International Eye Foundation
Nsanje District Health Management Team

IMPROVED CHILD SURVIVAL IN NSANJE DISTRICT, MALAWI THROUGH COMMUNITY BASED INTERVENTIONS AND STRENGHTENING OF THE HEALTH DELIVERY INFRASTRUCTURE

Mid-Term Evaluation, October 2004

Implementing a XVIII Child Survival Project
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ACRONYMS

ARV	Anti Retro Viral Drugs
BCC	Behavior Change Communication
BCI	Behavior Change Intervention
CHAM	Christian Hospitals Association of Malawi
CSMC	Child Survival Management Committee
DHMT	District Health Management Team
DHO	District Health Officer
DOSA	Discussion Oriented Self Assessment
DRF	Drug Revolving Fund
DTC	District Technical Committee
EPI	Expanded Program for Immunization
GMV	Growth Monitoring Volunteer
HF	Health Facility
HH/C IMCI	Household and Community Integrated Management of Childhood Illness
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HSA	Health Surveillance Assistant
IEC	Information, Education, and Communication
IEF	International Eye Foundation
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Presumptive Treatment
IR	Intermediate Result
ITN	Insecticide Treated Net
KPC	Knowledge, Practice, Coverage Survey
LQAS	Lot Quality Assurance Sampling
MCH	Maternal Child Health
MK	Malawian Kwacha (monetary unit of Malawi)
MOHP	Ministry of Health and Population
NDH	Nsanje District Hospital
OCAT	Organizational Capacity Assessment Tool
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PD Hearth	Positive Deviant Hearth Community Nutrition Methodology
PMTCT	Prevention of Mother-to-Child Transmission (of HIV/AIDS)
PSI	Population Services International
SO	Strategic Objective
SP	Sulphadoxine-pyrimethamine (Fansidar)
TBA	Traditional Birth Attendant
U-5	Under Five
VCT	Voluntary Counseling and Testing
VHC	Village Health Committee

A. SUMMARY

The partnership of International Eye Foundation (IEF) and the Nsanje District Health Management Team (DHMT) is implementing a four year (2002-2006) Child Survival Project in the Nsanje District in southern Malawi. The project includes the technical interventions of Pneumonia Case Management 20%, Malaria 20%, Nutrition 20%, HIV/Aids 20%, EPI 5%, and Diarrhea Case Management 15%. The project's Strategic Objective is: *Families and caretakers with young children increase the practice of healthy behaviors and seek medical care from quality sources*. This objective will be achieved through four Intermediate Results:

IR1. District Organizational Effectiveness and Management Support for Quality Child Care Strengthened.

IR2. Health Provider Skills in Prevention and Management of Childhood Illness Improved.

IR3. Availability and Accessibility to Quality Preventative and Curative Health Services Increased.

IR4. Community Participation, Ownership, and Demand for Health Services Increased.

The implementation of facility based and household/community IMCI through the training of health providers and community volunteers and a system of supportive supervision has been the major thrust of the CSP during the first two years. The IEF/DHMT team is implementing a good quality project in compliance with the DIP and work plan. Some activities have been delayed due to staff shortages at both IEF and the MOHP but there is no evidence that the project is not capable of completing all major activities before the end of the grant period. The strong points of the CSP at the mid point are:

- Population coverage-increased well beyond original targets.
- Development of village health committees is a good step towards improving community structure for sustainability.
- The CSP has contributed to a wider national movement to distribute bednets to make a significant impact on prevalence of malaria.
- Introduction of concepts and tools for supportive supervision has changed the paradigm of supervision as a policing action.
- The analysis and improvement of operational systems is a sustainable way to use resources more effectively and efficiently.

The focus during the next two years should be on:

- Continued focus on systems improvement.

- Implementation of Quality Assurance tools for systems analysis and improving quality of care at HFs.

- Investigation of needs for IEC and BCI activities in order to have the most impact in the district, focusing on improving nutrition behaviors.

- Increased emphasis on HIV/AIDS activities.

- Implementation of the cost sharing activities of cost ward and spectacle shop.

All stakeholders interviewed during the MTE reported an increased demand for services. The increased demand places increased pressure on the MOHP system due to lack of staff. The solution to this problem is outside the scope of this project, but has been the most important barrier to implementation during the two years of the CSP and will continue to be the primary barrier in the future.

The CSP emphasizes capacity building through strengthening the quality of district programming (primarily IMCI); assisting the DHMT to improve planning skills, establish more effective supervision and monitoring systems, and strengthen their ability to manage small funds achieved through cost recovery mechanisms. As part of the sustainability strategy, the CSP is introducing two concepts for cost sharing; a cost ward within the Nsanje District Hospital, and an eye glasses shop that offer an innovative way to bring additional funds into the hospital.

The 14-member Mid-Term Evaluation Team developed recommendations for improvement. As the recommendations came from the project implementers, there is a high level of "buy-in" and commitment to putting them into action for improving the CSP. A detailed action plan will be written by the principal implementers during November, but work has already started on finding ways to improve project implementation. The following represent the priority recommendations for the DHMT and IEF:

1. Strengthen and implement a comprehensive behavior change communication strategy on HIV/AIDS including VCT and PMTCT.

2. Conduct a review of the planned need for ITNs and of the management system of the sale of ITNs in communities and HFs.

3. Develop a system for sharing information with the villages using maps and/or information recorded in poster form at the village level to stimulate action planning

4. Liaise with BCI Coordinator to identify, procure and distribute IEC materials for use by CHVs, HSAs, and Health Facilities.

5. Develop and implement a comprehensive IEC/BCI plan for the CSP, including PD Hearth, the BEHAVE Framework, or other appropriate methodologies.

6. Initiate a mechanism for information sharing and to enhance coordination between principal organizations in the district; NGOs, DHMT, and CHAM.

7. Monthly meetings between IEF and DHMT should be planned on a set day and time through out the year for planning and monitoring project activities.

8. Introduce Quality Assurance strategies and tools to conduct systems analysis to determine what the root problems are in each system; what aspects are working well, and how systems can be improved to be more efficient and effective.

9. Conduct a review of the HIMS to verify the quality of data being collected and processed, and encourage the use of data for decision making at all levels.

B. PROGRESS MADE TOWARD ACHIEVEMENT OF OBJECTIVES

1. Technical Approach

a. Overview

International Eye Foundation (IEF) and the Nsanje District Health Management Team (DHMT) are in the process of implementing a four-year (2002-2006) Child Survival Project (CSP) in the Nsanje District in southern Malawi. The CSP has reached the mid point of implementation, the motive for conducting this Mid Term Evaluation (MTE).

The CSP works with the Ministry of Health and Population (MOHP) and the Christian Hospitals Association of Malawi (CHAM) health infrastructure throughout the district, which consists of the Nsanje District Hospital, one mission hospital, 11 health centers and eight health posts providing basic services. Nsanje District is one of the neediest districts in Malawi.

The original population planned for the project was 194,481, which included 33,000 children under five and 45,000 women of reproductive age in 450 villages in the district. The project has far exceeded those figures. The population data used in the Detailed Implementation Plan (DIP) and proposal and officially by the MOHP is based on 1998 census figures, the last available official data. In a census carried out in 2003 by Health Surveillance Assistants (HSAs) the actual population was estimated to be 237,000. While this is not an official census, it does show a probable population growth in the area. There has been a large inward migration (both temporary and permanent) from Mozambique due to civil strife and lack of development in Mozambique. There are no official figures on the number of Mozambicans who are accessing health services within Malawi. The project is actually working in 513 villages with a corresponding increase in the number of Community Health Volunteers (CHVs) compared with the original estimates.

The partnership between IEF and the DHMT is responsible for the overall implementation of the CSP. The Child Survival Management Committee (CSMC) was created during the first year of the project to strengthen coordination. The team is comprised of MOHP personnel, the DHMT, IEF Technical Advisors and Program Manager, the IEF Country Director, the Director of Planning from the District Assembly, and a representative of CHAM. The CSMC is responsible for project planning, monitoring and evaluation, supervision, providing technical support, reviewing the technical content, and financial monitoring, and for ensuring that project implementation follows the overall plan as outlined in the Detailed Implementation Plan (DIP). The group meets on a quarterly basis to analyze progress, identify barriers, and problem solving. The District Health Officer chairs the committee, and the CSP Project Manager serves as the Committee Secretary.

Based on both quantitative and qualitative research in the district, the CSP decided to divide their efforts in improving child health by working in the following technical interventions: Pneumonia Case Management 20%, Malaria 20%, Nutrition 20%, HIV/AIDS 20%, Expanded Program for Immunizations 5%, and Diarrhea Case Management 15%. All interventions are included under the umbrella strategy of IMCI (Integrated Management of Childhood Illnesses).

The overall goal of CSP is to reduce infant and child mortality in the district. The project's Strategic Objective (SO) is: *Families and caretakers with young children increase the practice of healthy behaviors and seek medical care from quality sources*. To achieve this, the project outlined the following Intermediate Results (IR) in the DIP:

IR1. District Organizational Effectiveness and Management Support for Quality Child Care Strengthened. This will be achieved by strengthening planning, training, supervision, and evaluation skills; increasing inter-sectoral coordination, and introducing new financial sustainability strategies.

IR2. Health Provider Skills in Prevention and Management of Childhood Illness Improved. This will be achieved by increasing inter-sectoral understanding of Household/Community IMCI (HH/C IMCI), increasing the skills of health facility providers at all levels, and increasing the skills of community volunteers.

IR3. Availability and Accessibility to Quality Preventative and Curative Health Services Increased. This will be achieved by strengthening under five clinic services; increasing the availability to malaria Insecticide Treated Nets (ITN) and Intermittent Presumptive Treatment (IPT) services, improving nutrition by adopting the Hearth strategy, and expanding HIV/AIDS prevention, testing and counseling services.

IR4. Community Participation, Ownership, and Demand for Health Services Increased. This will be achieved by improving community mobilization and support to HSAs and CHVs in prevention and promotion activities; increasing access to appropriate and quality care and information by trained CHVs, and improving district communication skills using the BEHAVE framework.

The main strategies of the CSP remain as originally described in the DIP. Some activities that were scheduled for the first two years have been delayed, but there is no evidence that the project is not capable of completing all major activities before the end of the grant period.

The following tables summarizes activities completed during the first two years and activities which need to be completed during the second half of the project. Results for the SO and each IR based on Monitoring and Evaluation activities are also included. While many of the changes comparing baseline to MTE levels are not statistically significant, they represent a trend towards improvement in most indicators.

SO: Families and Caretakers with Children Under Five Years of Age Practice Healthy Behavior and Seek Care From Quality Providers

	Performance Indicator (%)	Baseline KPC	Target MTE	LQAS	MTE KPC
1	% of children 12-23m who are fully immunized before their first birthday	63 CI: 55-71	75	72	59 CI: 51-67
2	% of children 12-23m who receives measles vaccine before 1st birthday	70 CI: 62-77	80	73	64 CI: 57–71
3	% of children 6-23m who received VAC within 6 months of the survey date	89 CI: 84-93	90	67	77.5 CI: 72-82
4	% of caretakers who treat children 0-23 months with ORT during their last diarrhea episode	55 CI: 47-64	65	90	85 CI: 79–91
5	% of children 0-23m who slept under an ITN the night prior to the survey	17 CI: 13-21	35	53	52 CI: 46-58
6	% of women who took SP to prevent malaria during her last pregnancy	75 CI: 70-80	80	88	72 CI: 67–77
7	% of caretakers who took children 0-23 months to health workers for diarrhea, fever, or difficult breathing after recognizing illness symptoms	84 CI: 72-92	90	78	90 CI: 82–98
8	% of children 0-5 months who are exclusively breastfed	55 CL: 44-66	60	-	66 CI: 55-77
9	% of children 6-23m who consumed the same amount of foods during most recent episode of reported illness	49 CI: 50-58	60	68	52 CI: 43–61
10	% of children 0-23 months who are underweight (-2SD from median WFA WHO/NCHS reference)	39.5 CI: 33-45	35	-	-
11	% of household that possess a bed net	29 CI: 24-34	-	59	64 CI: 59-69

IR1. Strengthened Organizational Effectiveness and Health Management Systems

Major Activities Completed	To Be Completed
Management Functions • IEF established the project office within the district and contracted appropriate staff	**Management Functions** • Maintain adequate staff levels
Strengthen Planning • Supervision and Planning workshop for CSMC • DIP, Baseline and MTE surveys • OCAT DHMT organizational assessment • Zones established and functioning	**Strengthen Planning** • Conduct LQAS and final survey • Develop and review District Organizational strengthening plan • Repeat OCAT DHMT organizational assessment before EOP evaluation • Assess district Zone system
Strengthen Systems • Introduced LQAS as monitoring tool • Established training and supervision systems • Supervision teams functional • Provided TA for financial system	**Strengthen Systems** • Introduce concepts of Quality Assurance and systems analysis • Use bi-annual LQAS monitoring survey • Conduct analysis of logistics & inventory system • Improve use of information
Strengthen Sustainability • Introduced concepts of cost sharing activities	**Strengthen Sustainability** • Finalize Cost ward and spectacle shop
Improve Inter-Sector Coordination • Conducted DTC and District Assembly orientation • Conducted CSMC coordination meetings and annual planning session	**Improve Inter-Sector Coordination** • Continue to improve coordination within the district, particularly with other NGOs

IR1. Strengthened Organizational Effectiveness and Health Management Systems

	Performance Indicator	Base line	Target MTE	LQAS	IMCI Super Aug 04	Qtrly Super Aug 04	MTE
1	% of facilities that have a stock out of essential medical supplies (e.g., ORS, SP, Cotrimoxazol)	-	8	-	21	21	1/5 HF (20%)
2	% of facilities by zone that have received at least 1 supervisory visit using observation of health worker practice in the 3 months prior to the facility assessment	67	85	-	92	100	100% received but not specific observation
3	% of HSAs by zone received at least 1 supervisory visit using observation of performance and feedback in 3m before assessment	89	90	61	-	-	100% received but not specific observation
4	% of VHC/GMVs by zone that have received at least 1 supervisory visit by HSA using a checklist in the 3 months prior to the facility assessment	-	60	64	-	-	5/7 received but 1/7 (14%) with checklist
5	% of VHCs that are established, trained that meet at least 1 time per quarter as verified in village records	70	80	37	-	-	9/12 met No village records
6	% of CSP annual work plan activities completed on time	-	85	-	-	-	76% completed
7	% increase in self-earned revenue from hospital sustainability activity per year	0	5	-	-	-	0%

IR2. Improved Prevention and Management of Childhood Illness.

Major Activities Completed	To Be Completed
Establish HH/C-IMCI Framework • Health staff in 13 Health facilities trained and implementing IMCI • Established supervision system for IMCI • Training held in adult learning techniques. • Trained CHVs in HH/C-IMCI • Conducted Orientation for HH/C-IMCI for Facility support staff, HSAs, Traditional Healers, Drug Vendors • Conducted Training of Trainers for IMCI	**Establish HH/C-IMCI Framework** • Focus on Quality Improvement • Continue supporting Zone training

IR2. Improved Prevention and Management of Childhood Illness

	Performance Indicator	Base line	Target MTE	IMCI Super Apr 04	IMCI Super Jun 04	IMCI Super Aug 04
1	% of sick children 0-5 years health cards were checked for immunization, VA status and growth monitoring.	-	85	100	71	100
2	% of sick children 0-5 years who present with fever and are correctly assessed, counseled & treated for febrile illness/malaria	-	80	92	44	96
3	% of sick children 0-5 years who present with difficulty breathing and or cough and are correctly assessed, counseled & treated for ARI	-	70	100	17	100
4	% of sick children 0-5 years who present with diarrhea and are correctly assessed, counseled & treated for diarrhea	-	70	23	-	86
5	% of HSAs demonstrate competence in EPI vaccination and GM protocols at time of assessment	-	60	-	-	-
6	% of HSAs demonstrate competence in counseling VHC & GMV in promotion of home care practices (ORT, malaria, ARI, W & S) at time of assessment	-	60	-	-	-
7	% of GMVs demonstrate competence in counseling mothers and families in home care practices (ORT, malaria, ARI, BF, W & S) at time of assessment	-	65	-	-	-
8	% of sick children referred by GMVs received attention by HF	-	60	-	-	-
9	# of DRFs established & operational according to the new strategy.	-	20	-	-	-

IR3. Increased Availability & Accessibility to Quality Preventative & Curative Health Services

Major Activities Completed	To Be Completed
Strengthen EPI/ VA/ DCM, ARI Services • 22 static & mobile U5 outreach clinics providing vaccine and VACs services in 6 Zones • Supported annual District immunization campaigns and outbreaks	**Strengthen EPI/ VA/ DCM, ARI Services** • Continue strengthening logistics and referral systems
Malaria • Technical exchange and training conducted. • Conducted training for CHVs in ITN use • 100 ITN committees providing ITNs in 6 Zones	**Malaria** • 350 ITN committees providing ITNs in 6 Zones
Pilot Drug Revolving Funds • This intervention has not been implemented	**Pilot Drug Revolving Funds** • Recommended to not continue with this intervention
Improve Nutrition Services • Training conducted in PD/HEARTH including trial PD Inquiry • Identified community for pilot	**Improve Nutrition Services** • Develop a district wide forum to establish an inter-sector nutrition team • Develop comprehensive plan for using IEC/BCI strategies to improve nutritional status district wide • Proceed with PD/HEARTH pilot • Make informed decision to expand PD/HEARTH
Improve HIV/AIDS Counseling - VCT • VCT services available at district hospital, Trinity Hospital and 1 Health Center • Established communication with DHMT HIV/AIDS Coordinator	**Improve HIV/AIDS Counseling - VCT** • Improve HIV/AIDS Counseling - VCT • Strengthen VCT at 3 centers • Facilitate training of counselors and availability of essential testing equipment • Conduct formative research • Document best practices

IR3. Increased Availability & Accessibility to Quality Preventative & Curative Health Services

	Performance Indicator	Base Line	Target MTE	LQAS	Qtrly superv Aug 04	MTE KPC
1	% health facility that provide daily immunization services	-	80	-	21	-
2	% of planned (17,000) ITNs sold*	-	60	-	-	18,000 distributed
3	% of planned persons tested and counseled by NDH VCT unit in the 3 months prior to the assessment (600/yr)	-	50	-	-	Not operational
4	% of mothers of children 0-23 months who know at least 2 ways of reducing the risk of HIV/AIDS	58 CI: 52-64	70	23	-	66 CI: 61–71
5	% scheduled Under 5 clinics (static and mobile) conducted in the 12 months prior to facility assessment**	80	90	-	-	TBD

* Data on the number of ITNs sold is not available.
** Data on the number of scheduled U5 clinics was not available.

IR4. Increased Community Participation & Demand for Preventative & Curative Services

Major Activities Completed	To Be Completed
Improve Community Mobilization • Community mobilization strategy implemented • Conducted HH/C-IMCI for CHVs **Improve Health Communication Strategy** • Conducted assessment of MOH education materials and education practices. • Conducted BCI orientation meeting.	**Improve Community Mobilization** • Establish village maps • Strengthen VHCs understanding of role and responsibilities for supporting CHVs. • Assess Zone implementation strategy • Continue training and support of CHVs. **Improve Health Communication Strategy** • Coordinate with BCI Coordinator to inventory existing materials and approaches • Develop comprehensive IEC/BCI strategy; disseminate and implement • Establish links with partner NGOs for sharing of IEC materials • Obtain technical assistance for IEC/BCI • Implement PD Hearth and BEHAVE framework • Conduct BCI formative research • Identify strategies to address priority intervention's target audience in child health behaviors

IR4. Increased Community Participation & Demand for Preventative & Curative Services

	Performance Indicator	Baseline KPC	Target MTE	LQAS	MTE KPC
1	% of mothers with children 0-23 months able to demonstrate correct use of ORS	52 CI: 46-58	70	6	71 CI: 66–76
2	% of mothers with children 0-23 months who report hand washing with soap/ash before food preparation or child feeding, after use of latrine or cleaning after child	3 CI: 1-5	30	46	7 CI: 4–10

A Mid Term Evaluation was conducted during October 3 to 16, 2004 with a 14 person evaluation team comprised of representatives from IEF Malawi, IEF Headquarters, MOHP Nsanje District, Africare, and World Vision, and an external evaluator, principal author of this report. The team visited 12 villages and interviewed mothers, Village Health Committee (VHC) members, Breast Feeding Support Groups (BFSG), Growth Monitoring Volunteers (GMVs) and HSAs. Five health facilities were also visited and health staff interviewed. Additional interviews were held with DHMT and IEF staff, and a representative from the District Assembly and USAID in Malawi. For detailed information on the MTE methodology see Attachments B and C. A list of all persons contacted and interviewed during the evaluation is included in Attachment D. Recommendations,

developed primarily by the full evaluation team, are included throughout this report in **bold** lettering and summarized in Section D. Details on the results of the evaluation (outputs from the Analysis Workshop) are included in Attachment E.

b. Progress report by intervention area

Integrated Management of Childhood Illness (IMCI)
The implementation of IMCI, both facility based and household and community (HH/C IMCI) has been the major thrust of the CSP during the first two years of the project. All project intervention areas are included in the IMCI strategy. The activities carried out are generally as described in the DIP and in accordance with MOHP policy. The progress made in this activity is impressive, with 309 people trained at the hospitals and (Health Facilities) and 6,402 at the community level.

In June 2003 a IMCI survey was conducted in 12 HFs to provide baseline information on out patient services provided for children under 5 before district wide implementation of the IMCI program for evaluating the impact of IMCI training. The most common reason for clinic visits was malaria in 39% of the cases, followed by 31% for respiratory infections. Three fourths of the mothers interviewed were not told the diagnosis of their child's illness and only 12% of the cases were assessed for danger signs.

Three trainings on facility based IMCI were organized for the district health staff. A total of 53 personnel from health centers and hospitals participated in the eleven-day training. IMCI trainers from other districts facilitated the training. The material used during the training was the WHO/UNICEF/MOHP Malawi curriculum with Trainers Guide, which provides a completed IMCI training with field practice.

The following community members and staff received a three-day training in basic IMCI messages:

• HSA	184
• Village Health Committee (VHC)	5,298 members in 513 villages
• Growth Monitoring Volunteers (GMV)	400
• Breast Feeding Support Groups (BFSG)	513
• Traditional Birth Attendants (TBAs)	173
• Traditional Healers	10
• Drug Vendors	8
• HF Support Staff	72
• Ministry of Agriculture Extension Workers	54

Also 52 CSMC, MOHP and District Assembly Members received a one-day HH/C-IMCI orientation. Eleven nurses and clinicians and 2 IEF staff received a 5-day IMCI Training of Trainers workshop and a 5-day IMCI supervisor's training. Due to staff rotation some trained personnel have already left the area, mainly at the hospitals. **Continue IMCI Facility Based training during the next two years, plus HH/C-IMCI training for people who did not receive the initial training. A one-day orientation to IMCI should be used to train support staff, which are not directly responsible for IMCI implementation (drivers, clerks, Ward and Patient Attendants, administrative staff).**

The training of health providers is an essential element in the provision of quality health services. Supportive supervision coupled with a process of continuous quality improvement is the second crucial element in the provision of quality health services. Following the training, supervisory visits took place to consolidate the initial training and resolve problems with IMCI implementation. Weak areas identified in the supervisory visits included lack of child health cards and ORT corner equipment. These problems were analyzed and solutions identified during the supervisory visits. IMCI checklists have been developed for use with integrated supervision visits at HFs and at the community level.

Progress in improving the quality of care provided has been noted as a result of the IMCI training. Health care providers who have been trained have shifted their thinking to assess children holistically rather than simply concentrating on a child's symptoms. Some staff interviewed during the MTE mentioned that they do not have time to use IMCI consistently, and only use it a few days a week. **Introduce Quality Assurance strategies and tools to be used in strengthening ongoing IMCI supportive supervision.**

The following indicators show progress in measuring IMCI implementation:

Performance Indicator - IMCI	Base line	Target MTE	LQAS	IMCI Apr 04	IMCI Jun 04	IMCI Aug 04	MTE KPC
% of caretakers who took children 0-23 months to health workers for diarrhea, fever, or difficult breathing after recognizing illness symptoms	84 CI: 72-92	90	78	-	-	-	90 CI: 82-98
% of facilities that have a stock out of essential medical supplies (e.g., ORS, SP, Cotrimoxazole)	-	8	-	21	-	21	20 MTE visits
% of sick children 0-5 years whose health cards were checked for immunization, VA status and growth monitoring.	-	85	-	100	71	100	-
% of sick children 0-5 years who present with fever and are correctly assessed, counseled & treated for febrile illness/malaria	-	80	-	92	44	96	-
% of sick children 0-5 years who present with difficulty breathing and or cough and are correctly assessed, counseled & treated for ARI	-	70	-	100	17	100	-
% of sick children 0-5 years who present with diarrhea and are correctly assessed, counseled & treated for diarrhea	-	70	-	23	-	86	-

All stakeholders interviewed during the MTE, including community members, reported an increased demand for services. The increased demand places increased pressure on the MOHP system due to lack of staff. The solution to this problem is outside the scope of this project, but has been the most important barrier to implementation during the two years of the CSP and will continue to be the primary barrier in the future. The challenge for the project during the next two years will be to increase efficiencies and continued emphasis on supportive supervision, systems improvement, and a focus on improved quality. **In order to enhance the effectiveness of IMCI there is a need to supply durable, washable, visible IMCI flow charts for the wall of each HF, and a small personal copy for principal HF staff. Each HSA needs portable, durable IEC materials to use during home visits in villages to teach danger signs for common illnesses.**

Revolving Drug Funds were planned in the DIP but have not been implemented. There has been a change in the political climate since the DIP was written which makes it unfeasible for the drug funds to be implemented. A free drug program was developed, and even though it has not been implemented as widely as planned, does complicate the introduction of a revolving fund at this time. Also the CSP has a number of other priority activities for the second half of the funding period. The CSP is investigating the funding of HSA kits, which would contain essential medicines such as Vitamin A, iron, aspirin, etc. **The strategy of Revolving Drug Funds should not be pursued during the second half of the project due to a change in the political climate and time constraints and focus instead on piloting HSA's medical kits.**

The problem of lack of a functioning referral system was identified as a weakness of the health system. The CSP is working to establish a referral form to be used for referrals from the HF to secondary hospital facilities as well as the link between communities and HFs. Currently CHVs are told to refer, but no written system exists. **Design and implement a referral system, including a referral form for use by HFs and a community referral procedure based on the official child/maternal health card (Health Passport).** The design process should keep in mind the literacy levels and work loads of community volunteers.

Nutrition 20%

Nutrition indicators include the following:

Performance Indicator – Nutrition	Baseline	Target MTE	LQAS	MTE
% of children 6-23m who received VAC within 6 months of the survey date	89 CI: 84-93	90	67	77.5 CI: 72-82
% of children 0-5 months who are exclusively breastfed	55 CI: 44-66	60	-	66 CI: 55-77
% of children 6-23m who consumed the same amount of foods during most recent episode of reported illness	49 CI: 50-58	60	68	52 CI: 43-61
% of children 0-23 months who are underweight (-2SD from median WFA WHO/NCHS reference)	39.5 CI: 33-45	35	-	-

Anthropometric measurements were not included as part of the MTE KPC, but will be repeated as part of the Final Evaluation.

PD Hearth was the primary strategy for nutrition improvement outside of the inclusion of nutrition activities within IMCI (growth monitoring, nutrition education, breastfeeding, Vitamin A and iron supplementation). A consultant was hired to train IEF and MOHP staff in the methodology, including a practice session for conducting a Positive Deviance Inquiry. Twenty-five CSMC, IEF, HSAs and Zone Supervisors were trained during a five-day PD

Hearth workshop. Staff plans to introduce the methodology in one community in the South Zone beginning in October.

In view of the extremely limited human resources in the district to implement PD Hearth or to potentially sustain it in the future, the process should be temporarily suspended to allow the CSP to develop a more comprehensive nutritional plan for the remainder of the project. The project will concentrate their efforts during the next two years on improving the IEC/BCC strategies and it was decided during the MTE to focus this effort on nutrition. This issue is discussed further in Section B.2.b. Behavior Change Interventions.
The project should evaluate what role it can play in the district to improve nutrition on a district-wide basis. There was a Target Nutrition Program coordinating meeting which was previously held monthly with the DHMT and NGOs working in food security. The meeting is not currently active because World Vision, who sponsored the meeting, is no longer involved. This would be one forum for the CSP to involve themselves in to obtain a more global view of what is currently being done in the district. **Organize a review meeting for all stakeholders in nutrition programs to understand what is currently being done in order to develop a concrete plan for CSP involvement.**

The DHMT was advised that when PD Hearth is implemented, to ensure that 600-800 calories and 25-27 grams of protein is provided daily, divided between a snack and a meal to complement (not replace) normal feeding times of the child. Hearth sessions should run for 10-12 days followed by 2 weeks of follow up.

Growth monitoring is routinely carried out at Under Five (U5) clinics which are generally held once a week in the HFs and twice a week in the hospitals. Outreach clinics are usually an additional one to two days per month at each HF. The HSAs conduct the growth monitoring sessions and GMVs have been trained in some villages to help the HSAs. GMVs were only trained in villages which are not close to a HF. During the MTE some GMVs were interviewed, but they seemed to be the most problematic of the cadre of volunteers in terms of definition of their job responsibilities and motivation. **Clarify the role and function of the GMV and increase the number of trained GMVs.**

The indicator for children who have received Vitamin A was one of the few that showed a decline in coverage levels. There has been a supply problem with obtaining capsules but at the time of the MTE 80% of HFs and 75% of HSAs had capsules. The reasons for the decline were not clear and need to be investigated further. 100% of HFs had iron supplements, but only 50% of the HSAs had them. Improvements to be made in the supply system will be discussed further in Section B.2.c. Capacity Building.

Breast feeding support groups have been established in most villages to promote exclusive breastfeeding and child feeding. The groups interviewed during the MTE had an interpretation of "support group" which varies from the traditional concept. The groups

see themselves as being the primary educators of the rest of the community on child feeding issues. They meet primarily to plan education sessions for all of the mothers in the community. The "support" functions as mutual support in their role as educators. **The role of the BFSG in promoting PMTCT (Prevention of Mother To Child Transmission) is unclear and needs to be strengthened in the future.**

HIV/AIDS 20%

This intervention has been the weakest even though it represents 20% of project effort. The main activities implemented so far are:

- Inclusion of health messages on HIV/AIDS as part of HH/C IMCI
- The presentation of HIV/AIDS Basic Facts and Awareness messages to 49 District Assembly members and 105 Junior hospital staff
- CSMC members in collaboration with Churches Aid Relief Development trained several district drama groups on HIV/AIDS issues. These groups will be instrumental in disseminating HIV/AIDS health messages to communities.
- A district-wide HIV/AIDS Day was celebrated as part of a national campaign in September of 2003. The theme of the day was "LOVE US – LET'S LIVE." Songs, drama comedies, quizzes and testimonies from people living with AIDS were used to communicate information. The purpose of the day was to raise awareness on HIV/AIDS and other sexually transmitted diseases and their transmission and complications. Information on voluntary counseling and testing (VCT) services was also disseminated.
- Thirteen nurses and clinicians and one IEF staff participated in a 10-day course on Syndromic Management Approach of Sexually Transmitted Infections.

The indicator for this intervention is:

Performance Indicator – HIV/AIDS	Baseline	Target MTE	LQAS	MTE
% of mothers of children 0-23 months who know at least 2 ways of reducing the risk of HIV/AIDS	58 CI: 52-64	70	23	66 CI: 61-71

The district is involved in a number of new nationally directed initiatives in HIV/AIDS which were not established when the DIP was developed. The CSP choose to delay implementing activities until a clear need and role was defined. The process to obtain ARV (Anti Retro Viral) drugs for use in PMTCT has been initiated by the DHMT. A letter was sent from the district to the MOHP central Reproductive Health program to be forwarded

to UNICEF as the first step in the process to obtain Nevirapine for use with HIV positive pregnant women. A visit is scheduled in December for a site visit to determine ARV implementation strategies for the district. Three district staff are currently receiving training in ARV therapy but a supply of ARVs are not yet available in the district. A PMTCT Coordinator has been hired by the district and new activities are just beginning in this important area. VCT is currently available in three HFs (2 hospitals and 1 Health Center) but on a very small scale. For example in Trinity Hospital, the counselors have not received the currently required training and services are only offered 4 hours per week serving 25-40 people per month.

Due to the rapidly changing services for prevention and treatment of HIV/AIDS, the CSP needs to re-evaluate their role in district initiatives. **Strengthen and implement a comprehensive behavior change communication strategy on HIV/AIDS including VCT and PMTCT.**

Malaria 20%

The following indicators show an impressive increase in availability and use of Insecticide Treated Nets (ITN) for the prevention of malaria. The CSP has contributed to this change through the prevision of nets, training of ITN village committees, and a strong focus on education at the community level.

Performance Indicators - Malaria	Baseline	Target MTE	LQAS	MTE
% of mothers reporting the presence of a bed net in the house	29 CI: 24-34	-	59	64 CI: 59-69
% of children 0-23m who slept under an ITN the night prior to the survey	17 CI: 13-21	35	53	52 CI: 46-58
% of women who took SP Sulphadoxine-pyrimethamine (Fansidar) to prevent malaria during her last pregnancy	75 CI: 70-80	80	88	72 CI: 67-77

The DHMT Malaria Coordinator, who is also the Medical Assistant in charge of a Health Center, is in charge of the distribution of ITNs to HFs and villages. 3,000 nets were purchased by IEF, in addition to 3,000 nets being provided by PSI (Population Services International), and 7,000 from UNICEF/WHO. PSI developed a national system for ITN distribution which includes three types of nets: those distributed in communities by ITN committees which cost MK 100; those available in HFs for children under five and pregnant women which cost MK 50; and those for sale commercially at a cost of MK 400. Nets sold in either the community or the HF are part of a revolving fund whereby 80% of the cost is returned to the Malaria Coordinator for the purchase of additional nets and 20% remains with the community or HF.

One hundred ITN committees have been trained (50 with CSP funds); the goal in two years is to have 350 committees trained and functioning. In many cases the ITN committee is comprised of the same people as the VHC, but this is not always the case, thus diluting the effect of having funds go to the community-which are not under the control of the VHC, but a separate group of people.

In interviews with HF staff during the MTE, problems were reported in terms of allocation of nets, supply mechanism and monitoring of sales. The CSP should develop a plan for analyzing the flow of information and funds from the District to community ITN committees and back again to identify opportunities for strengthening the system. A good place to start would be in understanding exactly what systems have been developed by PSI for ITN management. **Conduct a review of the planned need for ITNs and of the management system of the sale of ITNs in communities and HFs.**

An additional challenge for the project during the remainder of the funding period is to investigate the current practices regarding dipping the nets with insecticide according to standard protocol, and ways to ensure the efficacy of the nets being used.

The use of SP for pregnant women has not shown an increase, even though at the time of the MTE, 100% of the HFs had SP on hand. **The CSP should investigate why the Intermittent Presumptive Treatment of malaria for pregnant women did not increase during the last two years.**

Expanded Program of Immunizations (EPI) 5%

The following results show no measurable change in vaccination coverage comparing the KPC at baseline with the MTE KPC. During the MTE, three out of the five HFs visited did not have the full complement of antigens on the day of the visit.

Performance Indicators – EPI	Baseline	Target MTE	LQAS	MTE
% of children 12-23 months who are fully immunized before their first birthday	63 CI: 55-71	75	72	59 CI: 51-67
% of children 12-23 months who receives measles vaccine before 1st birthday	70 CI: 62-77	80	73	64 CI: 57-71

One of the planned activities of the CSP was the encouragement of establishing continuous vaccinations at the HFs. District policy restricts this initiative due to the wastage of antigen by opening a vial of vaccines for only 1 or 2 children. Vaccinations are only available during U5 clinics. A three-day training on Cold Chain Maintenance was held for 47 HSAs.

Evaluate the number, distribution and frequency of Under 5 immunization clinics (static and mobile) to determine whether gaps remain which limit access by communities.

Pneumonia Case Management 20%
Diarrhea Case Management 15%

Both of these interventions are included within IMCI and specific activities were already addressed in the IMCI section. Indicators specific to diarrhea case management include:

Performance Indicators – PCM and DCM	Baseline	Target MTE	LQAS	MTE
% of caretakers who treat children 0-23 months with ORT during their last diarrhea episode	55 CI: 47-64	65	90	85 CI: 79–91
% of mothers with children 0-23 months able to demonstrate correct use of ORS	52 CI: 46-58	70	6	71 CI: 66–76
% of mothers with children 0-23 months who report hand washing with soap/ash before food preparation or child feeding, after use of latrine or cleaning after child	3 CI: 1-5	30	46	7 CI: 4-10

The CSP focus has been on:

- Revitalization of ORT corners, ORT equipment was provided to 13 HFs.
- Improvement in the supply of ORS, antibiotics, and other supplies; All HFs and 75% of HSAs had ORS but there is no mechanism to make ORS available permanently in the communities through the VHC or other system. Cotrimoxazole was available in four out of the five HFs visited and is not available to the HSAs, according to MOHP policy.
- Timers or a watch with a second hand were available in only two of the five facilities visited. The DHMT expressed a preference for using a watch for measuring respiratory rate, as they felt this was more sustainable than a timer.
- Community education in hygiene and hand washing.
- Education on recognition of danger signs and referral.
- Increased liquids during illness and recuperative feeding.

Strengthen hygiene promotion activities to target hand washing instead of general promotion of latrines and rubbish pits.

c. New Approaches

As part of the sustainability strategy, the CSP is introducing two concepts for cost sharing; a cost ward within the Nsanje District Hospital and an eye glasses shop. While neither initiatives are functioning yet nor will they be the answer to financial sustainability, they offer an innovative way to bring additional funds into the hospital. The additional value of the activity is to raise awareness about cost recovery, and improvements in the management systems of recovered funding providing positive experience in advance of national decentralization initiatives.

The model for the cost-ward is the CHAM facilities that have semi-private and private rooms set aside for those who prefer to select and pay for services. The ward itself will be an existing room at the district hospital that will be improved by repairing and painting walls, floor, windows, ceiling, and doors and providing new amenities including a toilet and shower area; new curtains, beds and bedding, furniture, lamps, and either a fan or air conditioner. The service will be redesigned to include greater attention and time spent with patients by the medical doctor and nurses, greater privacy, and better food services. The changes are designed to provide a viable choice for patients to self-select whether they want to receive free services in the general ward, or pay a fee.

IEF has been working with eye hospitals in Lilongwe and Blantyre. A new spectacle shop in Blantyre will soon be operational. Once the shop is established IEF will extend services to Nsanje district. The optical shop is now operational since June, and is grossing approximately $10,000 month, but IEF extension to Nsanje is part of a larger plan to market glasses to several districts and awaits implementation in early 2005. At Nsanje District Hospital, the existing eye department will be improved and provided with a supply of ready-made low cost glasses in the range most commonly prescribed. Subsidized prices appropriate for Nsanje will be established, and a small profit based on sales will benefit the hospital. The spectacle shop fosters increased hospital management of a revenue generating activity and provides a new service to the public.

IEF will assist the CSMC in business planning and help strengthen management and accounting practices.

2. Cross-cutting approaches

a. Community Mobilization

Perhaps the CSP activity which has had the most impact at the community level has been the establishment and strengthening of the Village Health Committee (VHC). The VHC has responsibility for:

- Role as peer educator. According to groups of women interviewed during the MTE, all had received health education, and the most often mentioned source was the VHC and HSAs.

- Provides support for the other CHVs (Community Health Volunteers; GMVs, BFSG, and TBAs) which have received training from the CSP, although this role needs to be articulated and strengthened.

An unplanned impact has been the inclusion of women in the VHC, providing a vehicle for women to assume non-traditional leadership roles. Women were active VHC members in the majority of communities visited during the MTE.

Five of the 12 groups of mothers interviewed during the MTE mentioned that they had observed an increase in community participation in health activities since the beginning of the project. According to information received during the MTE, there are no major barriers to participation in health activities; all families participate. An ongoing challenge for the project is the motivation of CHVs and the community in general. Many community members take a very passive role in health activities, having an attitude of receiving benefits rather then promoting prevention. CHVs receive an allowance of 130 MK (US$1.25) to attend training. A payment which motivates in the short term but is unsustainable by the MOHP.

There is a lack of knowledge about the inter-relationship in the villages among various committees. Many of these committees are project driven (borehole maintenance), some are traditional (defense) and in many cases there is an umbrella organization (Village Development Committee). Competing community priorities may be effecting the project's ability to mobilize the community. For community structure to be sustainable it must fulfill a role within the community definition and not just the project defined role. **Leaders of different village committees should be encouraged to meet and outline modalities to coordinate their activities.**

During the MTE, innovative ideas for sustaining activities were presented by various VHCs. Emphasize the positive; identify positive deviant villages which can serve as models for other villages. **Identify well-functioning VHCs to be involved in sharing their experiences.**

One effective method of motivating volunteers is through frequent supervision visits. Malawi has a unique MOHP system of paid HSAs who are responsible for the health of the community, including responsibilities in environmental health, disease surveillance, information gathering and education. These people play an important role in the sustainability of health activities in the villages. **Strengthen follow-up and supportive supervision of CHVs by CSMC, HSAs and Zone Supervisors. Modify the system of community supervision to include VHCs as supervisors within their own communities.**

Another means of motivating volunteers is through the formation of a supportive network within the village; mutual support among all volunteers. In order to ferment this camaraderie, each person's role must be very clear and opportunities for support highlighted. **Identify mechanisms to encourage coordination at the village level of all community health volunteers. Clarify the job descriptions of all community health volunteers.**

At the time of the MTE, the project was beginning plans to implement a Village Register for use by VHCs. It was recommended that the register be re-evaluated to determine the feasibility of its use given the workload, level of motivation and level of literacy of the VHCs. Other ways information could be presented to communities include mapping, use of an annual calendar showing changes in disease conditions, coverage, sanitation services, etc., or graphics that display community health indicators compared with community goals. **Develop a system for sharing information with the villages using maps and/or information recorded in poster form at the village level to stimulate action planning.**

b. IEC and Behavior Change Interventions

The project is working with the entire Nsanje District, with a population of well over 200,000 people. In order to reach this number of people with health messages a mixture of IEC (Information, Education, Communication) and BCI (Behavior Change Interventions) methodologies are required. During the first two years of the CSP, the focus has been to disseminate basic IMCI messages to as wide an audience as possible. A continued emphasis on IEC is appropriate for the remainder of the project, given the audience size and the scope of the project. All messages are up-to-date and in line with national and international standards.

A three-day training course was given to 6 CSMC members in adult learning and facilitation skills and 16 CSMC members received a one-day orientation to BCI. **CHVs and HSAs need**

reinforcement on their communication skills i.e. adult learning and facilitation. This could be accomplished through supportive supervision visits and feedback after actual education sessions.

One of the weaknesses of the current IEC strategy is the lack of materials for use in educating community members. HSAs and CHVs have almost no materials to help explain concepts or to remind them of key messages. Any materials used need to take into account the level of illiteracy. **Liaise with BCI Coordinator to identify, procure and distribute IEC materials for use by CHVs, HSAs, and Health Facilities.**

In addition to using IEC methods, the project will begin exploring BCI options to increase the focus on behavior change for specific high risk behaviors. In the DIP it was originally planned to introduce PD Hearth as a response to the high levels of malnutrition in the district and the use of the BEHAVE framework as a means to targeting high risk populations. At the time of the MTE, it was felt that instead of simply moving forward on introducing these two concepts, it would be advisable to re-evaluate the needs of the district and plan a comprehensive IEC/BCI strategy for the next two years. The IEC/BCI emphasis will be on nutritional improvement and will require technical assistance. **Develop and implement a comprehensive IEC/BCI plan for the CSP, including PD Hearth, the BEHAVE Framework, or other appropriate methodologies.**

c. Capacity Building Approach

i. Strengthening the PVO Organization

During December 2003 IEF conducted a two-part exercise to strengthen its strategic planning and self-assessment processes. This is part of an annual review and planning meeting at IEF Headquarters and a biannual use of the Discussion Oriented Self Assessment (DOSA) methodology to re-assesses core capacity indicators.

Seven headquarters staff participated in the DOSA self-assessment exercise. In comparison with the assessment conducted in 2000 there were minor changes in the Core Capacity scores (strengths and weaknesses), however, there were marked decreases in the Consensus scores in all Core Capacity areas. Capacity scores ranged from a low of 63 to a high of 80, and the Consensus scores ranged from a low of 51 to a high of 72. Explanation of the differences may be due to the small number of participants, the length of service of staff, and the diverse IEF programming (Child Survival/nutrition, onchocerciasis, sustainability planning for eye care hospitals, and the IEF social-enterprise SightReach Surgical®).

IEF recognizes the value and limits of the DOSA methodology and uses the exercise to stimulate discussion for planning purposes, and not to measure change over time.

Eight headquarters staff and one Board Member met for a one-day group exercise to review and revise IEF's strategic plans. A Strengths, Weakness, Opportunities, Threat analysis was conducted of each of the major program areas including SightReach Surgical, SightReach Management, Childhood Blindness, Child Survival and Vitamin A, onchocerciasis, and fundraising. The objectives of the meeting were: 1) create clear understanding of the mission, program initiatives, development activities, and funding sources, 2) Review consensus on perceived strengths and weakness in key capacity building areas, and 3) identify priority programs and activities and options to be included in a new operational plan for the next 3 – 5 years.

One of IEF's strengths is the emerging success of the SightReach Management program that is demonstrating the effectiveness of a sustainability planning model for eye care hospitals presently operational in six countries. The lessons learned from these experiences is a reference for work in other programming including child survival. Emphasis on establishing standards and benchmarks for productivity and efficiency; improving the quality of care and services, and establishing mechanism for cost recovery are crucial to meet patient and community demand for services.

IEF Malawi did not conduct a separate institutional assessment. **It is recommended that IEF Malawi conduct an institutional assessment and strengthening plan, similar to the process proposed for the DHMT.**

In order to more effectively and efficiently implement the CSP, IEF needs to take a leadership role in working with all NGOs working in the district, not just health NGOs, but a more global vision of how health is part of development. What organizations exist with programs in education, agriculture, civil society which could be partners in enhancing the impact of the CSP's efforts in health? The project could improve the synergistic effect of coordinating with other organizations such as Family Health International, Salvation Army, PSI, and World Vision. This also applies at the national level, where increased coordination with other organizations is crucial. **A mechanism for information sharing and to enhance coordination between principal organizations in the district; NGOs, DHMT, and CHAM facilities, should be initiated by IEF.**

ii. Strengthening Local Partner Organizations

The principal partner for the implementation of this CSP is the district level MOHP District Health Management Team (DHMT). The roles and responsibilities of the DHMT within the CSP remains the same since it was initially described in the DIP. One of the major constraints in working with the DHMT is the severe shortage of professional staff at all levels. This is a national problem, as there has been a lack of development of new human resources and a migration of Malawian professional to other countries. This shortage limits the pace at which new concepts can be implemented, as anything new is perceived to require more effort and time (and initially, usually does).

In order to have a starting point for discussions on capacity building between IEF and the DHMT, the Organizational Capacity Assessment Tool (OCAT) methodology was used. This methodology is based on an adaptation of the Organizational Capacity Assessment approach developed by PACT. Numerous changes were made to develop a tool that could be used in a governmental setting where the organization provides direct service delivery. A total of 13 persons participated in the Organizational Capacity self-assessment conducted February 2004. The purpose of conducting the assessment was to initiate discussion on what is meant by strengthening "capacity building" by introducing the DHMT to a series of indicator/questions related to institutional capacity.

Prior to administrating the questionnaire, additional time was taken to clarify the group's understanding of "stakeholder" as this term is used throughout the questionnaire. Secondly, a lengthy discussion took place to clarify what was the subject of analysis. Unlike an NGO with a private legal identity, the DHMT is a committee with loosely defined authority and decision making powers. It was generally understood that the District Health Officer, representing the district hospital and the district health centers is the *Local District Health System*. The District Health Office through the DHMT is a representative management structure responsible for oversight of this health system. This loose definition was employed during the assessment.

A total of 144 indicator questions are included in the assessment. Organizational assessment team members respond to each item using a 1-5 scale. Capacity scores ranged from 78 to 50 percent among the seven capacity score areas. In general, the greatest weakness of the DHMT are organizational in nature especially the limitations on the DHMT to 'govern' themselves; lack of clarity over decision making in regards to staff and financial management; incomplete management systems, lack of transparency in reporting, especially financial, and limited use of information. A repeat use of this tool is planned as part of the 3rd year assessment and report, but no follow-up has been given to the results of the assessment, nor is any action plan based on the results evident. Additional follow up to this exercise is required to discuss issues raised in the assessment and develop an Action Plan.

The CSP emphasizes capacity building through strengthening the quality of district programming (primarily IMCI); assisting the DHMT to improve planning skills, establish more effective supervision and monitoring systems, and strengthen their ability to manage small funds achieved through cost recovery mechanisms. The principal capacity building activities that have taken place are:

Training:

Training was planned and conducted in the areas of Planning and Supervision, Adult Learning and Facilitation Skills, IMCI, and PD Hearth. Eighteen DHMT members, 11 HF In-charge Staff, and 6 Zone Supervisors received a three-day training course on Supervision and Planning Skills. Training in IMCI and PD Hearth was previously described.

Systems Strengthening:

Planning – in the areas of implementing the annual planning processes, sharing of monthly plans, and quarterly zonal meetings held in the 6 zones. These areas should be strengthened further through monthly planning meetings. **Monthly meetings between IEF and DHMT should be planned on a set day and time through out the year for planning and monitoring project activities.**

Training – in the areas of adult learning and facilitation, introduction of BCI concepts, and adaptation of IMCI curriculum. These areas should be strengthened through increased emphasis on IEC and BCI activities.

Supervision – in the areas of development of a zonal supervision system, supervision tools, and annual or bi-annual integrated HF visits. The district was divided into six supervision zones, with zone supervisors assigned in each zone which has enhanced direct supervision. The overall supervision system needs to be strengthened through the implementation of draft supervision tools for CHVs, and client satisfaction; and by looking at the whole process and its link to the training, logistics, and M&E systems, not just isolated supervision visits. Results from supervision visits should be summarized so that learning can take place about overall strengths and weaknesses to be used to identify training needs and to look at issues which need to be solved at other levels i.e. logistics. **Use supervision as a way to identify positive points for cross learning through exchange visits or peer supervision.**

Accounting – the district accounting system is still a manual system operated by one person; an accounting clerk. The IEF Administrator in Nsanje has been working with this clerk to implement a Quicken® system on a computer donated by the project. While the Quicken® system is not compatible with the official MOHP system which will be implemented in the future, it does give the clerk computer and spreadsheet experience. **IEF should continue the on the job training for the District Accounts Clerk.**

During the next two years, the project should continue efforts in strengthening the previously mentioned systems, as well as begin efforts to improve the functioning of the Information System and the Logistics System. The focus on systems analysis provides the DHMT with sustainable improvements to increase efficiency and effectiveness of services. **Introduce Quality Assurance strategies and tools to conduct systems analysis to determine what the root problems are in each system, what aspects are working well, and how systems can be improved to be more efficient and effective.**

Information System - Three main areas need to be improved; validation of information collected, information sharing, and use of information. These issues are further discussed in Section C. 7 Information Management.

Logistics System (transportation and supplies) - A number of issues were discussed by the MTE evaluation team regarding transportation. The number of issues underscores the importance of this problem, but also can lead to a band-aid approach unless the entire system is studied to determine where the most critical needs are, given the limited resources of the district and CSP. **A comprehensive study should be made of the transportation system to determine how improvements can be made.**

The following additional points should be taken into consideration:

- Improve the coordination of the transportation system.
- Continue to request new vehicles from central MOHP.
- Employ a full-time trained mechanic for the district.
- Examine and revise, if needed, policies and procedures for vehicle use.
- Repair or replace zone supervisors' motorcycles.
- Establish policies for HSAs purchase of bicycles and establish a spare part revolving fund or other maintenance plan.

A recent national modification in the logistics system whereby the MOHP Central Medical Stores is now directly supplying health centers with drugs has met with success so far. But continuing problems with the supply system elicited a number of recommendations:

Determine why materials/supplies are inadequate in some HFs and identify the solutions to those problems, including the timely requisitioning of drugs and other supplies.

Identify the HFs needs for equipment and office supplies essential for the implementation of the CSP; procure, distribute and monitor those supplies. (CSP to make initial purchase of files, hole punches, staplers, papers, and staples).

iii. Strengthening Health Facilities and Health Worker Performance

Project works with personnel in 1 MOHP hospital, 1 CHAM hospital, 8 MOHP Health Centers, 3 CHAM Health Centers and 8 MOHP Health Posts. HFs are assessed through the Health Facility Assessment carried out in 2002 which will be repeated for the Final Evaluation, and the ongoing IMCI and Integrated Supervision visits. Results from various supervision visits were summarized in the results tables on pages 5-11 of this document. In June of 2004, the CSP conducted an LQAS survey to look at HSAs knowledge levels. A sample of HSAs were asked seven questions on basic IMCI messages with an average score of above 90%.

The main activities to strengthen health facilities and health workers were:

Training:
Training of HF staff and HSAs in IMCI including Ward and Patient Attendants, other support staff IMCI training- three were held for 51 HF staff and two IEF staff. Fifteen people have been trained in IMCI and left the district. Thirteen people were trained in TOT to provide a sustainable pool of trainers for IMCI. **A sustainable system should be designed to conduct in-house IMCI training for the remaining untrained staff as efficiently as possible.**

Supervision:
A major focus has been on encouraging integrated supervision with a checklist for health facilities. Supervision checklist were being field tested at the time of the MTE to evaluate HH/C IMCI through the supervision of HSAs, VHCs, Traditional Healers, Drug Vendors, GMVs, BFSG, and TBAs. Checklists were also being developed to monitor community members' perceptions of work being carried out by HSAs, VHC, GMV, BFSG, Traditional Healers, TBA and Drug Vendors. Client satisfaction surveys have also been developed for use at inpatient and outpatient HF clinics.

Supply of materials:
IEF purchased and distributed 6,500 health cards for children under 5, 6,500 for women and 3,250 for the general public. The health card/passport used in Malawi is an interesting adaptation from the more commonly used growth/vaccination card as it contains those elements plus a clinical history for all visits to HFs. The cards cost MK 15 (US$0.13). This money is then used to purchase additional cards from the district.

IEF also purchased and distributed 3,000 ITNs, as well as, the supplies to establish Oral Rehydration Therapy Corners at HFs.

In interviews with HF staff during the MTE, they felt that supervision had been effective in problem solving and encouragement and that the training they had received had improved patient management. All HFs visited said that the demand for services had increased since the CSP began.

The major linkage between the health facility and the communities is through the government paid Health Surveillance Assistant (HSA). The HSAs responsibilities are varied, and is the primary entrance to the community for all MOHP programs, as well as NGOs.

The HSAs are directly supervised by Senior HSAs at each HF, who are supervised by the Zone Supervisors, a new supervisory structure introduced by the CSP to improve supervision and monitoring. The Zone Supervisors are supervised by the district. The

system works very well in terms of service provision. The job description of the HSAs, compared to actual tasks, is not realistic. There is often little coordination between district programs (MCH, HIV/AIDS, nutrition, TB) with the result of adding more and more tasks to HSAs. Due to the shortage of health staff, many times the HSA is assuming responsibility for tasks which are beyond their professional expertise, such as VCT counseling. Twenty-seven HSAs were brought to the district hospital to bolster gaps in staffing.

Of HSAs interviewed during the MTE, only one was female (out of 11) and 83% had worked for longer than five years. Ninety two percent of HSAs had a weighing scale, but only 75% had ORS and Vitamin A, 58% had Albendazole and 50% had iron tablets. The HSA is sustainable within the MOHP system, but their job descriptions, efficiency and performance could be improved in order to enhance the effectiveness of this vital position in bridging the gap between the HF and communities.

The ways in which the CSP could collaborate to improve the performance of the HSAs are:

- Improve the frequency and quality of supportive supervision received by the HSAs.
- Review and revise the job description of the HSAs and improve coordination of their use by multiple programs.
- **Ensure that HSAs have an Essential Health Package (ORS, iron, Albendazole and Vitamin A, etc.)**

iv. Training

The CSP uses the cascade approach to training, with CSMC members trained to train HF staff or HSAs. HSAs are responsible for training and supervising CHVs, who then provide education to community members. There is a great deal of overlap in these levels, as CSMC members sometimes directly train CHVs and HSAs provide education to community members. This strategy has been effective in reaching a large audience and surpassing training objectives, but during the second half of the project, a greater emphasis will be required on ensuring the quality of replication at all levels.

The MTE KPC survey showed increased knowledge and change in some behaviors as demonstrated by project indicators on pages 5-11. LQAS results also showed increases in project indicators.

Topics for community education should be determined by interest and need, focusing on one or two topics in each session, rather than providing an overwhelming amount of information in a single session. **Define themes for education messages by HSAs and CHVs based on a district IEC/BCC plan which includes disease patterns (months of high cholera prevalence), upcoming campaigns or activities (vaccination campaigns) or specific problems identified in the community (low existence of latrines).**

Training coupled with supportive supervision has been shown to be the most effective way to increase health workers' abilities. Training needs to be viewed more as a part of a process, not an isolated activity as the panacea for solving all problems. There is concern on the part of the MOHP that excessive amounts of training interfere with the normal staff workload.

d. Sustainability Strategy

The CSP did not use the CSSA sustainability framework during DIP formulation, but bases sustainability on five pillars:

1. Financial - implementation of a cost ward and spectacle shop within the Nsanje District Hospital and strengthen financial management systems.
2. Behavioral - maintaining positive health behaviors within the family and the community by demonstrated effectiveness of behaviors and the involvement of men in health decision making.
3. MOHP structure - focusing on systems improvement provides the DHMT with sustainable improvements to increase efficiency and effectiveness of services.
4. Community structure - strengthening intra community coordination both by forming a network of volunteers and by integrating the health committee into the larger village structure.
5. Links to MOHP - through strengthening the referral system and links via the HSAs and zone supervisors.

In February 2004, seven persons participated in a discussion on sustainability during a technical assistance visit by IEF's Program Director. There was limited participation from the DHMT due to scheduling constraints. The purpose of the orientation was to introduce concepts of sustainability and initiate steps towards developing a District Sustainability Plan. Group discussions were used to stimulate thinking about sustainability including the following points:

- Why discuss sustainability?
- What is sustainability?
- What are the critical components of sustainability?
- Based on what we are doing – what do we want to sustain, and why?
- What are we doing now that supports sustainability?
- What can we do to further our sustainability efforts?
- What do we need to know to develop a plan for sustainability?

The key concepts of the Child Survival Sustainability Assessment framework were also introduced.

The short time and inability of the DHMT to fully participate limited the effectiveness of the discussions. No follow up has taken place since the organizational assessment and

discussion on sustainability took place. Given that the major training activities in IMCI are now completed, the CSP will resume the development of a plan for capacity building with the DHMT and to develop a realistic sustainability plan in early 2005.

During interviews with groups of mothers during the MTE, when asked how they have been able to support CHVs, the principal response was to follow their advice; little focus was found on helping them financially (labor sharing strategies). However, when mother were asked how health activities could be continued in the future the three most common responses were: the Community to continue practicing healthy behaviors (7); the VHC should continue providing health messages (6) and, Coordination among community members (5). These observations fit within the sustainability framework of the CSP of focusing on strengthening the community structure and maintaining positive health behaviors at the household level.

Project participants and village volunteers were asked during the MTE about the desire to sustain activities and their ideas on how that could be done. Suggestions included; doing piece work to have enough money to buy ITNs, and work sharing to motivate CHVs and to provide them with enough time to do health activities. Some VHCs are experimenting with establishing a family quota for health emergencies and small income generating projects such as tree nurseries and gardens. This concepts need to be further explored with villages so that they also focus on strategies for sustaining activities. The potential for financial sustainability of services in these villages is extremely limited.

The CSP proposed two mechanisms for cost recovery in the DIP 1) cost wards in the Nsanje District Hospital, and 2) an eyeglass shop. The hospital has identified some potential rooms for renovation, but much planning remains to be done. IEF has been working with the MOH at the Lions Eye Unit of the Queen Elizabeth Central Hospital in Blantyre and the IEF sponsored eyeglass production workshop began production in June. A wider plan to market glasses in the districts is being developed and should start in early 2005. Both of these activities have been slightly delayed, but will be a focus of the project during the next two years.

C. PROGRAM MANAGEMENT

1. Planning

The DIP was developed in a participatory manner during a workshop conducted in Nsanje. Twenty-one people participated in the workshop included members of the CSMC and a representative from World Vision and Africare. The workshop analyzed KPC survey results and streamlined strategies for implementing the project. The DIP has been shared with all project partners and there is general understanding of project objectives. Being the project "roadmap," the DIP is used as a reference guide for all activities, especially for the monitoring of activities.

The work plan of the DIP has been implemented on schedule except for the introduction of BCI methods (PD Hearth and BEHAVE Framework) and Quality Assurance activities. Both of these activities will be completed during the second half of the project. The Drug Revolving Funds will not be implemented.

There are mechanisms in place for annual, quarterly and monthly planning. The monthly planning process could be more participatory if all actors met together and planned as a group, rather than presenting individual plans which are then summarized. It is unusual that a project follows the DIP as closely as this project has. Given the ambitious number of activities in the DIP especially the roll out of C-IMCI training, and the complexity of the supervision, and monitoring, the workplan provided good guidance for the first two years. Some of the major planned activities were not implemented on time based on judgments made by the CSP team, e.g., VCT. While the DIP is the official work plan of the program, the environment in which a project is implemented changes over time and flexibility is needed to adjust to new opportunities and challenges. Program monitoring data should be used for revising program implementation plans during the remainder of the project time period.

2. Staff Training

IEF staff has taken advantage of various training opportunities. Many of the staff had previously worked in another IEF USAID funded health project, so they came to the CSP with substantial experience. One of the weaknesses of staff training is the lack of a training plan, based on an assessment of project needs and staff abilities. Adequate funds are available for staff training.

The IEF Maternal and Child Health Trainer attended a 5-day international workshop organized by WHO/AFRO, focusing on the implementation community IMCI. The workshop took place in Blantyre during May of 2003. The goal of the workshop was to train

IMCI facilitators on specific techniques, procedures and tools for community interventions to improve child health, growth and development.

The Child Survival Project Manager along with the Nsanje District Environmental Health Officer attended a 5-day, CORE-sponsored workshop in May of 2003. The workshop focused on the use of qualitative research to improve child health programs. The workshop included why and when qualitative research techniques are appropriate as well as how qualitative research findings can and cannot be used.

Two project staff participated in a workshop organized by the National AIDS Commission of Malawi. The purpose of the workshop was to develop national indicators for HIV/AIDS. In addition, participants designed a format for consistent reporting on HIV/AIDS activities in the country.

The IEF Malawi Country Director and IEF HQ Child Survival/Vitamin A Coordinator participated in the Mini University at Johns Hopkins University in June of 2003.

Other training received by IEF staff included: IMCI case management 11 day training; Proposal writing 2 days; Quality Assurance Training of Trainers 10 day, and PD Hearth 5 days.

Assess training needs for all IEF staff based on project objectives. Project Manager should receive additional mentoring/training in management, especially budget management.

3. Supervision of Program Staff

Supervision of project staff was reported to be adequate. There is no supervision schedule or supervision form but all staff felt they received adequate support, with appropriate frequency, to be able to complete their job responsibilities. There are frequent meetings between the Project Manager and other staff for problem solving.

4. Human Resources and Staff Management

All staff has written job descriptions, but there is not a comprehensive personnel policy manual for the IEF Malawi office even though policies are covered with contracts and written memos. Personnel policies such as leave allowance, hardship allowance and benefits need to be clearly documented to ensure transparency and clarity for all employees. **IEF Malawi should develop a personnel policy manual which includes employee benefits, policies, and procedures.**

Staffing problems for the MOHP were previously discussed but staffing has also been problematic for IEF. Because Nsanje District is perceived as a 'hardship post,' retention of qualified staff has been difficult. Three staff hired to fulfill IEF technical advisor positions resigned within three months of their employment, citing other opportunities in better locales as the reason for leaving. For over a year, two critical staff positions were vacant. IEF currently has a full complement of planned staff, but the MCH and IMCI coordinators were recently hired respectively 2 and 3 months ago. Staff morale and motivation is low and staff retention may continue to be a problem.

IEF Malawi provides a severance package for staff when the project ends, amounting to one month of salary for each year they worked for the project. No other severance benefits are anticipated, but an attempt will be made to retain employees for other projects, if possible. Three of the current staff were retained from a previous project.

5. Financial Management

IEF's Director of Administration and Finance visits the project annually to ensure compliance with IEF accounting practices and financial management. The Director of Administration and Finance provided an orientation to the new Country Director, and provided refresher training to IEF staff at the beginning of the project. He also performs an annual internal audit, assuring that bookkeeping is properly and fully completed according to IEF and USAID policies. An annual external A-133 audit is also completed at IEF headquarters.

The organization uses a Quicken accounting system to track project expenditures. To guarantee that project expenditures are completely accounted for, all payments are made by check. In conjunction with the Country Director, the Project Administrator is responsible for the project's financial management. The Project Administrator has many years of service working with IEF and is well trained and experienced in the use of the Quicken system, along with IEF procedures and policies. There are no banking facilities available in Nsanje, making financial transactions difficult.

Budget management needs to be decentralized from the Blantyre office, with greater exchange of information and shared decision making between the Blantyre and Nsanje offices. Technical assistance for the Project Manager in budget management would increase her effectiveness as a manager.

6. Logistics

The principal procurement issue which limited project implementation was the delayed purchase of a project vehicle, which was not completed until 2004. The government of Malawi imposed an obligatory 40% excise tax over-and-above the regular duty tax on the

purchase of goods. This substantially increased procurement costs and the project's solution to this problem was to stall the purchase of the more expensive items in the budget until a wavier could be obtained. Now that this issue has been resolved, there should be no other logistics challenges for the remainder of the project. The only other large purchase to be made is motorcycles for use by Zone Supervisors.

7. Information Management

The Monitoring and Evaluation plan of the CSP consists of:

- Knowledge Practice and Coverage (KPC) survey, using a 30 cluster sample at baseline, MTE, and final, and the use of Lot Quality Assurance Sampling (LQAS) every six months beginning in 2004.
- Health Facility Assessment at baseline and final.
- IMCI, integrated, and community supervision used for monitoring.
- Health Management Information System (HMIS) of the MOHP.
- Training reports after each training event.
- Organizational Capacity Assessment for DHMT and DOSA for IEF.

Four baseline surveys were conducted during the first year of the project: KPC survey (11/02); Health Facility Assessment (2/03); Community Health Workers survey (4/03); and a second Health Facility Assessment focusing on service provision and IMCI performance. The three survey reports were included in the DIP.

In June 2003 an IMCI survey was conducted in 12 HFs to provide baseline information on outpatient services provided for children prior to district wide implementation of IMCI for evaluating the impact of IMCI training. Integrated supervision visits were conducted during February and September of 2004.

A LQAS was conducted as part of a training exercise in April 2004 using selected questions from the KPC 30 cluster baseline survey. A three-day training on the methodology was attended by 17 IEF staff, HSAs, and Zone Supervisors. The CSP plans to continue using the LQAS sampling methodology every six months as a monitoring tool. Suggestions for simplifying the process were made during the MTE and included 1) Using a "spin the bottle" technique for selecting the random household rather than community mapping, 2) Only include a subset of indicators based on a prioritization of activities during each LQAS, and 3) Incorporate the interviews within the monthly supervision visits of the Zone Supervisors

The CSP has an adequate system for collecting information including the MOHP official HMIS which has been recently revised. The weakness is the lack of systematic use of information for decision making at all levels. The need to strengthen the information

system was previously discussed as an important step in capacity building for the DHMT and also at the community level.

One of the problems identified during the MTE was the lack of techniques for the clear presentation of data and the use audience segmentation to identify specific needs for reporting and information sharing which leads to decisions being made and actions being taken. **Train DHMT/IEF on techniques for presenting data to enhance the use of information for decision making.**

This is directly related to the need to strengthen how information is shared between people and organizations. **Create a "library" for reports, documents, statistics that is accessible to everyone.**

To avoid a band-aid approach, it will be necessary to review the information system as a whole, particularly the HMIS. As the official system for the nation, the accuracy of information being used in the system needs to be verified as well as educating people on how best to use the information, not simple reporting it to the next level. **Conduct a review of the HIMS to verify the quality of data being collected and processed, and encourage the use of data for decision making at the district and HF levels.**

The use of information for decision making at the community level also needs to be strengthened. This was previously discussed in B.2.a. Community Mobilization.

8. Technical and Administrative Support

The following technical assistance has been received by the project to date:

Date	Who provided	Purpose
September 2002	IEF's Director of Programs	Assist in the hiring process of the CS project Technical Advisors, as well as provide an initial orientation to project stakeholders
September-October 2002	IEF's Child Survival and Vitamin A Coordinator	Develop a baseline KPC instrument, as well as to conduct KPC training for KPC team members
February 2003	IEF's Director of Programs	Orient the new IEF Country Director to IEF policies and procedures, as well as overall programming in Malawi
March - April 2003	IEF's Child Survival and Vitamin A Coordinator	Conduct a DIP orientation workshop for the DHMT and IEF staff, and to write the DIP
February 2004	IEF's Director of Programs	Conduct Institutional Assessment and develop Sustainability Plan
May 2004	Consultant	Train IEF, DHMT and other MOHP staff in the PD Hearth methodology
October 2002	IEF's Director of Programs	Participate in the Mid Term Evaluation

The technical assistance received was reported to be helpful and timely. Communication between the IEF Malawi Country Director and IEF Headquarters Director of Programs is frequent and supportive, both by email and telephone. In the original project proposal IEF anticipated having two staff members to provide technical assistance to the Malawi project. Since that time, the Child Survival and Vitamin A Coordinator has resigned and not been replaced. IEF's Director of Programs is providing technical support to the CSP. He devotes approximately 15-20% of his time to the project.

The primary technical assistance need in the future is for IEC/BCC to define what the appropriate integration between IEC and BCC should be for the CSP to best complement the Nsanje District implementation plans.

D. CONCLUSIONS AND RECOMMENDATIONS

The IEF/DHMT team is implementing a good quality project in close compliance with the DIP and generally in line with the work plan. Some activities have been delayed due to staff shortages at both IEF and the MOHP. The strong points of the CSP thus far are:

❖ Population coverage - increased well beyond original targets.

❖ VHC-development - of health committees is good step towards improving community structure for sustainability.

❖ ITNs - the CSP has contributed to a wider national movement to make a significant impact on prevalence of malaria

❖ Supervision - introduction of concepts and tools for supportive supervision has changed the paradigm of supervision as a policing action.

❖ Focus on Systems - the analysis and improvement of operational systems is a sustainable way to use resources more effectively and efficiently.

The focus during the next two years should be on:

- Continued focus on systems improvement.
- Implementation of Quality Assurance tools for systems analysis and improving quality of care at HFs.
- Investigation of needs for IEC and BCI activities in order to have the most impact in the district, focusing on improving nutrition behaviors.
- Increased emphasis on HIV/AIDS activities.
- Implementation of the cost sharing activities of cost ward and spectacle shop.

All stakeholders interviewed during the MTE, including community members, reported an increased demand for services. The increased demand places increased pressure on the MOHP system due to lack of staff. The solution to this problem is outside the scope of this project, but has been the most important barrier to implementation during the two years of the CSP and will continue to be the primary barrier in the future. The challenge for the project during the next two years will be a continued emphasis on supportive supervision, systems improvement, and a focus on improved quality while working within the constraint of limited health personnel. The CSP should also work more closely, where possible, with the District level actors (Agriculture, Water, Education, and Community Development) under the DEC and DCs office to improve collaboration of resources focused at the community level.

A participatory evaluation was carried out by a 14 person team comprised of representatives of the DHMT, IEF Malawi, IEF Headquarters, other NGOs, and an external evaluator. The majority of the recommendations included in this document were written by the team, some additional recommendations were added by the external evaluator. The priority recommendations for improving implementation of the CSP during the next two years are:

1. Continue IMCI Facility Based training during the next two years, plus HH/C-IMCI training for people who did not receive the initial training. A one-day orientation to IMCI should be used to train support staff which are not directly responsible for IMCI implementation (drivers, clerks, Ward and Patient Attendants, administrative staff).

2. Introduce Quality Assurance strategies and tools to be used in strengthening ongoing IMCI supportive supervision.

3. Design and implement a referral system, including a referral form for use by HFs and a community referral procedure based on the official child/maternal health card (Health Passport).

4. Organize a review meeting for all stakeholders in nutrition programs to understand what is currently being done in order to develop a concrete plan for CSP involvement.

5. Strengthen and implement a comprehensive behavior change communication strategy on HIV/AIDS including VCT and PMTCT.

6. Conduct a review of the planned need for ITNs and of the management system of the sale of ITNs in communities and HFs.

7. Evaluate the number, distribution and frequency of Under 5 immunization clinics (static and mobile) to determine whether gaps remain which limit access by communities.

8. Leaders of different village committees should be encouraged to meet and outline modalities to coordinate their activities.

9. Identify well-functioning VHCs to be involved in sharing their experiences.

10. Strengthen follow-up and supportive supervision of CHVs by CSMC, HSAs and Zone Supervisors. Modify the system of community supervision to include VHCs as supervisors within their own community.
11. Identify mechanisms to encourage coordination at the village level of all community health volunteers.

12. Clarify the job descriptions of all community health volunteers.

13. Develop a system for sharing information with the villages using maps and/or information recorded in poster form at the village level to stimulate action planning

14. Liaise with BCI Coordinator to identify, procure and distribute IEC materials for use by CHVs, HSAs, and Health Facilities.

15. Develop and implement a comprehensive IEC/BCI plan for the CSP, including PD Hearth, the BEHAVE Framework, or other appropriate methodologies.

16. It is recommended that IEF Malawi conduct an institutional assessment and strengthening plan, similar to the process proposed for the DHMT.

17. A mechanism for information sharing and to enhance coordination between principal organizations in the district; NGOs, DHMT, and CHAM facilities, should be initiated by IEF.

18. Monthly meetings between IEF and DHMT should be planned on a set day and time through out the year for planning and monitoring project activities.

19. Introduce Quality Assurance strategies and tools to conduct systems analysis to determine what the root problems are in each system, what aspects are working well, and how systems can be improved to be more efficient and effective.

20. A comprehensive study should be made of the transportation system to determine how improvements can be made.

21. Determine why materials/supplies are inadequate in some HFs and identify the solutions to those problems, including the timely requisitioning of drugs and other supplies.

22. Identify the HFs needs for equipment and office supplies essential for the implementation of the CSP; procure, distribute and monitor those supplies. (CSP to make initial purchase of files, hole punches, staplers, papers, and staples).

23. Train DHMT/IEF on techniques for presenting data to enhance the use of information for decision making.

24. Create a "library" for reports, documents, statistics that is accessible to everyone.

25. Conduct a review of the HIMS to verify the quality of data being collected and processed, and encourage the use of data for decision making at the district and HF levels.

Other important recommendations are:

1. Clarify the role and function of the GMV and increase the number of trained GMVs.

2. In order to enhance the effectiveness of IMCI there is a need to supply durable, washable, visible IMCI flow charts for the wall of each HF, and a small personal copy for principal HF staff. Each HSA needs portable, durable IEC materials to use during home visits in villages to teach danger signs for common illnesses.

3. The role of the BFSG in promoting PMTCT (Prevention of Mother To Child Transmission) is unclear and needs to be strengthened in the future.

4. The CSP should investigate why the Intermittent Presumptive Treatment of malaria for pregnant women did not increase during the last two years.

5. Strengthen hygiene promotion activities to target hand washing instead of general promotion of latrines and rubbish pits.

6. The strategy of Revolving Drug Funds should not be pursued during the second half of the project due to a change in the political climate and time constraints and focus instead on piloting HSA's medical kits.

7. CHVs and HSAs need reinforcement on their communication skills i.e. adult learning and facilitation. This could be accomplished through supportive supervision visits and feedback after actual education sessions.

8. A sustainable system should be designed to conduct in-house IMCI training for the remaining untrained staff as efficiently as possible.

9. IEF Malawi should develop a personnel policy manual which includes employee benefits, policies, and procedures.

10. IEF should continue the on the job training for the District Accounts Clerk.

11. Define themes for education messages by HSAs and CHVs based on a district IEC/BCC plan which includes disease patterns (months of high cholera prevalence), upcoming campaigns or activities (vaccination campaigns) or specific problems identified in the community (low existence of latrines).

12. Ensure that HSAs have an Essential Health Package (ORS, iron, Albendazole and Vitamin A, etc.)

13. Assess training needs for all IEF staff based on project objectives. Project Manager should receive additional mentoring/training in management, especially budget management.

E. RESULTS HIGHLIGHT

Two years ago, the International Eye Foundation and the District Health Management Team (IEF/DHMT) introduced a Child Survival Project in the southern district of Nsanje bordering Mozambique. Nsanje district (population 200,000) is notorious as a very hot place full of mosquitoes, due the low-lying areas next to the Shire River running the length of the district. Malaria accounts for 39% of patient cases and is the leading cause of morbidity and mortality of children under five in the district.

The major thrust of the child survival project during the first two years has been the implementation of facility and community-based Integrated Management of Childhood Illness (C-IMCI) through the training of health providers and community volunteers and a system of supportive supervision. One focus of the project is to promote malaria prevention and use of Insecticide Treated Bed-Nets (ITNs). The project works with Village Health Committees to select and train community members and form ITN committees.

After the training of the ITN committees, there was a huge change in the peoples' perception of malaria. The committees teach community members on the causes and prevention of malaria focusing on the dangers to pregnant women and children under five. The project also helps increase the availability of ITNs at the rural health facilities and in the community. More than 18,000 ITNs, provided by UNICEF, PSI, IEF, and other NGOs were provided to health facilities and village ITN committees for distribution.

- The percentage of mothers reporting the presence of a bed net in the house increased from 29% to 64% in less than two years
- The percentage of children 0-23 months who slept under an ITN the night before the survey increased from 17% to 52% in less than two years.

KPC survey data 2002 and 2004

The increased availability of ITNs at low price ($0.50 to $1.00) has resulted in more people buying and using ITNs, and the demand is increasing each day. After two years of the project's assisted implementation, about 52% of mothers with young children report sleeping under an ITN.

During a recent visit to one ITN committee, a member commented that *"less children are visiting the health facility due to malaria today than two years ago, we are safe at last."* Many more people understand the benefits of using bed nets, and there is growing confidence that the demand for ITNs is increasing as knowledge and access to a reliable supply continues to improve.

F. ACTION PLAN

The MTE report highlights the progress made towards results to date, uncovering areas of challenge, and evaluating stakeholder concerns at all levels. The CSP is developing an Action Plan ensuring that there is a high degree of participation from all stakeholders. After the final report is received a planning process will be carried out. The DHMT and other key district actors (District Planning Officer) will convene a planning meeting to 1) review the report and the recommendations, 2) reach consensus on recommendations, prioritize and clarify where needed, and 3) define activities, establish time lines, responsibilities, and budgets. A summary work plan document will be drafted, reviewed, and forwarded to IEF for submission to USAID by the end of November.

G. ATTACHMENTS

A. **Baseline information from the DIP**

B. **Evaluation Team Members and their titles**

C. **Evaluation Assessment methodology**

D. **List of persons interviewed and contacted**

E. **Results of the Evaluation**

F. **Project Data Sheet form**

G. ATTACHMENTS

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A. Baseline information from the DIP

No substantial changes have been made in the IEF/DHMT Child Survival Project in southern Malawi since the approval of the DIP. A few minor changes include:

- Elimination of Drug Revolving Funds
- Increase in total population coverage from 194,000 to over 200,000 people

B. Evaluation Team Members and their titles

Name	Position	Organization
Hellen Phallaza	HIV/AIDS Coordinator	Africare Project
Renee Charleston	Team Leader	Consultant
Kennedy Ndau	MCH Coordinator	DHMT
Edna Tembo	Project Manager	IEF
Elton Chiumia	HIV/AIDS Advisor	IEF
Frank Chola	Administrator	IEF
Geoffrey Ezepue	Country Director	IEF
George Mekiseni	Monitoring & Evaluation Advisor	IEF
Henry Dzuwalatsoka	MCH Advisor	IEF
Hopson Ntenthaonga	IMCI Advisor	IEF
John Barrows	Director of Programs	IEF USA
Kalima Chikafa	Clinical Officer	MOHP
Dikilani Chadza	Health Inspector/Zone Supervisor	MOHP Ndamera HC
Peter Benson	Health Coordinator	World Vision International

Participated only in the Analysis Workshop

Hans J. Richter	Head of Medical Department Lulwe & Chididi HCs	CHAM
Kennedy Chikonde	DHO	DHMT
Wasili Mathumula	DEHO	DHMT

C. Evaluation Assessment Methodology

I. Objectives of the Evaluation

The purpose of the Midterm Evaluation was to;

1. Assess progress in implementing the DIP.
2. Assess progress towards achievement of objectives or yearly benchmarks.
3. Assess if interventions are sufficient to reach desired outcomes.
4. Identify barriers to achievement of objectives, and
5. Provide recommended actions to guide the program staff through the last half of the program.

The evaluation was carried out in accordance with Child Survival and Health Grants Program USAID/GH/HIDN/NUT mid term evaluation guidelines (MTE) dated August 2004 and the evaluation report follows the suggested format.

The objectives of the evaluation were to:

- Identify the principal achievements of the project, focusing on which strategies are most effective and the barriers encountered and how they were addressed during implementation.
- Develop recommendations for improving project strategies in order to achieve greater impact during the next two years.
- Develop recommendations on whether to pursue certain interventions to full scale during the next two years.
- Develop recommendations on how to obtain sustainability in all aspects of the project.

II. Composition of the Evaluation Team

The team was composed of IEF Malawi staff, an IEF Headquarters' representative, MOHP staff, representatives from Africare and World Vision, plus an external consultant who served as team leader. The team leader was responsible for coordinating all evaluation activities, supervision of the teams, meeting all specified objectives, collaborating with IEF and MOHP, and submitting a draft and a final report according to the defined timeline. Three team coordinators functioned as the coordinators of the teams for field data collection, including overall coordination, planning and logistical support of the team.

III. Methodology

Using both a participatory approach and participatory methodologies, a multi-disciplinary term of key project stakeholders examined the implementation of CS activities using a variety of qualitative methodologies. Field visits allowed project participants and community volunteers to provide their inputs and suggestions to the evaluation process.

Questionnaires were developed to collect information from mothers, GMVs, BFSG, HSAs, VHC, and HF staff through individual or group interviews. Two indicators from the KPC survey were also shared with community mothers and VHCs using a participatory methodology to stimulate discussion about project activities, barriers to change and sustainability of activities. The evaluation focused on the process of activities including; District Health Management Team organization and team building, planning, information use and feedback, IMCI capacity building, supervision, referral, logistics and monitoring systems, community participation, coordination with all partners, quality of services and sustainability issues.

The methodologies used to obtain information for the evaluation included:

- Document Review, Key Informant Interviews, and Group Interviews

IV. Evaluation Plan

The evaluation was divided into four phases:

Phase I - Planning

- Preplanning (Formation of team, logistics, document review, selection of communities)
- Planning Workshop (Content, methodologies, design of instruments, review of KPC)

Phase II - Data Collection

- Community visits
- Visits to Health Facilities, including 2 hospitals
- Visit to District Office
- Other interviews
- Document review

VILLAGES AND HEALTH FACILITIES VISITED BY THE EVALUATION TEAM

	Day 1 *Friday Oct 8*	*Day 2* *Saturday Oct 9*
	SOUTH ZONE	***BOMA ZONE***
Team 1 Franck Chola* Geoffrey Ezepue Kalima Chikafa Peter Benson George Mekiseni	Tizola Kumbukani Mbenje Health Center	Nkhutche Kaledzera Chididi Health Center
	BANGULA ZONE	***TENGANI ZONE***
Team 2 Henry Dzuwalatsoka* John Barrows Hopson Ntenthaonga Dikilani Chadza	Laiton Chadzuka Kalemba Health Center	Mpamba Mthembwe Tengani Health Center
	MAKHANGA ZONE	***MLOLO ZONE***
Team 3 Edna Tembo* Elton Chiumia Kenneth Ndau Hellen Phallaza Renee Charleston	Mbingwa Nkolimbo Makhanga Health Center	Kanyelamalo Gundani Trinity Hospital

* Team Coordinator

Phase III - Data Analysis

- Team members summarized and presented field observations
- Analysis of information by the evaluation team (2 day Analysis Workshop)
- Outputs from the Analysis Workshop

Phase IV - Presentation

- Written report
- Action plan to be developed after report is finalized
- Debriefing of USAID Malawi Mission

The evaluation team was divided into 3 smaller groups to collect information from the field. Each team consisted of 4-5 people. The teams were in the field for 2

days to visit 12 communities and 5 Health Centers (in 6 supervision zones) selected for visits. Communities were selected using a stratified random process. The area of Misamvu in Bangula Zone was removed from the sampling frame due to the difficulty in traveling there.

During the Field Visits the following people were interviewed:

- 228 Mothers in 12 villages
- 12 HSAs
- 7 GMV
- 11 BFSG
- 80 Members of 12 VHCs
- 5 Health Facilities visited to interview 16 Health Staff
- Other interviews were conducted with DHMT and IEF staff and 6 Zone Supervisors. See Attachment D for a complete list of people interviewed.

A two-day Planning Workshop was held for all team members to review the results of the KPC and to develop methodologies and instruments for identifying the actual project situation through interactive field visits to communities and MOHP health facilities and the CHAM hospital.

A two-day Analysis Workshop was held for all team members plus additional resource people to present the results of the fieldwork and to formulate recommendations for the next two years.

V. Evaluation Schedule October 2004

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
4 Evaluation Planning	5 * Planning Workshop	6 * Planning Workshop	7 District Office Visit Interviews	8 * Field Work	9 * Field Work	10 Preparation of Workshop
11 IEF Office Visit Interviews	12 District Office Visit Interviews	13 * Preparation of findings	14 * Analysis Workshop	15 * Analysis Workshop	16 Wrap up and de-briefing	17 Travel

- All of the Evaluation Team was present

Planning Workshop Agenda

October 5, Tuesday

8:00-8:30	Welcome - Introduction of Participants
8:30-9:30	Participatory Evaluation
9:30-10:00	Tea Break
10:00-12:30	Presentation of CSP
12:30-1:30	Lunch
1:30-3:00	Ideal Situation - Small Groups
3:00-3:15	Tea Break
3:15-4:15	Plenary

October 6, Wednesday

8:00-8:30	Evaluation Content
8:30-10:00	Formulation of Questions - Small Groups
10:00-10:30	Tea Break
10:30-11:30	Formation of Teams - Team Leaders
11:30-12:30	Summary of KPC Survey
12:30-1:30	Lunch
1:30-2:30	Development of Methodology for KPC
2:30-3:30	Review of Interviewing Skills
3:30-4:00	Next Steps

Analysis Workshop Agenda

October 14, Thursday

8:30-9:00	Experiences in the field
9:00 – 10:00	KPC Gallery Walk
10:00 - 10:30	Review of Information
10:30 - 10:45	Tea Break
10:45 – 12:30	Small Groups by IRs
Define Actual	Situation
12:30 – 1:30	Lunch
1:30 – 3:00	Develop Recommendations
3:00 – 3:15	Tea Break
3:15 - 5:00	Plenary

October 15, Friday

8:00- 9:00	Continuation of Plenary
9:00 – 10:30	Small Groups
	Cross cutting Issues
10:30 – 10:45	Tea Break
11:00 - 1:00	Plenary
1:00 - 2:00	Lunch
2:00 - 2:30	Five Stars
2:30 – 3:30	Cycles of Development
3:30 – 4:00	Additional Recommendations
4:00 - 4:30	Tea Break
4:30 - 5:00	Evaluation and Closing

VI. Evaluation of the Process

Fourteen evaluation team members completed a written evaluation of the MTE process, during the Analysis Workshop. The results from the questionnaires were:

- 7/14 (50%) of participants felt that the process used was very effective, and 7/14 (50)% that it was effective.
- Two people felt that the step of reviewing the finalized questionnaires before using them was missing.
- What people liked best about the process was the participatory nature of the evaluations, the open discussions, and the methodology of comparing the ideal situation to the actual situation. Various team members also mentioned the field visits as what they liked best.
- The majority of participants said there was nothing that they liked least. Several people felt the time for the evaluation was too short.
- 7/14 (50%) felt the content of the evaluation was an effective way to focus the evaluation on sustainability. 6/14 felt the content was very effective and 1 person felt the content was little effective.
- 8/14 people felt that the evaluation process was applicable to their work, 5/14 felt it was very applicable, and 1 person felt it was little applicable.
- The main suggestion for improving the process in the future was to identify the most critical indicators to include in the evaluation, to involve a greater mix of team members and more DHMT staff and an HSA representative.
- Other comments included that it had given strength to the partners, and that they felt they had gained a lot of knowledge and that is had been a positive learning process.

D. List of persons interviewed and contacted

The following people were interviewed during the MTE. In addition 228 mothers, 16 HF staff, 80 VHC members, 12 HSAs, 6 GMVs, and 11 BFSG were also interviewed.

Name	Position	Organization
Mr. Malunga	District Humanitarian Officer	District Assembly
Kennedy Chikonde	District Health Officer	MOHP/DHMT
Kennedy Ndau	Maternal Child Health Coordinator	MOHP/DHMT
Wasili Mathumula	District Environmental Health Officer	MOHP/DHMT
Izak Phiri	District Nursing Officer, Nsanje Hospital	MOHP/DHMT
George Mlolo	Malaria Coordinator	MOHP/DHMT
Kalima Chikafa	IMCI Coordinator	MOHP/DHMT
Mr. Kandulu	BCI Coordinator	MOHP/DHMT
M. Sosono	HIV/AIDS Coordinator	MOHP/DHMT
Frank Chola	Administrator	IEF
Geoffrey Ezepue	Country Director	IEF
George Mekiseni	Monitoring & Evaluation Advisor	IEF
Edna Tembo	Project Manager	IEF
Elton Chiumia	HIV/AIDS Advisor	IEF
Henry Dzuwalatsoka	Maternal Child Health Advisor	IEF
John Barrows	Director of Programs	IEF/USA
Hopson Ntenthaonga	IMCI Advisor	IEF
Henry Tsamdoka	Zone Supervisor	Mlolo Zone
Martin Sempulo	Zone Supervisor	Makhanga Zone
Ovious Chauluka	Zone Supervisor	Bangula Zone
Richard Martin	Zone Supervisor	Tengani Zone
Rose Kapitapita	Zone Supervisor	Boma Zone
Dikilani Chadza	Zone Supervisor	South Zone
William Allen	Administrator	Trinity Hospital
Mexon Nyirongo	Health and Nutrition Program Officer	USAID Malawi

E. Results of the Evaluation

IR 1. District Organizational Effectiveness and Management Support for Quality Child Care Strengthened.

	Ideal Situation	Actual Situation	Recommendations
Materials	• Office supplies • Office equipments i.e. Computers, printers, fax, email, etc • Vehicles • Motorcycles • Manuals, checklists, questionnaires, other tools • Display case for glasses • Ophthalmic equip/supplies • Equipment/supplies for cost ward	District Most supplies are available but have occasional shortages especially at the Health Center i.e. punches, staples, files etc. Equipment Chronic lack of functioning ambulances and utility vehicles. Six zones have motorbikes but repairs and replacements are required. Many HSAs have pushing bicycles but spares are a problem. Manual + checklist Manuals, checklist, supervisory tools are available. General documents, reports, schedules are available, but some could be widely available for distribution.	Identify the HF supply needs for office supplies, procure, distribute and monitor (CSP to make initial purchase of files, punchers, staplers, papers and staples) Equipment • Continue to request new vehicles from central MOH. • Employ full-time mechanic for district • Examine and revise, if needed, policies and procedures for vehicle use. • Repair or replace zone supervisors' motorcycles. • Establish policies for HSAs purchase of bicycle and establish a spare part revolving fund.
Human Resource	• Motivated and aware: • DHMT, CSMC • CO, MA, Nurses, OMA, HSAs, VHCs, Volunteers • Consultant for sustainability, BCC, QA/PI, Epi Info/data entry	• COs, MAs, Nurses Account Clerks are very few at District Hospital level and Health Facility. Urgently needed. • Sufficient HSAs, there is need to replace those that are lost.	• Procure one photocopy machine and other equipment to serve CSP • Create "library" for reports, documents, statistics that is accessible to everyone.

Systems	Planning, Supervision, Monitoring/Evaluation, Logistics (EPI, drugs, maternity, ITNs, vehicle maintenance), Accounting/budgeting/management Communication/coordination	• There is on going planning, supervision, monitoring and coordination supported by CSP. HIMS on going but problems with data entry and analysis + use. • Most drugs and vaccines are available but experience shortages due to national availability and lack of transport. • ITNs are supplied direct by PSI to facilities. • Maintenance of vehicles is done locally but very costly to District budget. • Basic Accounting (manual) system is in place and managed by clerk but need more staff. • Communication:- the district has improved access to telephone, radio messages but internet and email is limited.	• Conduct review of HIMS and data collection then processing and using data for decision at district and HF level. • Conduct review of management system of ITNs • Continue on job training for district accounts clerk.
Activity	• Conduct surveys, assessments (KPC, LQAS, HFA etc) • Conduct training/orientation DTC/DA, CSMC, DHMT, District forum • Train Accountant • Conduct Annual Review meetings (Analysis, work plans etc) • Conduct supervision visits • Monitor zone activities.	The district has conducted a variety of surveys, assessments; Annual Review meetings etc. There has not been District wide Forum to discuss health.	Quarterly district forums where all stakeholders (technical) and NGOs representatives.

IR2. Health Provider Skills in Prevention and Management of Childhood Illness Improved

	Ideal Situation	Actual Situation	Recommendations
Materials	Health cards, Weighing scales, MUAC tapes and Height Board, Functioning Fridge with Thermometer, Cotton wool, Gauze, Thermometers, Drugs (IMCI), Respiratory Rate Timer/second hand watch., IMCI Guidelines, Desk/Table, cups of different sizes, buckets, spoons, Syringes, Cooler boxes, |Bicycles, Posters, Referral forms, Registers, HIMS, Drug boxes, Inventory sheets, Radio communication, Vehicles, Vaccines.	Most materials were available with erratic supplies on: vaccines, health cards, bicycles, stationary, register, IEC materials, Iron tabs, and village maps.	• Find out why these materials are inadequate by conducting rapid + random assessment. • Encourage HF staff to order adequate materials + drugs in time • Each HSA should be given his/her own bicycle and should be maintained by him/her • Encourage/advise HSA to have the map for his/her catchment area. • The DHO should budget according to the District requirements.
Human Resource	Trained IMCI Providers, Trainers/Supervisors, HSAs, Home craft workers, Hospital servants/ward attendants, Drivers, Clerks, GMVs, VHCs, TBAs, BFSGs, Traditional Healers, Drug Vendors.	Trained in IMCI available but inadequate. Partially trained: Drivers, Traditional Healers, Hospital servants, Drug Vendors, Clerks.	• Plan to train the remaining cadres (driver, clerks, Hospital servants, Drug Vendors and Traditional Healers) on HH/C-IMCI.
Systems	• Capacity building • Quarterly Supervision (monitoring) • Monthly Drug Delivery form • CMS – Health Units • Referral System (Community to HF and HF to Hospital)	Most are operational/done but: quarterly supervision inadequate, feedback from Health facility to community not done, referral forms not available.	• Referrals form should be devised and staff be oriented. • Implement planned activities as planned and share responsibilities and strengthen coordination among project staff and partners.
Activity	• Under five clinics (daily, weekly) * • IMCI (quarterly) Assessments • Trainings of different cadres • Establishment of DRFs • Timely Drug ordering • Health Education • Meetings with partners.	Most activities done except: • Training of the hospital servants, Traditional Healers, Drug Vendors. • Establishment of DRF. • Meetings with partners not regularly done	• Train all the remaining cadres

IR3. Availability and Accessibility to Quality Preventative and Curative Health Services Increased

	Ideal Situation	Actual Situation	Recommendations
Materials	• Drugs • Syringes • Needles • Cleaning agents • Consumables -cotton wool, gauze • Sterilizers, Thermometer, BP machines, Weighing scales • Medical equipment –Forceps, Scissors • Health Education Materials: Posters, Leaflets • HIV/AIDS Testing: Drug boxes, ITN • Patient cards • Amby bags • Vaccines • Cold chain system: Refrigerator, Cooler boxes, Vaccine carriers • Transport: ambulance, motor bike, pushing bikes, lorries • Stationery: forms, registers	Most materials were readily available except vaccines, ITNs, Transport system (bicycles), Stationary. Other materials were not investigated eg. Cleaning agents, sterilizers, and instruments.	• Coordinate transport system for supplies. • Procure more ITN • Evaluate ITN revolving system
Human Resource	DRs, COs, Nurses, HSAs, CHVs, Pharmacy Technicians, Lab Technicians, Administrators, Accountants, Support staff, (Clerks, drivers, Cleaners, Patient attendants, Ward Attendants).	At Health Facility level, Human Resources are not adequate. At community level, most community volunteers are available except GMVs that are still inadequate.	• Train more GMVs • Clarify job description of community health volunteer

Systems	• Referral system • Feedback • Communication • Logistic • Transport • Inventory (record system at District Hospital with Health Centers) • Maintenance	All the systems are in place but they are not functioning as expected except the communication system.	• Produce uniform referral forms • Coordinate transport system
Activity	Trainings on: • IMCI • PD Hearth • Behave • Counselors/VCT • Conducting clinics • Scheduling immunization • Supervision • Procure, distribute, store • Mobilization of communities, patients, staffs. • Coordinating activities • Conduct PD Hearth sessions	• IMCI and supervision activities have been done effectively. • PD Hearth has partially been done • Conducting clinics, immunizations, ITN distribution, coordinating activities are on-going but needs much strengthening.	• Train community and introduce PD Hearth model • Continue IMCI training • Scheduled community activity plan should be distributed to communities concerned early. • Coordination at village level of all community health volunteers. • Organize a review meeting for all stake holders in nutrition programs to appreciate what is on the ground and make future plans. • Strengthen and implement comprehensive behavior change communication strategy on HIV/AIDS including VCT and PMTCT

IR4. Community Participation, Ownership, and Demand for Health Services Increased.

	Ideal Situation	Actual Situation	Recommendations
Materials	• ORS sachets • 25 l water buckets • 1 l jar • 250/500ml cups • Teaspoons • ORT Room • Benches • Tables • DTC Register • Writing materials • Basin • Soap/ashes • Running tap • Bucket fixed with tap • IEC materials eg. Posters • 0.5% stock solution of HTH	Most materials are available except for stationery and IEC materials (Benches, Tables, Soap, Teaspoons, basins were not assessed)	• Liaise with BCI Coordinator to identify, procure and distribute IEC materials • Essential materials/equipment to be monitored [ORT materials] • Maintain availability of stationary.
Human Resource	• Health workers • Extension workers eg. HSAs, VHCs, CHVs, TBAs, GMVs, Local leaders,, Care takers, Administrator and Drivers	At Health Facility there were few Health Workers trained and manning the Health Facilities. At community level, there are trained CHVs but not fully discharging their duties.	• Regular follow up and supervision to CHVs • Managers, Supervisors, Administrators to motivate staff to be dedicated.

<table>
<tr><td>Systems</td><td>Communication transport
Referral
Record keeping
Monitor
Procurement
Recruitment
Distribution
Supervision
Co-ordination</td><td>Most aspects of the system are in existence but require concerted efforts to improve. There is critical shortage of health workers at facility level.
Inadequate information sharing affecting the system.</td><td>Improve on communication and coordination among stakeholders.
Introduce and use referral forms
Continue monitoring/supervision
Keep track of records
Proper timely requisition of drugs
Ensure that HSAs have Essential Health Package (ie ORS, Fe, Albendazole and Vit A.)</td></tr>
<tr><td>Activity</td><td>Community mobilization
Health Education
Conduct village census
Conduct training to VHCs in HH/C-IMCI
Conduct training to HSAs in HH/C-IMCI
Follow – up and supervision
Conduct area health meetings
Conduct adult learning/facilitation skills
Procure and distribute ORT equipment
Train Health workers in IMCI
Train staff in Behave
Conduct formative research
Solicit IEC materials and distribute
Develop strategies and materials
Monitor and evaluate.</td><td>Most activities were conducted and others are on-going, ie facilitation skills for adult learning, area health meetings.
BFSG and GMVs roles not well defined.
Folllow-up/ supervision by HSAs to CHVs inadequate
Soliciting and distribution of IEC materials has not been taken place.
Behave and formative research not done.
Insufficient number of health workers trained in IMCI.
Inadequate supply of ORS.
Not all the trained CHVs are holding meetings and some do not know what to impart to community members.</td><td>Regularize supervision and follow-up to CHVs.
Solicit and distribute IEC materials for use by CHVs, and Health Facilities
Train staff in Behave (i.e HSAs and Health Workers)
Continue IMCI Facility based training.
Conduct meetings with CHVs.
Managers and Supervisors to continue monitoring and supporting staff
Have laminated posters that last
Review IEC materials inventory
Identify, procure and distribute IEC
Enhance use of information system.</td></tr>
</table>

KPC FEEDBACK—MOTHERS

Team 1		
ACTIVITIES	**BARRIERS**	**HOW TO SUSTAIN**
	ITN	
• Supply and availability of ITN • Relatively low price of ITN • High Health Education on malaria • Formation of ITN committees	• Lack of knowledge • Low income • Presents of alternatives like burning cow dung • Negative attitude • Priority to buy food	• Sustain supply + availability at village level • Reduce price to K50 as Health Facility based • Continue health education
	HIV	
• Health Education through drama • Training session to VHC	• Stigma • Cultural practices sexual diseases • Reluctant to change • Shyness	• Stop ritual cleansing. • Modify ritual practices that promote HIV through use of herbs.
Team 2		
	ITN	
• Increased Health Education messages • Trained ITN committees • Trained VHC	• Lack of money • Inadequate IEC • Large families • Uncomfortable to sleep under a net • No interest • Fear of unknown • Use net for fishing • Prioritize food/ nets	• Mass nets re-dipping • Do piece work to find money for nets • Continue giving Health Education • The poor to be given free nets

HIV/AIDS		
• Training of VHCs • Drama shows • Increased Health Education	• Pretending not to know • Inadequate IEC messages • No interest to HIV/AIDS messages • Not free to express themselves • Lack of knowledge • Not believing that HIV is real	• Give Health Education on condom use and HIV/AIDS • Advice to be given to stubborn people • Hold village meetings to discuss HIV/AIDS issues • Encourage shy ones to talk about HIV/AIDS during discussions
Team 3		
ACTIVITIES	**BARRIERS**	**HOW TO SUSTAIN**
ITN		
• Education through GMVs and VHCs • Increased knowledge on ITN importance	• Lack of money • Women don't attend health education meetings	• Reduce ITN prices • Continue education on ITNs
HIV/AIDS		
• HH/C-IMCI • IEC through drama	• Women usually don't attend meetings • Messages are not clear	• Men & VHC to encourage women to attend Health Education meetings. • Messages given to community be clear.

KPC FEEDBACK--VHC

Team 1		
ITNs		
ACTIVITIES	**BARRIERS**	**HOW TO SUSTAIN**
• Health Education • Accessibility to cheap ITNs • Train sessions to VHCs	• Lack of knowledge on dangers of malaria • Low income levels	• Increases IEC • Increase supervision by HSAs
HIV/AIDS		
• Health Education • Training sessions imparted knowledge on HIV/AIDS	• Lack of knowledge • Shyness	• Increase IEC • HIV/AIDS messages door to door • Increase women participation in drama • Promote VCT before sexual cleansing
Team 2		
ITN		
• Reduce net prices • Easy access to nets	• Inadequate IEC • Lack of money • Use of cow dung	• The poor to be given free nets • Continue Education on ITNs • Committees to continue selling nets • Net should be readily available at the community
HIV/AIDS		
• Trained VHC	• Not affected and/infected • Most people do not accept young people to give HIV/AIDS messages • No interest	• Older people should be involved in giving out HIV/AIDS messages • Prefer external education

Team 3		
	ITN	
• HH/C-IMCI • Establishment of ITN committees • Reduce ITN prices	• Poverty • Negligence • Ignorance • Mozambicans purchase nets for fishing • Inadequate supply of ITNs	• Reduce ITN price • Continued education through village headmen's reinforcement • Restrict Mozambicans from buying nets (put tough measures) • Increase ITN supply
	HIV/AIDS	
• HH/C-IMCI • Education through drama groups • Meetings with community leaders	• Poor attendance when Health Education meetings are organized (cultural beliefs) • Not interested in the messages during meetings	• Intensify IEC • Community leaders should be actively involved in educating the community.

Cross Cutting Issues

Sustainability		
What have we done	**What needs to be done**	**Recommendations**
• Trainings i.e IMCI Facility Based and HH/C-IMCI. • Supervision and Planning skills workshop • Supervision • Zonal system enhanced (supervision prominent) • Quarterly meetings	• Information sharing to be enhanced • Participation of Community Health Volunteers in supervision. • Zonal meetings/Area Health meeting. • Exchange visits (i.e VHC toVHC and DHMT to other DHMT)	• Modify the system of community supervision to include VHC. • Identify well-functioning VHCs to be involved in exchange visits. • Review and strengthen information sharing system. • Reinforce adult learning and facilitation skills through supervision.
Communication		
What have we done	**What needs to be done**	**Recommendations**
• Training Community Health Volunteers • Provided IEC materials to some Community Health Volunteers • Partial supervision • Meetings – Community Health Volunteers, HSAs (DHMT/IEF/CSMC	• Refresher courses to Community Health Volunteers • Improve on supervision • Distribute IEC materials to all Community Health Volunteers. • Improve on how HSAs use IEC materials on daily basis • Provide feedback to the Community Health Volunteers.	• Refresher courses – CHV, HSAs, on communication skills • Strengthen supervision of CHVs by DHMT, IEF. • Train DHMT/IEF on varieties of presenting data (Information). • Implement targeted messages based on community interest and need.
Coordination		
What have we done	**What needs to be done**	**Recommendations**
• Providing trainings • Quarterly Integrated supervision • Quarterly zone meetings • Coordination meetings quarterly (stakeholders)	• Regulate quarterly zone meetings • The VHCs should identify other committees that exist in their village. • Leaders of village committees should be encouraged to meet regularly. • HSAs should identify Extension Workers and plan work together • Include a concept of coordination in all training	• Leaders of different village committees should meet and outline modalities to coordinate their activities. • Strengthen quarterly meetings. • Hold monthly meetings between IEF and the DHMT on a set day and time for planning and monitoring project activities

F. Project Data Sheet form – MTE Updated Version

Child Survival Grants Program Project Summary
Mid Term Submission: Nov-08-2004
IEF Malawi

Field Contact Information:
First Name: Dr. Geoffrey
Last Name: Ezepue
Address: Laws Road (Between Ryalls Hotel & Gov. Hotel Training School
PO Box 2273
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E-mail: ief@malawi.net
Project Web Site: www.iefusa.org

Project Information:

Project Description:	The International Eye Foundation (IEF), in collaboration with the District Health Management Team (DHMT) of Nsanje District, Malawi, is implementing a four-year child survival project entitled "Improved Child Survival in Nsanje District, Malawi, Through Community-Based Interventions and Strengthening of the Health Delivery Infrastructure." The project is creating synergy between the DHMT, heath facilities and the communities they serve. Health worker performance and the health system are being strengthened through Integrated Management of Childhood Illness strategies, both clinical and community based activities. New supervision and monitoring systems are functioning a 6 Supervision Zones. Health interventions include immunization, vitamin A, nutrition, diarrhea, pneumonia, malaria, and HIV/AIDS. New interventions such as Voluntary Counseling and Testing, use of the Behave framework, and PD Hearth are being utilized. The project is stimulating coordination between different district departments, such as Agriculture, Community Development, and Water, as well as, coordination between villages and health facilities. Innovative sustainability strategies to generate income from a "cost ward" and sale of eyeglasses are being introduced.
Partners:	The main partners are the District Health Management Team, 2 hospitals (1 MOHP and 1 semi-private), 11 health centers, and 8 health posts. At the community level, the project is working with a network of 184 Health Surveillance Assistants, and a network 513 Village Health Committees, 1,096 community volunteers and traditional healers. IEF is also collaborating with Malawi-based NGOs such as the Christian Hospital Association of Malawi, Population Services International (for the provision of bed nets), and the National AIDS Commission, and other.
Project Location:	The project is located in Nsanje District, in the southern extreme of the Lower Shire Valley. The district is one of the poorest districts in the nation, and has many of the country's poorest health indicators. The 1998 national census shows Nsanje District's total population at 194,481 (census 1998), but the district estimates over 230,000 persons (unofficial census).

Grant Funding Information:

USAID Funding:(US $)	$1,112,811	**PVO match:(US $)**	$1,082,667

Target Beneficiaries:

Type	Number
0-59 month old children:	33,000
Women 15-49:	45,000

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
5%	95%

General Strategies Planned:
Strengthen Decentralized Health System
Strengthen Decentralized Health System

M&E Assessment Strategies:
KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Organizational Capacity Assessment for your own PVO
Participatory Rapid Appraisal
Lot Quality Assurance Sampling
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation) KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Organizational Capacity Assessment for your own PVO
Participatory Rapid Appraisal
Lot Quality Assurance Sampling
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:
Interpersonal Communication
Peer Communication
Support Groups Interpersonal Communication
Peer Communication
Support Groups

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (General) Field Office HQ CS Project Team US HQ (General) Field Office HQ CS Project Team	(None Selected)	Pharmacists Traditional Healers Private Providers Pharmacists Traditional Healers Private Providers	Dist. Health System Health Facility Staff Dist. Health System Health Facility Staff	Health CBOs CHWs Health CBOs CHWs

Interventions:

Immunizations 5 **%**
** IMCI Integration
** CHW Training
** HF Training
Nutrition 10 **%**
** IMCI Integration
** CHW Training
** HF Training
Vitamin A 3 **%**
** IMCI Integration
** CHW Training
** HF Training
Micronutrients 2 **%**
** CHW Training
** HF Training
Acute Respiratory Infection 20 **%**
** IMCI Integration
** CHW Training
** HF Training
Control of Diarrheal Diseases 15 **%**
** IMCI Integration
** CHW Training
** HF Training
Malaria 20 **%**
** IMCI Integration
** CHW Training
** HF Training
Breastfeeding 5 **%**
** IMCI Integration
** CHW Training
** HF Training
HIV/AIDS 20 **%**
** CHW Training
** HF Training

Indicator	Numerator	Denominator	Estimated Percentage	Confidence line
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	0	0	0.0	0.0
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	0	0	0.0	0.0
Percentage of children age 0-23 months whose births were attended by skilled health personnel	188	300	62.7	5.3
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	227	300	75.7	5.3
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	48	73	65.8	11.0
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	38	43	88.4	9.6
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	94	160	58.8	7.8
Percentage of children age 12-23 months who received a measles vaccine	121	160	75.6	6.4
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	156	300	52.0	6.0
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	208	300	69.3	5.7
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	46	118	39.0	9.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	199	300	66.3	5.0