospital before being discharged

- From the Interviews and results more Health Talks were given by Nurses HSAs and Female Ward Attendants as opposed to Health Assistants and Clinical Officers

- More Health Talks were based on Breast feeding, Exclusive Breastfeeding Family Planning and Sanitation as opposed to Vitamin A and Control of diarrheal diseases

- 4 children (3 1%) did not receive BCG on 11th August, 1997 at Ngabu Rural hospital The vaccine was out of stock

- 3 mothers (2 3%) did not receive Vitamin A on 11th August 1997 at Chikwawa District hospital An action was taken (mothers were sent back to the Nurse to get Vitamin A capsule)

- Approximately 90% of the mothers interviewed had TTV cards

- The average number of TTVs received by the 31 mothers who had their TTV cards was TWO

SECTION C

6 0 RECOMMENDATIONS

From the results the following are my recommendations

- Medical Personnel should not forget to give Vitamin A lactating mothers while they are in maternity ward
- All cadres of MoHP should be serious with Health Talks Clinical Officers and Health Assistants should also take a lead in these Health Talks
- Vitamin A and Control of diarrheal disease messages should be addressed to pregnant and Postpartum mothers equally as other Health TAlks

NB Lactating mothers should eat Vitamin A - rich foods to maintain Vitamin A levels in their milk Mothers who live in Vitamin A deficient areas should also receive a Vitamin A capsule within 2 months of birth to help protect the breast-fed infant

SECTION D.

7 0 CONCLUSION.

I should extend my gratitudes to the DHO of Chikwawa and Senior Clinical Officer of St Montfort for giving me the permission to go ahead with my assessment

8 0 APPENDICES

i) English Questionnaire used
ii) Enumerators and Community Health Supervisor who did the exercise

APPENDIX II.

NAMES OF TWO ENUMERATORS AND ONE IEF COMMUNITY HEALTH SUPERVISOR WHO WERE INVOLVED IN THE ASSESSMENT AND THEIR STATIONS

NAME	STATION
Mr Rex Kashort	Chikwawa District Hospital
Mr Michael Kamcheka	St Montfort Hospital
Mrs Ruth Zangazanga	Ngabu Rural Hospital

TRADITIONAL HEALERS ASSESSMENT (THUS FOLLOW-UP OF LAST YEARS TRAININGS ON PEC)

In order to assess the Knowledoe and Practice of Traditional Healers on what they learnt during last year trainings on Primary Eye Care an assessment of 45 healers was conducted from 13th to 22nd May 1997 The main purpose was to find out whether there was a need of conducting refresher course to over 400 healers who attended trainings last year Appendix 1 is the questionnaire which I and Grace Funsani administered

Our target was to interview 100 but the number dropped to 60 due to pressure of work In all we only managed 75/ of our target number thus 45 out 60
Below are our results and recommendations -

(a) RESULTS

- 58/ of the healers had assistants who assist them in their daily work

- 50/ of them were members of Traditional Healers Association These healers treat young children women and men

- On average they treat about 2 people with eye problems everyday especially Conjunctivitis

- 69/ of the Interviewed Healers knew a blind person living either in their village or nearby village

- 47/ of them diagnose eye diseases by examining and listening to the patient

- 80/ of the interviewed healers reported to have attended last years training On average each of them attended twice thus in November/December 1995 and July 1996

- 18/ and 22/ of the Healers still use Traditional Eye drops for treating Conjunctivitis and Cataract respectively

- 31/ and 53/ of them use other Traditional medicine such as blowing the medicine into the eye for treating Conjunctivitis and Cataract

NB Fore more details of our findings refer Table 1

(b) RECOMMENDATIONS

- From our results mainly on questions 20 to 22 Traditional Healers should undergo a two- day refresher course where they could be reminded the following things

  (i) Dangers of keeping on using their traditional eye drops and blowing traditional medicine directly into the eye

  (ii) Duration they can take in treating a Conjunctivitis patient Even though in our table the average number of days is 2 some healers reported to treat the patients for 4 up to 6 days

  (iii) Referring all Cataract patients to hospital In our exercise only 7/ thus 3 out of 45 reported to make referrals of Cataract patients

  (iv) Good advice which they can tell patients soon after treatment Only 27/ reported on hygiene as opposed to 4/ who reported on proper diet

- Healers should be advised to have reasonable charges It was found that 56/ were charging more because of using different techniques

- Regular evaluations should be carried in order to assess changes of practice which healers take in treating eye diseases

TRADITIONAL HEALERS & AIDS CONTROL IN CHIKWAWA DISTRICT

PRESENTED BY GEORGE MEKISENI
EVALUATION & TRAINING COORDINATOR
INTERNATIONAL EYE FOUNDATION (CS) PROJECT,
BOX 142
NCHALO

In 1991 and 1992 a series of [illegible] in Chikwawa District to build a [illegible] of Health and [illegible] HIV/AIDS [illegible] were started in 1[illegible]

Baseline evaluation was [illegible] traditional healers to assess their knowledge attitude Practices and Beliefs (KAPB) on HIV/AIDS. Below are our results

- Few healers felt that they could cure AIDS
- All healers understood that HIV is a sexually transmitted disease
- 8[illegible] of them said that AIDS could be prevented
- Few healers [illegible] to have counselled AIDS patients
- Healers did not understand the difference between HIV and AIDS
- Healers charged a considerable amount for the treatment of STIs especially in trading centres

Training programme was developed in 1994 which emphasized the following points

- Importance of prevention behaviour [illegible]
- Difference between HIV and AIDS
- [illegible]
- Importance of underlying STI [illegible]
- Potential treatment [illegible] HIV
- [illegible] for AIDS
- [illegible]
- [illegible] their [illegible]

[illegible] training programme started [illegible] of traditional healers [illegible]

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[illegible] Evaluation [illegible]
[illegible]

- [illegible] healers [illegible]
- almost all healers [illegible] HIV [illegible]
- about [illegible] of the healers [illegible] education [illegible] healers and distribute [illegible]
- Healers are interested in learning [illegible] HIV [illegible] education
- Healers talked to [illegible] Health [illegible]
- Female healers were [illegible] males

A two day training of this nature [illegible] 1995 1996 there a total of 112 healers were trained on HIV AIDS [illegible] essential for Primary Eye care [illegible] Mr Steven Kamuzi [illegible] CUMA [illegible] Highway Institute and [illegible] Eye care [illegible] that [illegible] were [illegible] facilitated [illegible] training [illegible]

Evaluation of these training [illegible] in May of this year in conjunction with PAPH [illegible] healers were [illegible] and it was found that

- [illegible] reported that the [illegible] HIV
- almost all healers [illegible]
- [illegible] HIV [illegible]
- almost all healers [illegible]
[illegible] HIV
- [illegible] healers [illegible]

[illegible]

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INTERNATIONAL EYE FOUNDATION
CHILD SURVIVAL PROJECT

MID-PROJECT SURVEY REPORT ON DRUG REVOLVING FUND AND INCOME GENERATING ACTIVITIES

G L MAKATA
DRF/IGA COORDINATOR

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I DRUG REVOLVING FUND

A BACKGROUND

DRF centres were set up in six pilot areas of six constituencies selected by commmunity with the assistance of Health extension workers The major aim behind was to assist communities living far away from rural government Health Centres by supplying simple medicines such as SP, Aspirin and TFO

Six volunteers, one from each constituent were chosen by community IFF supported their training in DRF management through collaboration with the Ministry of Health and St Montfort Hospital who provided facilitators IFF also provided DRF boxes and purchased the first batch of medicines from St Montfort Hospital to start up the DRF centres The funds were obtained after sales of project used items

Meanwhile, six Health Assistants each from the nearest health facility to the village were orientated on the management of DRF centres and will act as overall supervisors when IEF pulls out The volunteers immediate supervisors will be HSAs in whose catchment areas exist DRF centres

B OBJECTIVES

The objectives of the survey were to obtain the following information from the beneficiary communities

- For DRF Volunteers knowledge of dispensation of drugs, recording and keeping of records, communication with supervisors, keeping of cash, referral system and drug replenishment

- For Village Health Committee Members knowledge of their roles about the DRF in their community, of improvements to the running of the DRF centres by IFF

C METHODOLOGY

A questionnaire was developed by the Evaluation Coordinator assisted by the Training Coordinator It was then polished by the Project Manager and the final product consisted of two parts, twelve questions for the volunteer and ten for the VHC members Three IFF community health supervisors administered the questionnaires to three DRF centres The data was then analysed by the Evaluation Coordinator assisted by the Training Coordinator

D RESULTS

I Village health Committee members

A total of 12 committee members were traced and interviewed, representing 20% of VHC members involved in DRF and the following information was obtained

25% of VHCs said they held meetings with their volunteers once a month to discuss DRF activities

- 33% of the VHCs thought their volunteers performed their duties well

25% of VHCs knew about IFF support to DRFs

- 42% of VHCs proposed that Bactrim be included in the DRF box for acute respiratory infections

- All VHCs interviewed felt that the DRF box was very beneficial to the community

- All VHCs interviewed thought that the DRF Volunteer should be available at all times in order to attend to patients
- 66% suggested the box be enlarged to accommodate more drugs

II DRF Volunteer

3 DRF volunteers were interviewed, representing 50% of DRF volunteers and the following information was obtained

- Over half of the volunteers felt that correct dosage, humbleness and dedication to duty made the community have confidence in them

- 50% of the volunteers mentioned malaria and conjunctivitis as major problems in their communities

The DRF volunteers' records indicated that volunteers did refer seriously sick people to hospital 1 volunteer referred 8 patients to a hospital in a month
2 of 3 interviewees felt that they were not visited regularly by their supervisor

- All interviewed volunteers suggested three major drugs to be added to the drug box and ranked them according to their importance as follows,
1 bactrim, 2 tetracycline 3 penicilin

- All interviewed volunteers suggested additional equipment as follows, 1 bicycle 2 hurricane lamp 3 cashbox

- 2 of 3 DRF volunteers wrote but did not submit monthly reports

- All volunteers interviewed encountered encountered the following problems

  a patients complained of bad side effects of SP drugs
  b they faced difficulties in sending monthly reports
  c they did not have soap for handwashing

- The following were suggested ways to improve DRF
  a IEF supervision be intensified
  b new types of drugs be supplied
  c community should build shelters to be used as dispensary

E DISCUSSION

I Introduction of new drugs

The introduction of new drugs to the drug box such as bactrim and tetracyclin was highly reflected in the responses of both the VHC and The DRF volunteer The general impression here is that these drugs are obtained and used by the community from other sources

II Lack of Supervision

There is general lack of constant supervision or follow-up on the DRF activities as can be observed The problem is attributed to two factors first, the trained HAs do not have means of transport toget to the centres some of which are as far as 20km from their duty stations Second, their immediate supervisors to-be (HSAs) have not yet been trained by IEF in the management of DRF centres This leaves the IEF's DRF Coordinator as the sole supervisor

III Basic equipment

IEF support in terms of equipment appears to be highly desirable Paraffin lamps to allow for dispensation of drugs at night, a push bike to facilitate movement of patients and the volunteer, and handwashing soap for general cleanliness

IV Cash management

All volunteers interviewed said they kept the money raised from drug sales in the drug box in their homes The DRF Coordinator still goes around collecting cash from the volunteers and does the locking and replenishment on their behalf A mechanism for a proper banking and purchasing y tem for each DRF centre is yet to be developed depending on the demand for drugs

* * *

II INCOME GENERATING ACTIVITIES - POULTRY KEEPING

A BACKGROUND

One of the recommendations in the 1994 Child Survival Project Evaluation was that TFF should collaborate with elected VHCs and VHVs in pilot efforts to develop small scale income generating activities (IGAs) which may be used to support health activities at the village level.

In pursuit of that, TFF established a position of IGA Coordinator to oversee the setting up and running of such activities. Following a Participatory Rural Appraisal Conducted by CURE a non-governmental organization working in the same district in which the IGA Coordinator participated, communities highlighted a number of income generating possibilities including permaculture, poultry keeping and vegetable growing.

At first attempt, the community vegetable project failed to take off because gardening coincided with the beginning of rainny season. Gardening was therefore abandoned due to unexpectedly high rainfall, leaving permaculture and poultry keeping as alternatives. Six poultry keeping clubs were instead formed on the periphery of Lengwe game park, while a community in Changoima got TFF support in permaculture. Out of the six clubs originally planned for, only three have survived.

B OBJECTIVES

The objectives of the survey were: knowledge of how receptive the VHCs and VHVs were to the idea of poultry keeping as an income generating activity; TFF - support to the VHC/VHV poultry keeping projects.

C METHODOLOGY

A questionnaire was developed by the Evaluation Coordinator and tested by the Training Coordinator. The questionnaire was then polished by the project manager and was administered by TFF's community Health Supervisors. The results were then analysed by the Evaluation and Training Coordinator.

D RESULTS

A total of 11 members from 3 clubs of 30 each were reached and interviewed representing 18 3% of the total number of club members Below are compiled responses to the questionnaire

All interviewees mentioned money as the motive behind poultry keeping

8 of 11 said they were satisfied with the trainings in poultry management and record keeping which were organized and supported by IFF

2 clubs said they held meetings two and threr times every month respectively

- One club said they had not been meeting in a long time because chickens took too long to be delivered Hence, committed themselves to other taske

2 clubs not satisfied with the support IFF provided

- Major problems cited were as follows

a lack of cooperation among some committee members
b late delivery of chickens

Suggested ways of improving the running of the clubs included

a committees should organize meetings regularly
b IFF should provide adequate and timely assistance
c there should be constant supervision by the government veterinary assistant

all members intend to obtain loans from the poultry project and start up their own IGAs in future

E DISCUSSION

I IFF Support on project

It became apparent from the responses of club members that adequate and timely support from IFF wa desirable While the communities constructed chicken pens IFF were to support them with plastic sheeting chicken wire, barbed wire feeding troughs, drinking troughs, chicks doors, frames and initial medicines

II Supervision

Responses show some irregularities in routine supervision by the Veterinary Assistant The Vet Assistant is, by agreement with the Ministry of Agriculture to be visiting clubs in their catchment areas, discuss with club members problems they encounter and suggest possible solutions TFF's input would be to strengthen ties between the poultry clubs and all extension workers directly involved in the IGAs

* * *

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All volunteers interviewed said they kept the money raised from drug sales in the drug box in their homes. The DRF Coordinator still goes around collecting cash from the volunteers and does the locking and replenishment on their behalf. A mechanism for a proper banking and purchasing system for each DRF centre is yet to be developed depending on the demand for drugs.

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D RESULTS

A total of 11 members from 3 clubs of 30 each were reached and interviewed, representing 18.3% of the total number of club members. Below are compiled responses to the questionnaire.

All interviewees mentioned money as the motive behind poultry keeping.

8 of 11 said they were satisfied with the trainings in poultry management and record keeping which were organized and supported by IFF.

2 clubs said they held meetings two and three times every month respectively.

- One club said they had not been meeting in a long time because chickens took too long to be delivered. Hence, committed themselves to other tasks.

- 2 clubs not satisfied with the support IFF provided.

- Major problems cited were as follows:

  a. lack of cooperation among some committee members
  b. late delivery of chickens

  Suggested ways of improving the running of the clubs included:

  a. committees should organize meetings regularly
  b. IFF should provide adequate and timely assistance
  c. there should be constant supervision by the government veterinary assistant

  all members intend to obtain loans from the poultry project and start up their own IGAs in future.

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I. IFF Support on project

It became apparent from the responses of club members that adequate and timely support from IFF was desirable. While the communities constructed chicken pens, IFF were to support them with plastic sheeting, chicken wire, barbed wire, feeding troughs, drinking troughs, chicks, doors, frame, and initial medicin

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Responses show some irregularities in routine supervision by the Veterinary Assistant The Vet Assistant is by agreement with the Ministry of Agriculture to be visiting clubs in their catchment areas, discuss with club members problems they encounter and suggest possible solutions TFF s input would be to strengthen ties between the poultry clubs and all extension workers directly involved in the IGAs

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INTERNATIONAL EYE FOUNDATION
CHILD SURVIVAL(CS)

DRUG REVOLVING FUND (DRF) QUESTIONNAIRE

For VHC Members

1 Ndi udindo wanji muli nawo mu komiti ya za umoyo?

(a) Wapampando

(b) Mlembi

(c) Msungi chuma

(d) Membala

2 Nanga pa udindo wanu muli kukhudzidwa bwanji ndi nchito ya mankhwala a kumidzi?

(a) Kuona kuti Volontiya akuthandiza anthu moyenera

(b) Kukumana ndi kukambirana za mankhwala

(c) Kuoana kuti mankhwala alipo

(d) Ntchito zina

(e) Sindikudziwa

3 Mumakumana kanga kukambirana ndi Volontiya pa nkhani ya mankhwala anu?

(a) Kamodzi pa mwezi

(b) Kamodzi pa miyezi iwiri

(c) Sitikumana

4 Maganizo anu ndi otani pa magwiridwe antchito a Volontiya wanu?

(a) Akugwira ntchito bwino

(b) Sakugwira ntchito bwino

(Perekani chifukwa)

ı akatha mumapeza ena bwanji?

ve la IEF limabweretssa

ıa wa za Umoyo amatithandıza

Sındıkudzıwa

nwala atı amene anthu amafuna kutı tıonjezere?

(b) (c)

ısı la mankhwala lırıkuthandızanı?

Inde (b) Ayı (c) Sıtıkudzıwa

ıawı ımene Volontıya anaıka kutı mudzılandırıra mankhwala ıtı?

) M'mawa (b) Masana (c) Madzulo (d) Tsıku lonse

ə) Sındıkudzıwa

9 Nthawı yabwıno ımene mufuna kutı mudzılandırıra mankhwala ndı ıtı?

(a) (b) (c)

10 Mulı ndı maganızo ena pa nkhanı ya bokosı lanu la mankhwala?

RESULTS OF BREASTFEEDING PROMOTERS ASSESSMENT

[illegible]

[illegible]

[illegible] IFF [illegible]

[illegible]

[illegible]

[illegible] them [illegible] the [illegible]

All of them reported [illegible] problems such as lack of [illegible] supervision and [illegible]
[illegible] and [illegible]

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RECOMMENDATION

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3 0 THE ACTUAL EXERCISE (U 5 CLINIC EXIT INTERVIEWS)

SECTION B

4 0 OBSERVATIONS FINDINGS

ACTIONS TAKEN AGAINST VITAMIN A DISTRIBUTIONS AND VACCINATIONS

SECTION C

5 0 RECOMMENDATIONS

SECTION D

6 0 CONCLUSION

7 0 APPENDICES

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1 0 INTRODUCTION.

The idea of this exercise came in following last years External Evaluators recommendations of suggestions on how to increase vitamin A distribution and EPI coverage in Chikwawa District

With help of the Country Director and Acting Project Manager, I polished a questionnaire which we administered last year end of April 1997 Refer appendix I for the questionnaire which was used

A letter was forwarded to the District Health Officer Chikwawa requesting permission to carry out this exercise in 24 Health Centres both static and mobile clinics early May The main purposes of the exercise were to increase

- Vitamin A distribution to children aged 6 to 71 months and Postpartum mothers
- EPI coverage to children less than 2 years of age and mothers of child bearing age

Our target was to interview 600 mothers thus 25 from every Health Centre/Clinic By 27th of May, we only managed to interview 496 mothers representing 83% coverage due to problem which were beyond my control

Five Enumerators three Community Health Supervisors and two Coordinators were fully involved in this exercise Refer appendix II and III for the names of Health Centres/Clinics and staffs who participated in this task

SECTION A

2 0 TRAINING OF ENUMERATORS COMMUNITY HEALTH SUPERVISORS AND THE COMMUNITY HEALTH COORDINATOR

This was conducted from 5th to 9th May 1997 at Ishalo IEF Child Survival Office The staff mentioned above were trained on how to administer the questionnaire and techniques of discussing with in-charges of Vitamin A and the information at the Health Centre Clinic before they depart Practical work (field test) was [illegible] at Nsala Rural Hospital

3 0 THE ACTUAL U/5 CLINIC EXIT INTERVIEWS

Teams 1 [illegible] started this [illegible] 1997 whilst teams 4 and 5 commenced on 12th May 1997 [illegible] appendix III [illegible] the [illegible] of Supervisors/Coordinators and Enumerators involved in the teams.

Nsalu Rural Hospital and Chikwawa District Hospital were [illegible]

DETAILED REPORT OF U/5 CLINIC EXIT INTERVIEWS
14TH THROUGH 27TH MAY, 1997.

FOR THE PERUSAL OF

THE ACTING PROJECT MANAGER,
IEF CHILD SURVIVAL PROJECT,
P O BOX 142
NCHALO

COMPILED BY

GEORGE MEKISENI,
EVALUATION/TRAINING COORDINATOR,
IEF CHILD SURVIVAL PROJECT,
P O BOX 142
NCHALO.

COPY TO

THE COUNTRY DIRECTOR,
IEF
P O BOX 2273
BLANTYRE

THE DISTRICT HEALTH OFFICER
CHIKWAWA DISTRICT HOSPITAL
P O BOX 32
CHIKWAWA

DRF REFRESHER COURSE TRAINING PRE AND POST TEST RESULTS

	NAME OF PARTICIPANTS	PRETEST	POSTTEST
1.	Watson Siginata	100%	90%
2.	Daisoni Chiwindo	97%	96%
3.	Christina Goche	90%	86%
4.	Welasi Bande	97%	96%
5.	Ferson Chaphata	96%	100%
6.	Laston Mchimika	72%	82%
7.	Davie Finiasi	86%	88%
8.	Geofrey Chitcha	82%	100%
9.	Wilson Davie	80%	90%
10	Davie Gezani	-	80%
11	VHM Madeu	36%	-
12	VHM Mvula	74%	-
13	VHM Gola	45%	-
14	VHM Finiasi	55%	-
15	VHM Fello	60%	-
16	VHM Olalio Gezani	53%	-
17	VHM Matinesi Mchimika	77%	-
18	VHM Steveria Siginala	66%	-

REF. NO. CDH/PH/8 21 5.97

FROM THE DISTRICT HEALTH OFFICER, P.O. BOX 52, CHIKWAWA.

TO THE PROGRAMME MANAGER I E F., .O. BOX 142, NCHALO.

(ATT THE TRAINING CO-ORDINATOR).

REPORT ON DRF REFRESHER COURSE HELD ON 15TH TO 17TH MAY, 1997

The training was held at Kubalalika Health Post. The training compris 10 DRF Volunteers from 4 villages, 4 Village Headmen and 4 Village Hea Committee Chairpersons. 2 Health Surveillance Assistants from the are played the role of observors and 1 Health Assistart played the role in assisting the course orgnizer to facilitate training.

The course went on very well and the 4 villages shared their experienc This was the first time the DRF volunteers have had a refresher course since their first training in October, 1995. The area is one of the b places where DRF activities have taken roots.

Subjects covered during the training included: Malaria, Pneumonia, Diarrhoea management, Hookworm, Eye infection (conjunctivitis), First (simple cuts and bruises) Drug storage and doses and methods for pr drugs.

This training has an abled us to introduce co-trimoxazole, mebendazo tetracycline eye ointument to this area. With the funds that were prov we have been able to provide the DRFs with drug boxes for the proper s of drugs.

May we take this opportunity to thank you very much for the timely fin and materal assistance rendered to us.

Attached are the results for the pre and post-tests.

Yours Faithfully

N.J. Gobede

for, DISTRICT HEALTH OFFICER

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[illegible]

[illegible] the [illegible]

[illegible] what are the [illegible]

- Transport
- [illegible]
- Lack of Interest
- Other

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[illegible]

[illegible] why children [illegible] were receiving [illegible] at [illegible] when they were over 12 months, this was [illegible]
Reasons why the children who were over 6 months did not receive Vitamin A this was question # 1
Why the children [illegible] Vitamin [illegible] when the children [illegible]

[illegible]
cancelled due to lack of [illegible]

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SECTION B

4.0 OBSERVATIONS/FINDINGS

Our Findings have been summarized in Table 1 which is attached Below are some of our results which should be perused thoroughly

- 52% of the children of the mothers who were interviewed received vaccinations thus Polio DDPT 1,2,3 and Measles

It was observed that mothers could not different Polio Vaccine from Vitamin A or DPT from Measles This was erred from question # 4 concerning Measles vaccinations When asked if their children had received Measles on that day some mothers could say yes Checking from U 5 card, you could see that the child did not get Measles vaccine but rather DPT 1 2 3 or Polio 1 2 3

- In few Health Centres such as Thando Chuoni children are getting vaccines while they were over 12 months due to

i Lack of vaccines such as DPT and Measles
ii) Absence of mothers to attend U 5 clinics [illegible]

Due to lack of [illegible] at Nathumanila Health centre all mothers (25) who were interviewed did not receive the vaccine

- 16% of the children were observed to receive Measles vaccine at the right time Some were not due - they had already received the vaccine
- 27% of the children received Vitamin A during the survey period Some of them had already received Vitamin A in the past 4 months thus from January to April whilst other were not -

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- 2[illegible] children were escorted to Vitamin A [illegible] officers to receive Vitamin A after th[illegible] [illegible] cards. These were observed at [illegible] health [illegible]

  Chamwala Health [illegible] [illegible] Bwera [illegible]

- Some Health Centres start giving children Vitamin A at the age of 2 to 4 months [illegible] Chamwala and Bwera

- 91% of the mothers were [illegible] to have received TT [illegible] completed their TT [illegible] TT [illegible]

- [illegible] mothers were escorted to vaccination [illegible] officers to receive TT's. Some of these mothers were not screened accurately, whilst others ran away from the vaccine

- 73% of the mothers who did not receive TT in this study had various reasons such as
  Not due for either 2nd or 4th or 5th [illegible]
  Left their cards at home
  Lost their 1st card

- 4% (20 out of 196) Postpartum mothers received vitamin A during our exercise
- 15 mothers were escorted to Vitamin A [illegible] officers to receive Vitamin A. The had children [illegible] less 2 months

- [illegible] Health [illegible] [illegible] mothers [illegible] Health Centres such as [illegible]

SECTION C

5.0 RECOMMENDATIONS

[illegible]

There is a need of [illegible]

[illegible] Health Centres [illegible]

[illegible] mothers should [illegible]

[illegible]

and screening start

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TABLE I DEMOGRAPHIC INFORMATION FOR [illegible] MOTHERS

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BEST AVAILABLE COPY

TABLE II BREASTFEEDING AND NUTRITION KNOWLEDGE AND PRACTICE

BREASTFEEDING/EXCLUSIVE BREASTFEEDING NUTRITION N

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BEST AVAILABLE COPY

TABLE _ SUMMARY OF BREAST FEEDING PROMOTERS

[illegible]

[illegible]

[illegible]

[illegible]

4 What was discussed?

	Total	[illegible]
Exclusive Breast feeding	[illegible]	[illegible]
Importance of Colostrum	4	[illegible]
Care of breast	4	[illegible]
Supplementary Food	1	
Dangers of early weaning	[illegible]	[illegible]
Other	[illegible]	[illegible]

5 Who organized that [illegible]?

	Total
IEF	[illegible]
UNHF	
HCF	
OTHER	

[illegible]

[illegible]

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IEF/MALAWI CHILD SURVIVAL PROJECT

ASSESSMENT OF KNOWLEDGE AND PRACTICE ON BREASTING FEEDING AND EXCLUSIVE BREAST FEEDINNO

[illegible]

[illegible]

[illegible] mothers were [illegible] lower in each of the [illegible] [illegible] the had a child less than [illegible] six months [illegible] [illegible] months [illegible] were sampled

[illegible] mothers and [illegible] representing 45 % of mothers and 75 % of BF[illegible]

[illegible]

[illegible]

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SECTION D

6 0 CONCLUSION.

- Many thanks should go to all who were involved in this exercise and to the District Health Officer for allowing us to go ahead with our survey

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REPORT OF THE FOCUS GROUP DISCUSSION FOCUSING ON THE

(a) Makeup of the VHCS/VHVs and their responsibilities,

(b) Relationship of the VHCs with

- Community,
- VHV,
- HSA,
- Village headman and
- Health Centre/ Hospital Staff

(c) Progress of M4E and ways of improving it

FOR THE PERUSAL OF	The Project Manager, Child Survival Project, I E F, P O Box 142, Nchalo
COMPILED BY	George Mekiseni, Evaluation Co-ordinator, I E F P O BOX 142, Nchalo
DATE	21/10/96,08/11/96
CC	Mathews Alifinali, Community Health Co-ordinator, I E F P O Box 142, Nchalo
CC	Kristine Jones, M4E Project Consultant

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5 0 PROGRESS OF M4E AND WAYS OF IMPROVING IT

SECTION B

6 0 OBSERVATION

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1 0 INTRODUCTION

This suggestion follows the draft report of our three PRAs we wrote on 30th September,1996 It was found that Monitoring for Empowerment Programme (M4E) was not well implemented by the HSAs in Chikwawa North thus in Imfanjawo Dzimphonje and Moses village Some HSAs started the work on the ground but no proper definition and the purpose of M4E was explained to neither the VHCs nor the Community

I brought in the idea of assessing M4E Progress in Chikwawa Central and South through Focus Group Discussions This decision was supported by Mr Alifinali and Kristine Jones as well as the Country Director The exercise commenced on the 9th tnrough 11 of October, 1996 in Chikwawa Central Appendix 1 is a list of villages and dates when these FGDs were conducted and refer appendix 2 for names of I E F who were involved in this exercise Appendix 3 is a Guide line of questions used in our Focus Group Discussions

SECTION A

2 0 TURN UP OF THE PARTICIPANTS

The turn up of the VHCs/VHV and the HSA was extremely good At one site, thus in Mpingasa village, we had the highest number of participants (21) The least number we had was 13 this in Maide village To sum up, we had 19 at jeke, 21 at Mpingasa, 18 at Chagambatuka, 13 at maide and 20 at Pende thus Chikwawa Central We had 23 at Binya,18 at Chambuluka, 18 at Mandele, 21 at Rabu and 15 at Mponya On average, we had 18 participants at each session

3 0 MAKEUP OF VHVCs/VHVs AND DUTIES

Most VHV members we visited were formed by the Community at a village gathering Some members were chosen while they were at their respective homes In all the 5 villages in Eastern Bank the VHVs are not members of the VHC

3 1 COMPOSITION of VHCs

- Every Committee has 10 members On average, the Committees we came across were composed of 4 women and 6 men The table below shows what was noted in the ten villages, Thus numbers of women and men in the Committee

Village	Women	Men
Jeke	2	8
Mpingasa	4	6
Chagambatuka	2	8
Maide	6	4
Pende	5	5
Binya	4	6
Chambuluka	4	6
Mandele	4	6
Rabu	4	6
Mponya		

NB There was no new VHC in this village The Old VHC Chairman, two VHVs (one for CBD programme and the other for Vitamin A Supplementation), Village Headman and ten mothers attended the discussions They had their VHC in 1989/1990 in which there were 10 members thus 2 women and 8 men The HSA, Mr Mfune did not attend our Discussions forreasons beyond our control He promised to be at the meeting but proved in vain

3 2 ACTIVE/INACTIVE COMMITTEE

Out of ten villages, five had active VHCs thus Jeke, Pende,Binya, Mandele and Rabu having active VHCs, the rest had inactive members Below are various reasons why the Communities said that their VHCs were either active or inactive

i) Reasons for active VHC
- Conducting meetings regularly
- Giving Health Talks
- Doing village inspection on Sanitation

ii) Reasons for inactive VHCs
- Passive members, no meetings
- No cooperation among VHC members
- Some members reject positions especially when they were not present on the day of VHC election

3 3 ATTRIBUTES OF A GOOD VHC/VHV

- The following were revealed to be the attributes of a good VHC and VHV

i) Good VHC Members

- Those who could make home visits checking good Sanitation
- Members who could give Health Talks
- Good behaviours, manners, kindness, devotion, Hard working and self motivation

ii) Good VHV (Attributes)

- Education, self motivation, hard working
- He/She must be literate
- Calm and one who keeps her surrounding clean

3 4 FREQUENCY OF HSAs VISITS TO THE VHC/VHV

It was found that 70% of the HSAs who were visited attends VHCs meetings once every month or once after some months 60% of the HSAs just go straight to the VHVs whenever they want something to be done Sometimes they just meet the VHC Chairman only when they want something to be done by either the VHC or the Community

3 5 DUTIES OF VHC/VHV

60% of the VHCs and VHVs visited know their duties very well In some villages the VHCs nor the VHVs do not know their responsibilities Since they were selected by the Community, they have not under gone any training thus VHCs/VHVs from Maide and Pende In these villages, they don't meet regularly For instance, VHCs from Jeke last met on 29th August, 1996 whereas those from Chagambatuka last met in March, 1996 At those meetings they discussed about

- ways of preventing water - borne diseases
- Encouraging the Community to have or reconstruct latrines
- The need to make san plat/have TBA and U/5 mobile clinic/have minor treatments such as TEO, Aspirin and Fansidar (SP)

4 0 RELATIONSHIP OF VHCs WITH VARIOUS GROUPS IN CHIKWAWA CENTRAL AND SOUTH

Group	Villages										Average remarks
	1	2	3	4	5	6	7	8	9	10	
Community	G	B	B	B	G	G	G	G	G	-	Good
VHV	G	G	B	B	B	G	G	G	G	-	Good
HSA	G	B	B	B	B	G	G	G	G	-	Good
Village Headman	G	G	G	B	G	G	G	G	G	-	Good
Health Centre/ Hospital staff	B	G	B	B	G	G	G	G	G	-	Good

KEY

G stands for good relationship
B stands for bad relationship

	Name of Village	H/CENTRE
1	Jeke	Makhwira
2	Mpingasa	Makhwira
3	Chagambatuka	Maperera
4	Maide	Maperera
5	Pende	Chikwawa
6	Binya	Chipwaila
7	Chambuluka	Nkumaniza
8	Mandele	Dolo
9	Rabu	Dolo
10	Mponya	Ngabu

NB from the chart it can be reported that the relationship between the VHCs and the Community, VHV, HSA and Health

Centre staffs is bad in Chikwawa Central and good in Chikwawa North due to the following reasons

- Lack of cooperation among members of the VHCs
- Lack of supervision by the HSAs
- The HSAs channel of visiting the VHVs They do not follow the right channel
- Some of the VHC members are not known by the Community as well as by the Health Centre or hospital staffs
- Above all, the VHVs do not report their findings to the VHCs
- In Chikwawa South the relationship is good in most areas because of close supervision of the HSAs and cooperation among members of the Village Health Committees

5 0 DISCUSSION OF M4E BETWEEN THE VHCs AND THE COMMUNITY

- It was found that some of the VHC members as well as the Communities just saw the HSAs doing M4E in their respective villages This was reported in 8 villages out of the 10 which we visted

- The HSAs did not explain the definition and the purpose of M4E to neither the VHC nor to the Community

- Eventhough the HSAs did not explain the purpose of M4E, in some villages, they were accompanied by some VHC members

- Worse of all, most of the HSAs did not conduct feedback sessions From the ten villages covered ,only one HSA from Rabu was found to have conducted a feedback session after visiting 5 households

- To improve M4E, the VHCs as well as various Communities requested HSAs to hold meetings where they could explain the purpose of M4E They further more requested them to conduct feedback sessions where they could present their findings and discussing with the VHC/Community on the solutions of solving those health problems Besides this, the VHCs requested the HSAs to be accompanied by VHC members when doing their work

SECTION B

6 0 OBSERVATIONS

The following were our observations in task 5 0

- The HSAs did not follow the right procedure of conducting M4E in their respective villages They did not hold meetings with the VHCs nor the Communities where they could tell them what and the purpose of conducting M4E in Malawi

- It was also noted that some HSAs who did the work without the consultation of neither the VHCs nor the Communities, did not conduct any feedback sessions

- We were impressed at Rabu where it was found that Mr Luwis Katande, the HSA, was reported by the Community to be doing M4E properly Since he started this task n January he had already

conducted one feedback session in Rabu village

- In some villages, (Mponya as an example) there ~~are~~ was an old VHCs which ~~were~~ was selected in either 1989 or 1990 The~~se~~ committees is ~~are~~ not working

SECTION C

7 0 RECOMMENDATIONS

From what we observed with my workmates I would recommend

- Ministry of Health Personnel Official and I E F should jointly look at ways of supervising HSAs on M4E Programme

- Ministry of Health and Population (MOHP) in collaboration with IEF should reform VHCs in those villages where there are no VHCs and train them on there duties IEF should come up with an assessment where we could trace villages in Chikwawa South and Central which have no VHCs

- I E F to hold refresher courses with HSAs inorder to find out

  (i) problems which hinder the HSAs in carring out their M4E Programme

  (ii) reasons why M4E feedback sessions are not conducted by the HSAs

  (iii) ways of how they can make those 7 HSAs who were not trained in M4E to participate into this national exercise For instance, Mr Mangwaya an HSA who is responsible for Pende know nothing about M4E but surprisingly enough he was given the forms to do the work which he doesn't know

SECTION D

8 0 CONCLUSION

I sincerely thank the organization for allowing me and Mr Alifinali to conduct these assessments whose aim ~~is~~ was to monitor M4E progress in the entire Chikwawa district It is at these FGD where we have been asking HSAs to present M4E to both the VHCs and the Community

9 0 APPENDICES

Appendix 1

DATE	VILLAGE	CATCHMENT AREA
09/10/96	Jeke and Mpingasa	Makhwira
10/10/96	Chagambatuka and Maide	Maperera
11/10/96	Pende	Chikwawa
30/10/96	Binya and Chambuluka	Chipwaila/ Nkumaniza
31/10/96	Mandele and Rabu	Dolo
01/11/96	Mponya	Ngabu

Appendix 2

NAME	ROLE
Mr George Mekiseni	Facilitator
Mr Mathews Alifinali	Note-Taker
Mrs R Zangazaga and Mr H Kalavina	Core Note-Takers

Appendix 3

GUIDING QUESTIONS FOR OUR FOCUS GROUP DISCUSSION ON M4E

FOCUS GROUP DISCUSSIONS WITH VHCs AND THE COMMUNITY ON M4E

INTRODUCTION (10 minutes)

(a) Welcome all participants and thanks for their coming

(b) Self introduction,(your name, who you are in this village, how long you have been in this area and hobby)

(c) Points of our Focus Group Discussion are

- Makeup and purpose of VHC,
- Relationship of VHC to the Community, HSA,VHV, Headman and Health Centre / Hospital,
- Monitoring for Empowerment Programme
- "We are here to learn from you what you know about the three mentioned issues "
- "We are not here to teach or judge you We are interested in your ideas, comments and suggestions "
- "All comments both positive and negative are welcome "
- "There are no right or wrong answers "
- "Please feel free to disagree with one another We would like to have many points of views "
- "Your opinions and ideas are important because they will be used to suggest ways to improve M4E, to make it more accessible and useful to communities "
- ' Our discussions will take approximately two hours "

(d) Introduce the Note Taker

GUIDING QUESTIONS

1 Makeup of the VHC using name cards

(a) How are VHC members chosen within this community?
(b) Is your VHV a member of the VHC? Yes [ ] No [ ]
(c) How many members are on the VHC? ____ Women ____ Men____
(d) Why is this committee active/ inactive?
(e) What are the attributes of good (i) VHC, (ii) VHV?
(f) Does the HSA attend the VHC meetings? Yes [ ] No [ ] / Which ones?

2 Purpose of the VHC/VHV

(a) Duties of the VHC/VHV
(b) How often does the VHC meet among themselves? Who attends?
(c) When did the VHC last meet? What was discussed?

3 Relationship of the VHC with the

(a) Community
(b) VHV
(c) HSA
(d) Village headman
(e) Health Centre/ Hospital staff

3 1 Does the VHV report her findings regarding coverage or other indicators to the VHC on regular basis? Yes [ ] No [ ]
3 2 How do both VHC and VHV describe their current level of performance?

3 4 What problems hinder both groups in carrying out their duties? (that's if the VHC is inactive)

3 5 Why do VHCs work better in some communities than others ?

3 6 What can be done to improve your work for the better/best?

4 Discussion of Monitoring For Empowerment between the VHC and the Community

(a) Who in the VHC / Community knows of M4E?

(b) Who did the explanation ?

(c) How was it explained to VHCs/Community?

(d) Who has assisted/assists the HSA to collect data ?

(e) Who has attended M4E feed back sessions? How many times ?

NB If the VHC/Community knows M4E, then use action continuum to gauge progress

(f)Brainstorming ideas for ways of

- improving M4E,
- making M4E more accessible/useful to the community
- communicating information

REPORT OF 2ND INITIAL M4E TRAINING HELD AT MITOLE RESIDENTIAL TRAINING 7TH - 11TH OCTOBER 1997

FOR THE PERUSAL OF

THE PROJECT MANAGER
IEF CHILD SURVIVAL PROJECT
P O BOX 142
NCHALO

COMPILED BY

GEORGE MEKISENI
EVALUATION/TRAINING COORDINATOR
IEF CHILD SURVIVAAL PROJECT
P O BOX 142
NCHALO

COPY

THE COMMUNITY HEALTH COORDINATOR
IEF CHILD SURVIVAL PROJECT
P O BOX 142
NCHALO

DATE 25TH OCTOBER 1997

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1.0 INTRODUCTION

The purpose of this training was to equip newly recruited Government HSAs and their supervisors with methods of doing Monitoring for Empowerment in their respective assigned villages. It drew 36 participants from all the corners of Chikwawa District. Appendix I is a list of participants and their stations.

This was the second training of HSAs organised by IEF. The first one was in January of 1996 by MoHE followed by the second one which took place in August of this year funded by IEF.

On his opening speech The Project Manager encouraged all participants to be available through out the training period. He further asked all HSAs to collect the Data properly and to demonstrate the skills grasped at the training honestly.

SECTION A

2.0 THE COURSE CONTENTS

The Course Contents were as follows:

- M4E objectives and introduction of Empowerment
- Link between collection of the Data and its use
- Explanation of the overview History and Role of M4E
- M4E indicators and definitions of certain terms used in M4E such as household severe weight for age oedema etc
- Interview tips
- How to fill in village tracker sheet household monthly collection format weep sheets
- Vitamin A Definition Sources Importance Factors which hinder vitamin A availability to the body and consumption of VA vitamin A supplementation and Documentation

3.0 FACILITATORS

Facilitators for this training were only three instead of four. Mr Gondwe was committed to other duties. Appendix III is a list of the Facilitators who facilitated this training.

SECTION B

4 0 OBSERVATIONS

Below were my observations

- Participants participation was better as compared to what was observed at the first Initital Training we had at Ngabu in August
- A few of them did not take the training to be helpful in their field because of the behaviours they showed A good example are Messrs Msivarhanje Seven and Nyapigoti who did not show up when thier friends were doing Post Test
- Facilitators coordination and cooperation throughout the entire training was very good
- The venue of the training was quiet and good

SECTION C

5 0 RECOMMENDATIONS

- Some HSAs should be warned of their misconduct punctuality is very crucial on every business
- There is need to go round to the sites where these HSAs are working in order to supervise M4E activities

SECTION D

6 0 CONCLUSION

Sincere thanks should be extended to Mr Kanzondeni for his dedication Many thanks to Mr Allimali who fought tooth and nail in preparation of the budget for this training

7 0 APPENDICES

M4E INITIAL TRAINING HELD AT MITOLE RESIDENTIAL TRAINING CENTRE (CHIKWAWA) 7TH - 11TH OCTOBER, 1997

APPENDIX II RESULTS OF PRE POST TEST

	NAME	PRE	POST
1	Mr H Kalazina	90	100
2	Mr C M Kalipinde	78	94
3	Mr E Harawa	72	84
4	Mr P B B Lamanula	72	84
5	Mr W L Mpasanjesi	70	90
6	Mr S M Chakamba	70	90
7	Mr Kennedy W Thala	68	100
8	Mr P F Saidi	68	99
9	Mr G G Mpembereza	65	100
10	Mr S Mkuzi	65	77
11	Mr L Mwanza	63	88
12	Mr Lovemore seven	62	Did not write (run away)
13	Mr Hellence JB Mapanda	68	100
14	Mr D L R Chikuni	65	95
15	Mr V Chilenje	60	81
16	Mr Francis Kautale	60	95
17	Ms G Chatsilizika	60	95
18	Mr P A D Tsaka	59	95
19	Mr H J Msivabhanje	59	Did not write (run away)
20	Mr C P H Jangao	58	95
21	Mr T L Malunga	58	81
22	Mr A F Shuva	56	75
23	Mr M Billy	55	88
24	Mr L R P Mchakati	55	92
25	Mr V F Mombeza	50	100
26	Mr Kelvin Manjolo	48	95
27	Ms C Baba	48	68
28	Mr W L L Thengo	came late	95
29	Mr J Chelani	40	80
30	Mr Jailosi	39	95
31	Mr Mnesa	58	80
32	Mr Lauli	52	96
	Mr Muhame came late did not attend was committed in other unit		
34	Mr A L Nzapina came late run away from the test		
35	Mr V C Chimwaza came late did not write		
36	Mr Maida L	42	81
37	Mr Benson T	52	78
	average score ----	60%	94

* This shows an understanding increase of 34 this 94% - 60

APPENDIX III

Names of Facilitators who facilitated the training full time 7th to 11th October 1997

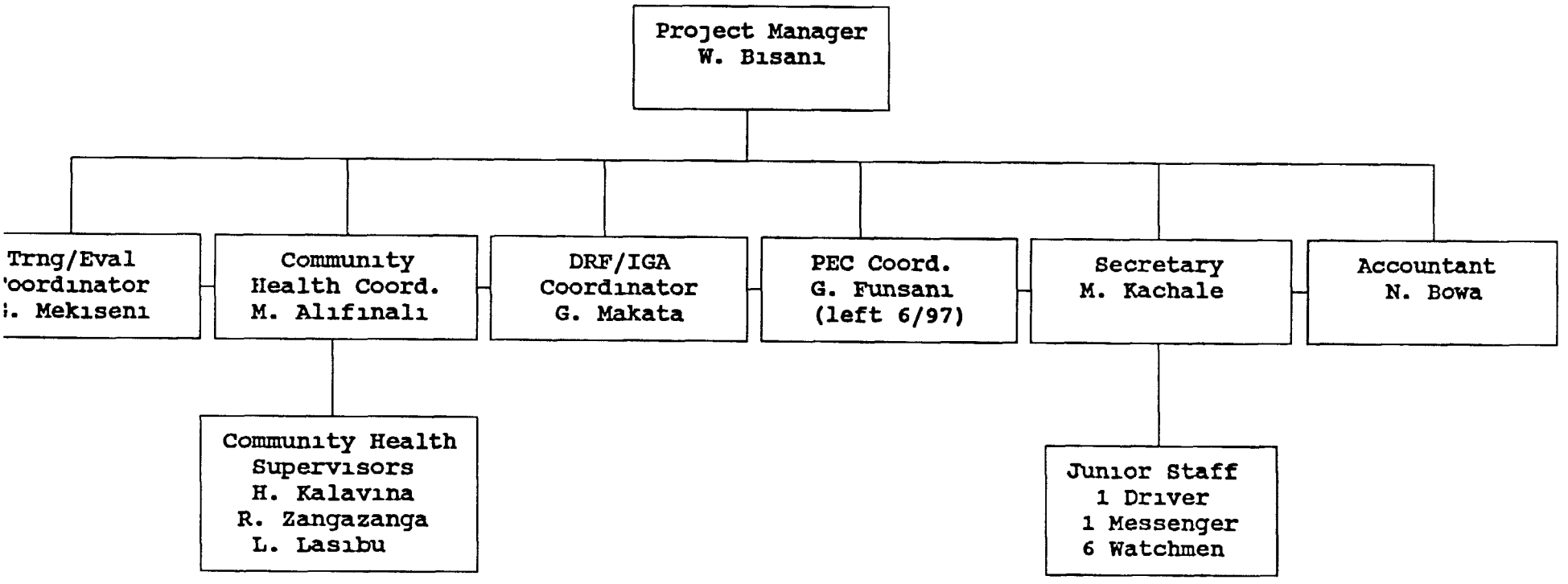
NAMES

1 Mr Kanzendeni from Chirwawa District Hospital
2 Mr Melisani from IEF (CS) Project
3 Mr Alitinali from IEF (CS) Project

ANNEX 8

IEF CS X ORGANOGRAM

IEF Malawi Child Survival Organogram



May 29, 1998

ANNEX 9

CS X PIPELINE ANALYSIS

PVO/COUNTRY MALAWI
Cooperative Agreement No FAO-0500-A-00-4041-00
DATE SUBMITTED TO USAID 08/31/98

COUNTRY PROJECT PIPELINE ANALYSIS PART C - HEADQUARTERS/FIELD

		Total Agreement Budget 09/01/94 to 02/28/98		Actual Expenditures to Date 09/01/94 to 02/28/98		Balance	
I DIRECT COSTS		AID	PVO	AID	PVO	AID	PVO
A PERSONNEL (salaries wages fringes)	1 Headquarters-wages/salaries	37,045	32,497	32,398	33,470	4,647	(973)
	2 Field Technical Personnel wages/salaries	179,192	41,387	194,355	32,202	(15,163)	9,185
	3 Field Other Personnel-wages/salaries	15,629	10,629	16,002	8,629	(373)	2,000
	4 Fringes Headquarters + Field	74,627	27,956	72,452	27,529	2,175	427
	SUBTOTAL PERSONNEL	306 493	112,469	315 207	101,830	(8 714)	10 639
B TRAVEL/PER DIEM	1 Headquarters Domestic (USA)	0	4,725	0	469	0	4,256
	2 Headquarters - International	34,610	0	7,235	7,451	27,375	(7,451)
	3 Field in country	6 000	0	24,929	5,964	(18,929)	(5,964)
	4 Field - International	15,450	18,800	15,079	4,039	371	14,761
	SUBTOTAL TRAVEL/PER DIEM	56,060	23,525	47,243	17,923	8,817	5,602
C CONSULTANCIES	1 Evaluation Consultants - Fees	6 250	6 250	11 612	2 275	(5 362)	3 975
	2 Other Consultants Fees	6,000	10,000	12,096	19,789	(6,096)	(9,789)
	3 Consultant travel/per diem	5 000	5 000	4 445	7 679	555	(2 679)
	SUBTOTAL - CONSULTANCIES	17 250	21 250	28,153	29,743	(10 903)	(8 493)
D PROCUREMENT (provide justification/ explanation in narrative)	1 Supplies						
	a Headquarters	3,000	0	0	951	3,000	(951)
	b Field Pharmaceuticals (ORS, Vit A, drugs, etc)	0	25,000	595	3,712	(595)	21,288
	c Field Other	18,600	0	45,866	14,161	(27,266)	(14,161)
	2 Equipment						
	a Headquarters	0	2,500	0	0	0	2,500
	b Field	0	6,600	0	31,688	0	(25,088)
	3 Training						
	a Headquarters	0	0	0	207	0	(207)
	b Field	144,550	0	77,800	12,400	66,750	(12,400)
	SUBTOTAL - PROCUREMENT	166 150	34 100	124 261	63 119	41 889	(29 019)
E OTHER DIRECT COSTS (provide justification/ explanation in narrative)	1 Communications						
	a Headquarters	0	9,900	202	5,876	(202)	4,024
	b Field	4,114	1,000	12,065	3,172	(7 951)	(2,172)
	2 Facilities						
	a Headquarters	0	0	0	0	0	0
	b Field	48 600	0	35 856	10	12 744	(10)
	3 Other						
	a Headquarters	0	4,200	0	2,770	0	1,430
	b Field	82 500	24 700	115 914	10 938	(33 414)	13 762
	SUBTOTAL OTHER DIRECT	135,214	39 800	164 037	22 766	(28,823)	17 034
TOTAL DIRECT COSTS		681 167	231 144	678 901	235 381	2 266	(4 237)
II INDIRECT COSTS							
A INDIRECT COSTS	1 Headquarters	110,349	32,731	112,615	32,390	(2,266)	341
	2 Field (if applicable)						
TOTAL - INDIRECT COSTS		110,349	32,731	112,615	32,390	(2,266)	341
[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]