

5th QUARTERLY REPORT

MARCH - JUNE 1999

CHIKWAWA DISTRICT

CHAPS PROJECT

CHIKWAWA DHMT

and

INTERNATIONAL EYE FOUNDATION

JUNE 1999

1. INTRODUCTION

Most activities planned for April to June 1999 have been carried out. Most staff members are now identifying themselves with the project and that each has a role to play. CHAPS is not just another of the NGOs project. Most members of staff are beginning to see the benefit of developing and using plans to carry out activities. However, continuous guiding and coaching are still necessary.

The plans for this quarter included those activities that were carried forward from the 1998/1999 Annual Plans and some new activities for the year 1999/2000.

2. ACTIVITIES

2.1 CAPACITY BUILDING

2.2 April to June 1999 Plans

- a. Completing fleet management plans and training for drivers and motorcycle riders
- b. Accounting and stock control management
- c. Radio communication system
- d. IEC needs assessment, training and material development and testing.
- e. QA training and development of QA training in response to QA assessment
- f. Development of architectural plans for Ngabu Rural Hospital
- g. VSC training
- h. Purchasing of NRH theatre equipment
- i. Health Information System
- j. District administration and management

- Cost sharing plan
- Open staff appraisals
- Staff and budget meetings

Achievements

a. Fleet Management

Most of the recommendations given by the consultant were carried out. All of the vehicles recommended for repairs were sent for repairs. Five out the six sent have been completed and returned for use, but the estimates for one double cabin Toyota pick up was prohibitive, the repair and body work costs were more than half a million. This was returned with no repairs done and as a result Chapananga health centre may not have a vehicle as planned or recommended. The truck is fully functional now. It is being used for all supplies collecting, distribution to NRU, CDH and some accessible health centres. The advantage for having the truck is its good fuel consumption and the amount of goods it takes at a time.

The mechanic was sent to Stansfield Motors to be trained on maintenance of motor cycles. He will carry out all the maintenance work except major repairs that would be referred to the dealers. The training lasted for three days and a list of tools for use in vehicles and motorcycles maintenance and repairs were recommended. Beta company has been asked to put together the recommended tools together for purchase. Once the tools are in place the mechanic may carry out most of the work thus reducing time lost while vehicles are in the garage and the high costs for repairs. A simple shed will be built for the convenience of the mechanic.

The Transport Officer is now being trained on the job and is proving quite capable.

The principle for one driver to one vehicle was discussed and approved by management, but will only be fully implemented when all the vehicles are on the road.

The policy for motorcycles has been developed and all riders given a copy. The motor cycles were included as part of the fleet and a motor cycle trainer was brought in from Stansfield Motors to train the riders. The training took three days and was very helpful training to both the new riders and the experienced ones. It was only after this training, that the motor cycles were allocated to the users. All other items that go with motorcycles were issued then and each rider was given the new formulated policy for motorcycles (see Appendix I for a copy other regulations).

b. Accounting and Stock Control

i. Accounting System:

During the QAP workshop, a detail plan for improvement of the system was developed. Technical assistance was evidently still a need, but before the arrival of the TA the district was to carry out two activities. The first was the formation of a Financial Management Committee (FMC) and secondly carry out an in house assessment of the current accounting system.

Early in June the FMC was formed. The members include Mr. Mgeni, Accounts Clerk, Dr. Ratsma, DHO, Mrs. Phiri, AG. District Administrator, Mr. Chola, IEF CHAPS Systems Advisor and Ms Naisho, Project Manager. Mr. Chola was asked by the team to study and produce a report on the present system. This report would help the FMC work out the scope of work for the TA.

ii. Accounts System Needs Assessment

An assessment of the present accounting system for the hospital revealed that no proper system is in place. The system does not have a trial balance that is the basic tool for checking the accuracy of the financial entries. No double entry book is keeping which would enable the accountant to extract a trial balance each month. However, the accountant records the payments in a ledger. This ledger does not show any account categories. It is therefore impossible to detect and control the expenditure for each category. All transactions are on cash basis. All vouchers for payment are written by the Accounts Assistant authorised by the Deputy District Health Officer and counter

signed by the District Health Officer. These vouchers are taken to the Regional Health Office where cheques are issued to the various payees.

The Accounts Assistant prepares and sends information as to hours and days worked. This information is therefore, used at the headquarters to prepare staff salaries. Wages are also prepared at Headquarters and only the pay sheets and the cheque is sent to the Accounts Assistant who cashes the cheque for payment to staff.

Similarly, all applications for salary advances and loans are made directly to Headquarters who keep all the necessary records. Salary increases for all staff members are done at headquarters. All salary deductions are recorded at Headquarters, but each individual has to follow their deductions very closely. The individual will inform the Accounts Assistant immediately the advance or loan is deducted in full. If the individual does not follow, deductions may be continued long after the loan or advance has been deducted in full.

MOHP has plans to introduce a new system by which all financial transactions. A bank account will be opened at nearest National Bank.

The project had planned that a computerized system would simplify budget transactions and serve as quick reference.

Their first meeting took place on 11 June 1999. The discussions were guided by a report on an internal assessment of the present accounting system. After discussions, the following scope of work for the account's TA was drawn and sent to QAP.

iii. Scope of Work for the Accounting Consultant

The consultant will be expected to:

1. Carry out an assessment of the present manual accounting system.
2. Suggest an accounting system that can probably produce certain pertinent financial statements or information such as:
 - a. Total expenditure per month by categories or accounts according to the way the budget will look.
 - b. Expenditures compared to budget each month showing the variances.
 - c. Best system to account for stores.
 - d. Help in developing a simple and applicable accounting system for keeping petty cash, bank account, debtors and creditors.
 - e. Preparation of wages. The consultant should liaise with headquarters.
 - f. Monthly management accounts.
3. Based on the size of the district's budget and the various transactions, advise the district on the number and level of personnel that would adequately manage the system.
4. Identify a computerised accounting package that would be compatible to both the district and headquarters.

5. Strengthening and the improvement of the district accounting system started last year. The DHMT set up a budget meeting. This meeting was to ensure that priority needs were taken into considerations before funds were disbursed and that some documentation was done. However, the accounting system was still a very weak area.

iv. Stock Control

a. General Stores

- During the QA workshop the participants went the PDSA cycle and suggested ways for improving stock control system in the district. An internal need's assessment was to be carried out. This was done end May 1999.
- The store staff member is one and has not had any formal training for store keeping. He was working as a ward's clerk before transferred to stores. This raised many problems in stores management. Some main problems identified were:
- The general cleanliness and layout of the store were not in order. New and boarded items were mixed up and this made any checking difficult
- Ledger books were badly, some pages were loose and recipients of issues do not sign for supplies
- Filing had not been carried out for ages
- No tally cards for stores
- Items were not stored according to categories
- Some items were expired

Recommendation for Improving Stores

While awaiting for a proper stores person, the current stores person was given a list of activities to put in place to improve stores. The DHO and the Acting Hospital Administrator will help the stores clerk to carry out the following:

- Carry out spring cleaning and this should be reinforced by daily routine cleaning.
- Arrange all store items according to categories, open tally cards for recording each item and label all supplies on shelves. Record new stocks in the ledger, ensure that any person receiving issues sign for all items taken and then file all delivery forms/notes. Separate consumable from non-consumables and set a section for all boarded items.
- Another stores inspection was scheduled for 30 June 1999.

b. Pharmacy

An indepth assessment for pharmacy will need to be carried out. This will identify bottlenecks for the lack of flow of drugs from CMS to District and from District to Health Centres. After this an ideal

manual system for drugs movement will be set.

3. RADIO COMMUNICATION BETWEEN HEALTH FACILITIES

In May 1999 most radios for health facilities and the two ambulances were installed. These are now functioning and since then 28 calls have been received. Out of these 12 were ambulance calls for maternity patients (11 with difficult deliveries and one with ectopic pregnancy), seven patients with anaemia, seven with severe malaria, one with meningitis and one with a fracture. Three remaining health centres, Gaga, Chithumba and Chapananga will have radios fitted once River Mwanza has subsided.

4. QUALITY ASSURANCE PLANNING WORKSHOP

A workshop was held at SUCOMA training Centre for two days, 22-23 April 1999. The agenda for this workshop was based on:

4.1.1 Fleet Management

The district had already developed its plans following the TA recommendations. Therefore, this workshop was used to review the plans and develop strategy for continuous improvement of its fleet. Areas reviewed were:

- a. Root causes identified through consultancy
- b. Proposed solutions and recommendations
- c. Scheme in place for monitors

(see full the report under fleet management)

4.1.2. Areas of Specialised Technical Assistance

- a. Accounting System
- b. Stock Control
- c. Coaching and Training of Trainers (TOT) in supervision and hygiene
- d. Operation research on customer satisfaction. (The participants felt that this may not be necessary for Chikwawa now, because the QA assessment that was done last year had given adequate information for areas of need).

a. Accounting

The participants and the facilitators worked out plans for the accounting systems. Most of these were to be carried out by the district with no outside help as reported earlier in this report. On the accounting system the district was to develop a scope of work for technical assistance while the QAP was to continue the search for a consultant.

b. Stock Control

The participants discussed at length the best option for improving stores, given the options for a computerized system and a manual system. Some issues discussed were the amounts /size of the district's stores, personnel available and the time factors. One concern was how sophisticated a system could the stores staff manage. In the end it was decided that the manual system would be better for the time being, a computerized system could be tried in the future.

A plan for what would be done to improve the store was developed. The achievement has already been written under Capacity Building Achievements.

c. Training of Trainers

July 1999 was set for coaching and TOT workshop and field practice. It was planned that the Chikwawa core team have the TOT training with the Mulanje core team in one venue and coaching of the same TOT members would then be done at their respective district.

4.1.3 Training Needs

USAID has some funds for capacity building for some members of staff from the six districts. Each district is expected to identify their training needs and persons to be trained, then send the information directly to USAID.

Chikwawa has already identified two Medical Assistants who are health-centre in charges to be trained on short courses for management of integrated community-based health care and health centre administration. Although the training needs are many, the district has definite shortage of staff, this is a concern that needs to be considered. Most health centres have one MA and replacement while away in training may be difficult. The Clinical Officer who is currently the in charge for Ngabu Rural Hospital has been identified for middle level management training. The actual training, venue and length will be completed by 25 June 1999.

5. NGABU RURAL HOSPITAL

The Ministry of Works have completed the plans for a theatre and the alternative building for a stores and hospital kitchen. Two quotations have already been received from two contractors.

6. DISTRICT ADMINISTRATION AND MANAGEMENT

6.1 Cost Sharing

During the DHMT meetings, it was found that the district was losing back to treasury funds

supposed to be spent in the district because it had no separate account. It was planned that the DHO will liaise with the region for a cost sharing account be opened for the district. This account would cater for staff soft loans refunds, i.e. telephone refunds, extended family members' expenses for coffins etc.

6.2 Open Staff Appraisals

In the past appraisal forms if filled were being filled without any discussion with the individual staff member participating in the exercise. Such reports could be open to some bias.

The open appraisal is a new system but will be introduced for it may give both the supervisor and the staff member to discuss on individual strength and weaknesses. The first assignment was to get samples of open staff appraisals, discussed with the DHMT, staff members for comments, the region and the headquarters for concurrence. Two samples have been collected and will be discussed on 22 June 1999 during the DHMT meeting.

6.3 DHMT, Staff General and Budget Meetings

The DHMT has met twice for the routine monthly meetings and discussed both technical and district administration and management issues. Minutes of both meetings are available for referral. One importance issue discussed were hospital cleaning day for both CDH and NRH. Ngabu Rural Hospital has cleaned the hospital and one can see the difference before and after. CDH hospital had some administrative differences and so the cleaning has not been carried out yet. This has now been planned to take place on (To be included after DHMT of 22nd)-----.

Staff general meetings have been held twice. The main agenda for staff meetings were issues related to staff welfare.

Eight meetings budget meetings have been held three were for monthly budget on funds given to the district for expenses incurred and purchasing. The government year ends in June. Each District was therefore expected to develop a three-year budget and present it to headquarter. Using the instructions given, the district held five meetings and worked on the requirements and costings. Mr. Chola, IEF Systems Advisor helped and trained the IEC Officer in a spreadsheet. Both of them then computerized the budget, produced the necessary document that was then sent to Headquarters.

6.4 Staff Development

1. Mr. Nyahoda, Clerk/Messenger was sent for a messenger course at Mpemba Training Centre
2. Mr. D. D. Semu, IEC Officer has been trained on the job on the Spreadsheet program
3. Mr. Mgeni, Accounts Assistant, is undergoing an on job computer training
4. Mrs. Y. Uzamba, the Copy Typist is undergoing an on job computer training
5. Mrs. Gausi, Mr. Gogoda and Makanjira have started the VSC training under at Banja La Mtsogolo from 25 June to 2 July 1999.

7. HEALTH INFORMATION SYSTEM

Mr. Chunga and Dr. Ratsma have collected some data and started working on the district's 1998 report. However, HIS in the district is still an area of concern, therefore a one day workshop have been set for health centre staff to take place on 23 July 1999. HSAs seemed to have been using different forms for sending reports to the district. Such a system is inadequate, therefore, all the different forms have been collected for review and possible development of a standard form.

8. PROJECT INTERVENTION

8.1 INFORMATION, COMMUNICATION AND EDUCATION (IEC)

Development of a Comprehensive Plan for IEC in the District

The district, with the help of IEF Blantyre office UNICEF gave the names of Abigael Dzimadzie and Mr. Gresha Mwandira. as possible local consultants but no response from these two through the contact numbers given. However, a consultant from Family Planning Private Sector, Nairobi has been contacted as a possible candidate for this work. These two consultants have not responded yet. Once the right person is identified, the work may begin in July/August.

8.2 REPRODUCTIVE HEALTH

8.2.1 April to June 1999 Plans

- a. Complete the ongoing need assessment for outreach shelters
- b. Complete needs CBD primary supervisors' assessment reports
- c. Start CBD training based on findings

Achievements

a. Outreach Shelters

April and May were busy months for the search on information on the ninety-three outreach centres in the district. Visiting and assessing all the ninety-three shelters, given the short life of the project would not be possible. However, the team that was working on this exercise drew up some criteria for the assessment.

- Geographical location and relationship to any of the existing health facilities
- Distance to facilities
- Area population
- Accessibility
- Community commitment
- Availability of a structure and its condition

The team that was working on the assessment included, Mr. Chunga, DEHO, Mr. Chimwaza, NRH ADEHO, Mr. Mulenga, Nchalo ADEHO, MR. Gobede, MCH Coordinator, Mr. Mtambarika, ADEHO Eastern Bank and Mr. Bwanali, CHAPS Community Health Coordinator. Six outreach centres were visited in this quarter.

The population ranged between 3,500 and 6424. The average distance that these communities have to travel to the nearest health facilities was 12 km with a range of 7km to 21km. Although some distances were as near as 7km to the centres, the geographical location made accessibility difficult. This was more so for those outreach centres that were on the mountains. Accessibility was made worse during the long rainy period.

Community commitment was found to be positive in all the six areas. Some communities had lost hope for two or three years had passed before the MOHP came to help them after their initiative of collecting and making construction bricks. Some communities had up to thirty five-thousand bricks the least had ten thousand. Some centres had up to MK10,000 for purchase of the extra needed bricks.

Early in 1998, Montfort Hospital constructed M'Bande outreach centre. This was not completed too small and was not built to the MOHP specifications. Some important structure were not fixed, e.g. windows and doors. The teaching area was too small to hold members of the communities for health education. Overall construction work for this centre was incomplete.

b. Needs Assessment for CBDAs Primary Supervisors

A community-based distribution program started in Chikwawa in 1992 and since then ninety three (93) CBDAs have been trained. While the CBDAs were being trained, thirty-two (32) HSA was trained as primary supervisors. However, very little or no report was being received at the district on CBDAs work.

International Eye Foundation STAFH and Child Survival Project have been involved in helping the MOHP in the Community-based Distributors Program (CBD) in Chikwawa District. The Program started seven years ago, in 1992. This program had several activities. The first activity was creating an awareness and helping communities in the selection of members for CBDA training, Second, carrying out the actual training. A system for supervision was developed. Selecting and training primary supervisors was also done. Since then, IEF Child Survival Project trained 20 CBDAs and 12 HSAs as primary supervisors, while IEF STAFH project trained 73 CBDAs and 18 supervisors. This gave a total of 93 CBDAs and 32 primary supervisors. The few trained CBDAs and supervisors cannot adequately cover the whole district. Therefore, need to select more community members for this role. CHAPS has funding for the DHMT to extend the CBD program to needy areas of the district.

IEF STAFH project who had helped the MOHP from 1992 to date had realized that the current trained CBDAs have not been adequately functioning. The primary supervisors did not report any progress on CBDAs activities neither did they collect any contraceptives for CBDAs in their catchment area. The project thought that the problem could have been due to poor supervision or could have been due to inactive CBDAs or that the primary supervisors were not doing what was expected of them. To find out the actual problem, it was decided that a study was necessary before any more CBDAs were trained. The targets for this study would have been either the CBDAs or the HSAs. However, after discussions and examining the logistics involved in any study, it was decided that HSA would be an easy target group than CBDAs.

Findings

The training was carried out following the government laid down standards were applied in the selection process and training of CBDAs. Recruitment was done by the communities following several publicity sessions. During these sessions, the Community Health Committees were given the laid down criteria for CBDAs selections. Once the selection was done by the community, four classes of 15 to 20 participants were carried out. Each group was trained for two weeks, where both the primary supervisors and the CBDAs were trained in all relevant aspect of family planning. At the end of two weeks the CBDAs graduated and each was issued with the CBDA family planning kit. The supervisor stayed in for one extra week, a period used to train them in supervision.

However, the program did not include the CBDAs Secondary Supervisor, the Family Planning Providers in the district. This oversight has had adverse effects in the CBDAs performance, no reports came to the district and the primary CBDAs supervisor had no support form the health facilities.

Besides many other findings it was found that most HSAs knew the types of contraceptives but most of them had forgotten the concept of supervision (59.3%).

Following these findings the following broad conclusions were drawn:

- Family Planning Providers be trained in CBDAs concept and management
- Refresher courses for HSAs especially on their role as primary supervisors
- Refresher courses for the existing CBDAs
- Training of additional CBDAs

In May 1999, eighteen FP service providers were trained in CBD concept and management. Their training will be followed by a series of refresher courses for HSAs and CBDAs. During these refreshers it was planned that a link between each group would be set, i.e. FPSP → ← HSA → ← CBDA.

8.3 COMMUNITY-BASED TREATMENT FOR MALARIA AND DIARRHEA PREVENTION AND ARI

Development of new and revitalizing the old DRF was an activity expected to lead to the achievement of this objective. The plan that was set since last physical year was as following:

8.3.1 April to June 1999 Plans

- a. Completing DRFs needs assessment
- b. Develop a map for location for active and non-active DRFs
- c. Develop a supplementary plan for DRFs activities
- d. Start activities based on findings (remobilise communities, train and replenish DRFs kits)

a. Drug Revolving Fund Analysis

The main objective of this DRF fact finding was to find out the performance of DRFs in the District and come up with a list of active and non active DRFs. Focus Group Discussions were conducted in all the 24 DRFs. Guiding questions were developed and used during the focus groups discussions for all the DRFs visited. These were based on the following:

General Findings

Most DRFs have similar problems. The main ones found were:

- (a) Volunteers or HSAs travel long distances to purchase drugs for their DRFs.
- (b) The District Hospital does not have adequate drugs for its DRFs.
- (c) Regular and effective supervision was not done by the MCH and Malaria Coordinators and the HSAs from the Health Centres.
- (d) DRF funds were misappropriated by some health staff, Volunteers and Village headmen.
- (e) The coordination among the DRF members was lacking.

It was also found that out of the 24 DRFs 14 (70%) were not active. A map showing the location of these DRFs has been developed. The DRFs were not active for one or two of the following reasons:

1. Some Volunteer lived out of the Village. Some of them moved to live near the river banks for farming, therefore, the drug kit was not available for the intended community.
2. Coordination between HSAs and Volunteers was lacking.
3. Most of the required drugs were out of stock.
4. Misappropriation of DRF funds by Volunteers, Village headmen or some health staff.
5. Untrained Villagers dispensing drugs when trained dispenser was absent.
6. In some DRFs, transparency on how the dispenser used the DRF funds was lacking.
7. Expired drugs were found in some drug kit.

General Recommendations

1. The DRF Coordinators may have to develop a system for the safe keeping of DRF funds to avoid misappropriation as was found during the assessment.
1. The district hospital should have adequate drugs for its DRFs. Right now some DRFs will need to be helped with a new start up drugs.
2. In future DRF drugs should also be available at health centre level to cut down on distance for resupply purchasing
3. The district hospital should have a training Curriculum for DRF for standardization of the programme
4. The DHMT should be involved in DRF activities to help recover funds misappropriated by some health staff
5. The Process for setting up and managing DRFs need to be redone in all the DRFs from 1995 to 1997

In planning for reactivating DRFs, the above recommendations will be started in the following priority centres.

- Mangulenje
- Maganga
- Supuni
- Nyalugwe
- Makhula
- Balala
- Njovuyalema
- Machilika
- Kholosi
- Thendo

Community remobilisation for all the above centres will be started early July. These will be followed by volunteer, HSA and VHCs refreshers or training. A system for monitoring and supervision will be set and all participants will be prepared on this.

One finding was that the starting for most of the inactive DRFs was not done to the MOHP specifications. To correct this situation, the training curriculum used in Mulanje is being reviewed to be adapted for Chikwawa District. This is being compared with the MOHP recommendations drawn during the DRFs symposium held in Mangochi in February 1998. Besides these, the district has developed a list of all the supplies needed to be purchased for the DRFs.

8.4 INCREASING ACCESS AND ACCEPTANCE FOR ORT AND DIARRHEA MESSAGES INCLUDING B/F

8.4.1 April to June 1999

- a. List of GMVs and procurement and distribution of ORS
- b. Training of health workers in Chikwawa District hospital for baby friendly approach (exclusive breastfeeding)

a. Inventory of Existing Growth Monitoring Volunteers

Between 1988 and 1996, the district trained 230 growth monitors volunteers (GMVs) spread out to 36 communities. These were expected to weigh all children under five years and distribution of ORS. At the outreach centres they help in organizing the community for immunization and administration of Vit A.

Out of the 230 GMVs 140 (60.9%) were found active and the rest have dropped out from action. A list for both groups and their locations is available in the district. The distribution of ORS has not been that regular due to irregular supplies to the district. This commodity has been included on the list of supplies to be bought this month.

b. Training of Health Workers in Exclusive Breast Feeding

The district planned to make both CDH and NRH Baby friendly. Due to the intensity of the program it was decided that the program would start in Chikwawa district Hospital. The success of this program depends on the commitment of all hospital staff and therefore different levels will require training and orientation.

Thirty health workers were trained in May 1999. Out of these, four were senior nurses who were being couched as future BF trainers in the district. Fifteen of these completed the training but the other fifteen need one extra day to complete what was expected.

8.5. INCREASE ACCESS TO AND ACCEPTANCE FOR CONSUMPTION AND PRESERVATION OF PROTEIN, MICRONUTRIENT AND OIL RICH FOODS

8.5.1 April to June 1999 Plans

- a. Assessment of the outcome of seasons' harvest and training farmers for preservation and use
- b. Prepare seeds and seedlings for November/December seasons

a. The outcome of the 1998/1999 Season's Harvest

In May 1999, Mr. Gobede, MCH Coordinator and Mr. Jamali, IEF Food Security Field Supervisor visited Gola soya and groundnut farms. The farmers have already harvested their crops. The soya was nearly a failure, its production stood at 15-20% but the groundnuts did very well. The production was more than 100% and the Headmen were collecting the 12kg of groundnuts per household for preservation for the next growing season. The soya failed for most of it was eaten by grasshoppers and the rains continued well into the harvest period, thus spoiling the crops before harvest. It was also the first time that the farmers attempted to grow soya, despite the failure, they seemed to like the little harvest and were interested to try again.

Besides the Gola farms, the Nutrition Unit had given the district maize seeds, fertilisers and some soya for communal gardens. In the fifteen villages that tried this program, 11 of them had a 100% crop harvest. Soya like in Gola area did not do as well.

Plans have been made for a series of trainings for the communities to be able to preserve and use their harvest, especially groundnuts and soya. The first training took place in 23th to 25th June 1999.

The district is not yet self sufficient in producing its own seeds to cover all the farmers who have shown an interest in growing both soya and groundnuts. Therefore, in preparation for the coming season, soya and groundnuts seeds have been purchased. Other crops, i.e. fruit trees will be distributed from farmers in Chikwawa through the IEF Food Security project.

b. Preparation for 1999/2000 Seasons

Four villages have shown an interest for developing backyard vegetable gardens. A survey on availability of a continuous supply of water has been done and therefore, these villages will be trained in vegetables growing techniques.

8.6. WATER AND SANITATION

Sato to bring his report on 23rd June

8.7 PRIMARY EYE CARE

8.7.1 April to June 1999 Plans

- a. Carry out a survey for traditional healers' practices
- b. Preparations for school children vision screening to be carried out in collaboration with the District education Officer.
- c. Training of MAs and Nurses in primary and preventive eye care.
- d. Collecting and/or develop primary eye school health education materials

Achievements

a. Survey on Traditional Healers Practices

In 1997, an assessment for KAP study for Traditional Healers (TH) trained on primary eye care was carried out. This study was planned to find out the need for further training for THs. The results were quite revealing especially in practice and the position of these THs in society.

Sixty of the trained healers said that they were registered members of the Traditional Healers Association of Malawi. Some findings were that 18% to 20% were still using traditional eye drops for treatment of conjunctivitis and trachoma, while 53% used other traditional medicines for eye irrigation. Out of the 45 THs interviewed, 69% reported blindness as one of the problem in the district, yet very few of these, 7% referred any cases of cataract to the health facilities.

Following these findings, doing another KAP study now may not be necessary. What was needed are organised refresher courses and/or training. Nevertheless, before these are organised, the district should await the result of a survey of the recently approved program for an alternative approach to eye care in the district. The new approach will:

- A population based survey on the current cataract and trachoma surgical outcome, and factors associated with patient acceptance of surgery in Chikwawa will be done in July through September this year. This information will not benefit Chikwawa only, but will be of benefit to the National Eye Care program too.
- Manage trachoma through surgery for trichiasis patients and treatment of conjunctivitis and prevention through water and hygiene (CU will play an important role in providing water and sanitation)
- Development of a cost efficient outreach system (community ← OMA ← hospital)
- Developing a referral mechanism between health centre, district and QECH

This approach will use process indicators like surgeries completed, people with trachoma effectively treated.

b. Training of Clinical Officers, Nurses and Medical Assistants in Primary Eye Care

Based on a report from the needs assessment for primary eye care, training workshops were organised for health workers in Chikwawa District. Forty-nine health workers, divided into three groups were given refresher courses on the structure and function of the eye, condition that affect the eye and their management.

A pre and post tests were administered for all the groups. The results for first groups ranged from 4% to 45% for the pre test, unfortunately the post test was not done for this group. In the second group the pre test ranged from 5% to 39% while the post test ranged from 41% to 87%. The third group pre test was between 3.8% and 63% while the post test was between 31% and 95%. The results after the courses were very encouraging, but actual practices need to be seen later in the field.

c. Primary Eye Care for School Health

This activity was to take two steps. The first one was to train teachers on PEC and vision screening, supply them with tools for vision screening, then start on school children PEC. The children's PEC will include vision screening and referral and health education on eye hygiene. These activities were to start in the fourth week of June but the timing for national elections have made it necessary to postpone to the month of July.

**8.8. INCREASE HIV/AIDS AWARENESS AND PREVENTION THROUGH
CONDOM PROMOTION AND ADULT LITERACY**

8.8.1 April to June 1999 Plans

- a. Distribution of three thousand condoms was to be carried out during the KAP survey
- b. The KAP questionnaire was to be revised, tested and survey carried out
- c. Request for at least 30,000 condoms for distribution in the district
- d. Review the National HBC survey and use the results in developing a comprehensive plan for Chikwawa HBC
- e. Development of training materials for women literacy and empowerment on negotiation skills in HIV/AIDS prevention

Achievements

**a. Condom Distribution and KAP Study for Bar and Rest Houses Owners and
Workers**

Condom Distribution in bars and rest houses. A consignment of 30,000 condoms has been received. Some of these will be distributed during the KAP study that will be done in July 1999. The questionnaire has not been revised yet.

b. Review of the National HBC Survey

Copies of the National HBC survey report have been produced. The DAC is coordinating the revision for this document. The area that the district is interested most was the recommendation because these could be adapted for Chikwawa and used for the development of a comprehensive HBC plan.

c. Teaching of women to read, write and negotiating skills in HIV/AIDS prevention

In the last quarter it was reported that different types of curricula were collected for review and possible adaptation for the training of women. The curricula that were MOHP HIV/AIDS program, STAFH HIV/AIDS program, MOHP CBD programs, Ministry of Women & Children Affairs and Community Services Literacy, AGLIT and APPLE. All these were reviewed and a CHAPS curriculum produced.

Twenty instructors have been selected from the existing 97 government instructors. These twenty will be trained on Learner Centred Problem Solving Approach (LePSA), an approach that helps the learner discover herself, her problems and how to solve problems identified. A consultant for this training has been hired for this activity. During the training guidelines for using the curriculum will be developed.

9. CONSTRAINTS

1. The district has a shortage of professional staff. This create a problem when rying to respond to the training needs.

10. PLANS FOR JULY TO SEPTEMBER 1999

A. Capacity Building

1. A consultant for Accounting work with the Accountant Assistance and Systems Advisor on the appropriate accounting system for the district
2. Monitoring of the transport management progress
3. Quality Assurance for supervision and health facility hygiene
4. Complete radio system for Gaga, Chapananga and Chithumba health centres
5. Work on HIS for all levels of health management
6. A consultant hired and IEC activities started
7. Ngabu Rural Hospital renovations begin
8. All management meeting continue as scheduled

B. Interventions

1. CBD refresher courses continue for HSA and CBDAs and CBDAs kits replenished
2. Ten inactive DRFs helped to start serving the communities with Malaria, ARI and Diarrhea management
3. Update 40 active GMVs on use of ORS and train 15 new ones on ORS and exclusive breastfeeding
4. Continue training facility health staff on baby friendly approach
5. Continue activities on water and sanitation as planned in the April/March 2000 Annual Plan
6. Start teacher training for a school health program when the schools are closed
7. Carry out the population-based survey of cataract and trachoma surgical outcome and community acceptance for surgery
8. Complete and write a report on literature review on HBC in Malawi and develop plans for the district.
9. Complete the adult literacy instructors training and start 20 female literacy classes

APPENDIX I

DISTRICT HEALTH MANAGEMENT TEAM REGULATIONS FOR MOTORCYCLE RIDERS SET IN APRIL 1999

In the past the motorcycles were assigned to riders with some or no regulation for running and maintenance. This system has had adverse implication on many things, i.e. high running costs for fuel and spare parts, difficulties in motorcycles inventory, the whereabouts and usage. Therefore, the MOHP identified the need to streamline the District's total fleet as early as 1997. The request for finances and technical assistance was included in the CHAPS proposal.

Following the consultants recommendations, the DHMT has developed some regulations governing motorcycles' management.

1. All riders should have either a provisional or a driving licence. Riders will be allowed to renew provisional licence three times, after which he or she must have a road test for the driving licence. It is planned that funds will be made available for riders to get provisional licences and afterwards the riders licence. Each rider must work hard to go through the test needed.
2. All motorcycles purchased under the CHAPS project, will be assigned to only competent riders. Members of staff who may need a motorcycle for work and are not yet competent will have one assigned after satisfying the authorities of his or her competency in motor riding. High codes will be purchased and kept by the Transport Officer who will make these accessible to eligible riders. Mr. Chunga and Mr. Chola will be assessing the riders' competency.
3. All riders must go through an in service training for on preventive maintenance. The training will be carried out by the District Mechanic.
4. **MOTORCYCLES ARE ASSIGNED TO DEPARTMENTS AND HEALTH CENTRES TO BE USED FOR HEALTH ACTIVITIES ONLY. DISCIPLINARY ACTION WILL BE TAKEN IF ONE IS FOUND USING MOTORCYCLES FOR PERSONAL TRIPS.**
5. The persons responsible for motorcycles at facility will be:
 - a. Health Inspector
 - b. Health Assistants
 - c. In special cases some Senior Health Surveillance Assistants

NOTE THE MEDICAL ASSISTANT IN CHARGE SHOULD AUTHORISE ALL TRIPS. If the MA or Nurse has an activity that requires a motorbike, the person responsible should sign it for the intended trip.

6. To help the smooth running and maximum use of motorcycles, the departments will be:
- Issue 40 litres of fuel per month. This will be for all health facilities other than Chang'ambika and Gaga that will be issued with 50 litres a month
 - Issued with Motorcycles Logbooks that must be well filled before and after every trip. These must be presented to the Transport Officer. All riders must have the skill to use the vehicle/motorbikes logbook. Riders and drivers will be trained by Transport Officer to use the document. These must be checked at the time fuel is being issued or at the end of each month. The Transport Officer will regularly assess the motorcycle fuel consumption and report to the DEHO.
 - The DEHO will be authorising trips for ALL motorcycles based at Chikwawa District Hospital, but in his absence the Transport Officer will authorise all trips.
 - The Mechanic will be checking all motorcycles at regular intervals. Each rider and person responsible will be given plans/modules of checking. These plans/modules must be followed for preventive care.
7. When not in use the Motorcycles must always be safely kept at the Health Centre and not at the staff houses. It must be kept indoors, with adequate security, at the Health Centre.
8. The in Charge must immediately report if the motorcycle develops some mechanical problems to the district mechanic
9. Careless riding and misuse of the motorcycle must be reported in writing to the DHO immediately. NOTE: any rider found guilty of misuse and careless breakdowns will be surcharged. On the other hand, if careless breakdown is found by the authorities, yet no report has been received from the In Charge, all riders will be surcharged.
10. Timely and efficient planning of activities for all health sections will enable staff to operate efficiently at a reduced cost in running motorcycles.
11. Motorcycles can only carry a certain defined weight. **DO NOT OVERLOAD** the motorcycle. Take good care of it and it will serve the health centre longer.